

Mid Essex Hospital Services NHS Trust

Inspection report

Broomfield Hospital
Court Road, Broomfield
Chelmsford, Essex
CM1 7ET
Tel: 01245362000
www.meht.nhs.uk

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

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

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust

Requires improvement 

Are services safe?

Requires improvement 

Are services effective?

Requires improvement 

Are services caring?

Good 

Are services responsive?

Requires improvement 

Are services well-led?

Requires improvement 

Are resources used productively?

Inadequate 

Combined quality and resource rating

Requires improvement 

Summary of findings

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

Background to the trust

Mid Essex Hospital Services NHS Trust was established as an NHS Trust in 1992. The trust provides local elective and emergency services to 380,000 people living in and around the districts of Chelmsford, Maldon and Braintree. The trust, based in the city of Chelmsford in Essex, employs nearly 5,000 staff, and provides acute services from five sites in and around Chelmsford, Maldon and Braintree. There are 21 inpatient wards and 502 inpatient beds at the main Broomfield hospital site.

Referrals are taken from 10 CCGs across the East of England. The trust also provides a county-wide plastics, head and neck and upper gastrointestinal (GI) surgical service to a population of 3.4 million and a supra regional burns service to a population of 9.8 million.

The trust is a part of the Essex Success Regime launched in 2015 with the aim of addressing the pressures on the local health and care system by tackling the gaps in clinical staffing, meeting the growing health demands of the population and enabling the system to achieve financial balance. In December 2016, the boards of the three acute trusts (Mid Essex Hospital services NHS Trust together with Basildon and Thurrock University Hospitals NHS Foundation Trust, and Southend University Hospital NHS Foundation Trust) decided to enter into a formal collaborative governance framework and contractual joint venture. This allows the organisations to plan services and make decisions together, whilst remaining three independent statutory organisations with their own boards and councils of governors (or equivalent). In November 2017, a public consultation started that included the option of the potential merger of all three acute trusts, this ended in March 2018. A draft business merger case is now being considered.

We previously inspected the trust in June 2016 under our comprehensive methodology and rated the trust as good overall. We conducted a focussed inspection of the urgent and emergency care services in February 2017 to follow up on specific concerns in the paediatric ED.

We inspected the trust under our current methodology in September 2018. We inspected the core services of urgent and emergency care, medical care, surgery, children and young people's services, diagnostic imaging and outpatients' services. A well led inspection took place in October 2018 and we issued requirement notices.

Overall summary

Our rating of this trust went down since our last inspection. We rated it as Requires improvement  

What this trust does

Mid Essex Hospital services NHS Trust provides acute services at five locations throughout Essex.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Summary of findings

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected six of the acute services provided at Broomfield hospital by this trust as we had concerns about the quality of the services due to the information that we held and had been shared by external stakeholders. This inspection was also a part of our continual checks on the safety and quality of healthcare services.

We also inspected the well-led key question for the trust overall. We summarise what we found in the section headed Is this organisation well-led?

What we found

Overall trust

Our rating of the trust went down. We rated it as requires improvement because:

- We rated safe, effective, responsive and well-led as requires improvement, and caring as good.
- We rated one of the trust's six services we inspected as inadequate and five as requires improvement. In rating the trust, we took into account the current ratings of the four services not inspected this time.
- We found inconsistencies in safety practices amongst the core services and an inconsistent approach to leadership.
- There were not effective processes in place to ensure that learning from serious incidents was shared and embedded to minimise the risk of re-occurrence.
- Individual teams did not have strategic plans in place to allow them to develop their services. Staff told us that this was due to the focus on plans for the potential merger with two other local NHS trusts and awaiting approval for the clinical reconfiguration. This meant that should either of the plans experience delay the services did not have clear plans for the future.
- There had been a significant churn in the executive management team since our last inspection. This had affected the leadership's team ability to implement their governance improvement plan.
- There had been significant issues with the implementation of a new electronic patient management system in May 2017. This had affected the trust's ability to deliver reliable validated information in regard to some key performance indicators.

However:

- The trust was focussed on planning for the future in line with sustainability and transformation plans.

Our full inspection report summarising what we found and the supporting Evidence appendix containing detailed evidence and data about the trust is available on our website –

Summary of findings

Are services safe?

Our rating of safe went down. We took into account the current ratings of services not inspected this time. We rated it as requires improvement because:

- Urgent and emergency care, surgery, children and young people's services, outpatients and diagnostic imaging were rated as requires improvement. Not all staff had mandatory training including safeguarding training. There were inconsistent safety practices across areas including safeguarding, records management, risk assessments and infection prevention and control.
- Medical care was rated as inadequate. There was a significant decline in safety practices since our last inspection. Staffing remained a challenge and the processes to ensure that temporary staff were competent in roles was not consistently followed.

Are services effective?

Our rating of effective went down. We took into account the current ratings of services not inspected this time. We rated it as requires improvement because:

- Urgent and emergency care and medical care were rated as requires improvement. There was not an effective process in place to support services to improve patient outcomes through audit.
- Outpatients and diagnostic imaging were not rated in line with our methodology.
- Surgery and children and young people's services were rated as good for effectiveness.

Are services caring?

Our rating of caring stayed the same. We took into account the current ratings of services not inspected this time. We rated it as good because:

- Urgent and emergency care, surgery, children and young people's services, outpatients and diagnostic imaging were rated as good.
- However, medical care was rated as requires improvement. Workforce challenges meant that staff did not always have the capacity to deliver compassionate care.

Are services responsive?

Our rating of responsive went down. We took into account the current ratings of services not inspected this time. We rated it as requires improvement because:

- Urgent and emergency care, surgery, outpatients and diagnostic imaging were rated as requires improvement. Patients could not always access care and treatment in a timely manner.
- Medical care was rated as inadequate. Access and flow was a significant concern and staff vacancies were high. The processes for ensuring that temporary staff were competent to carry out roles was not consistently applied.
- Services for children and young people were rated as good.

Are services well-led?

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

- We rated well-led at the trust as requires improvement overall. This was a decline from the last inspection. The trust is in a state of transition and significant churn in the senior leadership team has delayed development and improvement plans in key areas of governance and accountability. The trust is developing strategies to improve infrastructures however these are yet to be formalised and embedded.

Summary of findings

- The overall future strategy for the proposed merger had not been translated into meaningful and measurable plans at all levels of the trust. Staff were not always aware of their role in achieving the overarching strategy.
- There was a mixed culture in the trust. Most staff felt respected and valued in their roles, however some staff felt that the processes in place to explore grievances was not supportive or equitable. There were teams working in silos and some managers and clinicians were openly defensive when presented with concerns.
- There was limited progression with strategies related to succession planning. The trust did not have an established programme in place to ensure that leadership remained compassionate, inclusive and consistent to support the delivery of a strategy.
- Risks, issues and poor performance were not always addressed appropriately or quickly enough.
- Medicines optimisation was not given sufficient representation at performance and accountability meetings and executive level. This created a potential gap in escalation of concerns or areas for improvement.
- Information to measure performance and inform decisions on areas for improvement was not always available or accurate.

However:

- The trust worked well with external stakeholders to develop plans for the future provision of services in line with the local health care economy plans.
- The trust had undergone a recent review of governance systems by an external party and had developed plans in line with the recommendations and the future business model.
- Managers in all areas of the trust were engaged with recruitment initiatives to meet the required workforce establishment.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

We inspected the diagnostic imaging services as an additional service and whilst we rated these services, we did not aggregate these with ratings for core services ratings.

Outstanding practice

We found examples of outstanding practice in surgery and children and young people's services.

For more information, see the Outstanding practice section in this report.

Areas for improvement

We found areas for improvement including four breaches of legal requirements that the trust must put right. We also found 26 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement or to improve the quality of services.

For more information, see the Areas for improvement section of this report.

Summary of findings

Action we have taken

We issued three requirement notices to the trust. That meant the trust had to send us a report saying what action it would take to meet these requirements.

Our action related to breaches of three legal requirements at trust wide level and breaches in medical care, surgery, diagnostic imaging and outpatients.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

We found the following outstanding practice:

Surgery

- The service was expanding its use of robotics to allow surgeons to perform complex procedures and more minimally invasive procedures.
- After trialling on Notley Ward, the service had rolled out enhanced support workers to work alongside nursing staff to support patients with complex needs.

Children and young people's services

- There was innovative use of various techniques, such as sensory equipment and animal handling, for stimulation, distraction and comfort for children with different emotional and physical needs.
- The trust funded staff in the neo natal unit to complete their post registration education (Qualified in Speciality).

Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve the quality of services.

Action the trust **MUST** take to improve:

Trust wide

- The trust must ensure that governance processes are consistent and embedded across all services. This is to support the delivery of a strategy and ensure that there are clear lines of accountability. Systems and processes must be in place to effectively audit key areas of operational delivery to ensure patient safety, quality of care and adherence to statutory requirements. There must be effective systems in place to audit performance and develop clear plans for improvement when identified. Regulation 17 (1)(2)(a)(b)(f).
- The trust must ensure that there are effective safeguarding systems and processes in place and embedded across all areas. Regulation 13 (1)(2)(3).

Summary of findings

- The trust must ensure that the medicines optimisation strategy is consistently applied across all areas. Systems and processes must be effective for proper and safe management of medicines in all areas. Regulation 12 (1)(2)(g).
- The trust must ensure that there are effective systems in place and a consistent approach to monitoring to ensure that induction and competency checks are completed in line with trust policy for temporary staff. Regulation 12 (1)(2)(c).
- The trust must ensure that there are effective and consistent systems in place to prevent and control the risk and spread of infection, including those that are health care associated. This includes processes to assess and detect infection. Regulation 12 (1)(2)(h).

Core services

Urgent and emergency care services

- The trust must ensure that staff mandatory, safeguarding and mental capacity training meet the trusts compliance targets.

Medical care

- The service must ensure patient care records are accurate, complete and contemporaneous. This includes consistent means of documenting sepsis risk and National Early Warning Scores, and a clear order to records.
- The trust must ensure there are sufficient numbers of nursing staff, on all medical wards, to keep people safe from avoidable harm and to provide appropriate standards of care and treatment.
- The trust must ensure there are effective systems and processes for safe medicines management.
- The trust must ensure there are effective systems and processes for learning from incidents and sharing this consistently among staff.
- The trust must ensure staff are competent; in particular, by ensuring agency staff have their induction and competencies signed off before starting in the service.
- The trust must ensure staff are up to-date in training on the mental capacity act (MCA)
- The trust must ensure there are effective governance and risk management processes.
- The trust must ensure discharge processes are safe, including that there are appropriate care plans in place and that patients have their correct medicines with them before discharge.

Surgery

- The trust must ensure staff dispose domestic and clinical waste correctly, in line with national guidelines and trust infection prevention and control policy.
- The trust must ensure there is an accurate, complete and contemporaneous record for every patient.
- The trust must ensure learning from incidents is consistently shared amongst wider teams and embedded into clinical practice.

Children and young people's services

- The trust must ensure systems and processes are in place for effectively referring and investigating children safeguarding concerns effectively.
- The trust must ensure that all relevant staff are up to date with safeguarding children level three training.

Outpatients

Summary of findings

- The trust must ensure that there are clear processes in place to store and manage controlled stationery (prescription forms).
- The trust must ensure that there are effective systems in place to maintain oversight in relation to referral to treatment times to ensure that patients are safe to wait and all patients are identified to receive appointments.
- The trust must ensure that there are effective processes in place to share from learning incidents.

Diagnostic imaging

- The trust must ensure that systems are in place to ensure that staff are able to identify and respond appropriately to changing risks to people who used services. The trust must ensure that the environment within diagnostic imaging is appropriate to provide safe care and treatment, including access to emergency buzzers.
- The trust must ensure that there is an effective process for governance, risk management, information management and performance management.
- The trust must ensure that effective processes are in place for the management of consumable stock and carrying out checks on the environment and equipment.
- The trust must ensure effective processes are in place for the timely completion of diagnostic reports.
- The trust must develop a formal harm review process for patients who have experienced delays.
- The trust must ensure that non-radiology staff who report images are competent to undertake this role and that the quality of their reports is reviewed.
- The trust must ensure that mandatory training attendance improves to ensure that all staff are aware of current practices.
- The trust must ensure that the service improves the time taken to investigate complaints in line with its complaints policy.
- The trust must ensure that patient group directions are regularly reviewed.
- The trust must ensure that systems and processes to maintain cleanliness and control infection are consistently implemented and documented.

Action the trust should take to improve

We told the trust that it should take action either because there were minor breaches that did not justify regulatory action, to avoid breaching a legal requirement in the future, or to improve services.

Trust wide

- The trust should ensure that complaints are managed in line with trust policy and that feedback from complaints is used to improve services. (Regulation 16).
- The trust should consider improving the succession planning and talent management processes in line with national recommendations.

Urgent and emergency care:

- The trust should ensure that reception staff are trained and competent in recognition of red flag signs and symptoms, to allow for timely escalation of critically unwell or injured patients who self-present to the emergency department (Regulation 12).
- The trust should ensure the designated mental health room is safe and fit for its designated purpose (Regulation 15).

Summary of findings

- The trust should ensure that recruitment continues to meet the needs of the department (Regulation 18).
- The trust should ensure they complete, monitor and update action plans in relation to the Royal College of Emergency Medicine (RCEM) audits (Regulation 17).
- The trust should consider how to improve the average time patients wait for treatment in the emergency department and the overall time patients are in the department before they are discharged or accepted into the hospital as an inpatient (Regulation 12).
- The trust should consider ways to meet the RCEM standard that the department provides a minimum of 16 hours consultant presence each day.

Medical care

- The trust should ensure it improves its local audit schedule to ensure areas of risk are closely monitored, such as record keeping and call bells (Regulation 17).
- The trust should consider arrangements for attendance at regular mortality and morbidity meetings for every medical speciality to ensure learning from deaths is embedded, consistent and timely.
- The trust should consider improving forums for staff engagement to be more inclusive of all staff.

Surgery

- The trust should ensure that staff complete mandatory training in line with trust targets (Regulation 12).
- The trust should ensure systems to report, record and investigate incidents are robust (Regulation 17).
- The trust should ensure service risks are effectively identified and documented on the risk register (Regulation 17).
- The trust should ensure that it reviews processes to ensure that patients are able to access surgical services in a timely manner (Regulation 12).
- The trust should consider ways to promote an open culture where staff feel confident to speak up about poor practice.

Children and young people's services

- The trust should ensure that effective systems are in place for checking of fridge temperatures and areas where medications are stored. Appropriate actions should be recorded when breaches are found (Regulation 12).

Diagnostic imaging

- The trust should ensure all staff receive an annual appraisal, in line with trust policy (Regulation 18).
- The trust should ensure that processes for incident reporting and learning are embedded (Regulation 17).
- The trust should ensure that the quality of reports is regularly reviewed through a discrepancy audit (Regulation 17).
- The trust should ensure that timely action is taken to resolve concerns regarding compliance with Ionising Radiation Medical Exposure Regulations IR(ME)R in areas outside of radiology (Regulation 12).
- The trust should ensure that the frequency of and attendance rates at discrepancy meetings is in line with national guidance, and that learning from discrepancy meetings is appropriately used (Regulation 17).
- The trust should ensure that service level agreements with third parties are effectively monitored (Regulation 17).
- The trust should consider developing a formal recovery plan to address diagnostic imaging reporting backlogs.
- The trust should review and continue to take action to address staffing levels in diagnostic imaging.

Summary of findings

- The trust should review processes to ensure that patients are able to access diagnostic imaging services in a timely manner.

The Regulatory action section at the end of this report details the legal requirements the trust did not meet.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated well-led at the trust as requires improvement because:

- The trust future strategy was dependent on external approval and yet to be implemented. In the interim, there was no clear current strategy that staff could identify with to support the delivery of the trust's vision. Staff and managers were not all aware of how they could contribute to the delivery of the future strategy.
- There was an experienced leadership team in place, however, there had been significant churn within the leadership team. This had an impact on the trust's ability to implement improvement plans and strengthen governance processes. There was no formal succession planning strategy in place.
- There was a mixed culture within the trust. There were some concerns that staff did not always feel as if their concerns were listened to and managed appropriately. The trust had recently appointed a new human resources director who was in the process of developing action plans to address key areas including Workforce Race Equality Standards.
- Whilst there was a governance structure in place – lines of accountability were not always clearly defined. There were gaps in reporting lines, which meant that there was the potential for risks not to be escalated appropriately.
- There was not a holistic approach to managing performance and data was not always accurate or reliable due to unstable infrastructures. The trust had not clearly assessed the risks related to the implementation of the new electronic patient management system to identify actions for mitigation.
- The senior leadership team had developed an engagement plan to strengthen communication with staff at all levels, however, this was yet to be embedded and feedback from staff on effectiveness was mixed.
- There was not a systematic approach to encourage divisions to ensure learning across the trust and improve quality and safety.

However:

- The board and executive management team had set clear values in conjunction with staff.
- The future strategy for the proposed merger and clinical reconfiguration had been developed with internal and external stakeholders. The trust had worked hard to ensure that they engaged with all key stakeholders in the development of the business case and had made changes to initial recommendations based on stakeholder feedback.
- The future strategy was aligned to wider plans in the health care economy in line with Sustainability and Transformation Partnerships.
- The board and senior leadership team were committed to achieving the trust's vision and future strategy.

Summary of findings

- Senior leaders spoke compassionately and proudly about the strength, commitment and character of their workforce team.

Use of resources

Please see the separate use of resources report for details of the assessment and the rating. The report is published on our website at .

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	↔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↔ Jan 2019	Requires improvement ↓ Jan 2019	Good ↔ Jan 2019	Requires improvement ↓ Jan 2019	Requires improvement ↓ Jan 2019	Requires improvement ↓ Jan 2019

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

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Broomfield hospital	Requires improvement ↓ Jan 2019	Requires improvement ↓ Jan 2019	Good ↔ Jan 2019	Requires improvement ↓ Jan 2019	Requires improvement ↓ Jan 2019	Requires improvement ↓ Jan 2019
Overall trust	Requires improvement ↓ Jan 2019	Requires improvement ↓ Jan 2019	Good ↔ Jan 2019	Requires improvement ↓ Jan 2019	Requires improvement ↓ Jan 2019	Requires improvement ↓ Jan 2019

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

Ratings for Broomfield hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↔ Jan 2019	Requires improvement ↓ Jan 2019	Good ↔ Jan 2019	Requires improvement ↔ Jan 2019	Requires improvement ↔ Jan 2019	Requires improvement ↔ Jan 2019
Medical care (including older people's care)	Inadequate ↓ Jan 2019	Requires improvement ↓ Jan 2019	Requires improvement ↓ Jan 2019	Requires improvement ↓ Jan 2019	Inadequate ↓ Jan 2019	Inadequate ↓ Jan 2019
Surgery	Requires improvement ↓ Jan 2019	Good ↔ Jan 2019	Good ↔ Jan 2019	Requires improvement ↓ Jan 2019	Requires improvement ↓ Jan 2019	Requires improvement ↓ Jan 2019
Critical care	Good Jan 2019					
Maternity	Good Jan 2019					
Services for children and young people	Requires improvement ↓ Jan 2019	Good ↔ Jan 2019	Good ↔ Jan 2019	Good ↔ Jan 2019	Requires improvement ↓ Jan 2019	Requires improvement ↓ Jan 2019
End of life care	Good Jan 2019	Good Jan 2019	Good Jan 2019	Requires improvement Jan 2019	Good Jan 2019	Good Jan 2019
Outpatients	Requires improvement ↔ Jan 2019	N/A	Good ↔ Jan 2019	Requires improvement ↓ Jan 2019	Requires improvement ↓ Jan 2019	Requires improvement ↓ Jan 2019
Diagnostic imaging	Requires improvement Jan 2019	N/A	Good Jan 2019	Requires improvement Jan 2019	Inadequate Jan 2019	Requires improvement Jan 2019
Burns and Plastics	Good Jan 2019	Good Jan 2019	Outstanding Jan 2019	Good Jan 2019	Outstanding Jan 2019	Outstanding Jan 2019
Overall*	Requires improvement ↔ Jan 2019	Requires improvement ↓ Jan 2019	Good ↔ Jan 2019	Requires improvement ↓ Jan 2019	Requires improvement ↓ Jan 2019	Requires improvement ↓ Jan 2019

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

Broomfield Hospital

Court Road
Broomfield
Chelmsford
Essex
CM1 7ET
Tel: 01245362000
www.meht.nhs.uk

Key facts and figures

There are 21 inpatient wards and 502 inpatient beds at the main Broomfield hospital site located in Chelmsford. The hospital serves a local population of approximately 380,000 people living in and around the districts of Chelmsford, Maldon and Braintree.

Referrals are taken from 10 CCGs across the East of England. The hospital is a major trauma unit and the trust also provides a county-wide plastics, head and neck and upper gastrointestinal (GI) surgical service to a population of 3.4 million and a supra regional burns service to a population of 9.8 million.

At Broomfield hospital there is a 24 hour emergency department for adults and children. A range of acute services for adults and children include urgent and emergency care, general medicine including elderly care and general and elective surgery. There are a range of outpatient services including specialist clinics.

March 2017 to February 2018, the trust saw:

- 83,845 inpatient admissions
- 599,288 outpatient attendances
- 101,115 A&E attendances
- 1,420 hospital deaths
- 214,872 bed days

Summary of services at Broomfield Hospital

Requires improvement  

We did not inspect all services at this inspection but we combined previous inspection ratings for those not inspected to give an overall rating for the hospital. We inspected urgent and emergency care, medical care, surgery, children and young people's services, outpatients and diagnostic imaging.

Our rating of services went down. We rated it them as requires improvement because:

- We rated safe, effective, responsive and well-led as requires improvement and caring was rated as good.

Summary of findings

- Our rating for safe remained the same. Staffing remained a challenge for the trust and the processes to ensure that temporary staff were competent for roles was not consistently applied. There were inconsistent practices in medicines management and record keeping.
- Our rating for effective went down to requires improvement. Local and national audits were not being utilised to drive improvements and improve patient outcomes, there was a lack of training for staff in the Mental Capacity Act, 2005.
- Our rating for caring remained the same. However, we found in some areas of medical care services, that staffing challenges limited staff's capacity to always deliver compassionate care.
- Our rating for responsive went down to requires improvement. There were significant issues with access and flow throughout the hospital. Patients could not always access care and treatment in a timely manner.
- Our rating for well-led went down to requires improvement. There were no clear strategies for individual services. Staff were unclear of how they could contribute to the development and delivery of long-term objectives. The trust was going through a period of transition and infrastructures were being developed and were yet to be implemented.

However

- The trust had developed plans with external stakeholders for future provision of services in line with national objectives to achieve sustainable quality care.

Urgent and emergency services

Requires improvement   

Key facts and figures

The emergency department is a member of a regional trauma network and offers immediate emergency and urgent care to the patients of Mid Essex providing a 24-hour, seven day a week service. The department has facilities for assessment and treatment of minor and major injuries and illness with 16 major cubicles, five resuscitation spaces, dedicated children's area, emergency nurse practitioner (ENP), and general practitioner (GP) led services. The emergency department is co-located with an acute medical unit (AMU) with 32 beds, 10 trolleys and two triage rooms; its purpose is to support patients who can be managed in a short stay environment without the need for onward admissions or an extended stay in hospital and a frailty unit who provide comprehensive assessment and management plans for the majority of frail complex elderly patients attending the department. There is an ambulatory care unit (ACU) and emergency short stay (ESS) ward, situated adjacent to the AMU that receive patients via the ED and GP referral, that are reported under medical care. However, we visited these areas as they are crucial to the access and flow within the ED. The emergency senior assessment team (ESAT), used a four cubicle area adjacent to the ambulance handover point to triage patients who arrived via the ambulance bay. The trust refers to Emergency Department and supporting units and staff under the umbrella term of the Emergency Village.

We used a variety of methods to help us gather evidence in order to assess and judge the emergency services at Broomfield Hospital. We spoke with 25 members of staff (including 15 nurses and six doctors), nine patients (eight adults, and one child) and seven relatives. We reviewed 34 patient records during this inspection, nine of which related to children. We interviewed the associate director of nursing (emergency care), interim clinical director and we spoke with professionally qualified and auxiliary staff. We observed the environment, checked the safety and currency of equipment, we looked at records in relation to patient's treatment and medication and do not attempt cardiopulmonary resuscitation (DNACPR). We also looked at a range of documents relevant to the service including policies, minutes of meetings, action plans, risk assessments, and audit results.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The service provided mandatory training in key skills but not everyone completed it. Staff told us that high levels of clinical demand meant that staff could not always be spared to attend training. The emergency departmental (ED) medical staff team compliance for mandatory training was below the 85% target set by the trust.
- The ED medical and nursing staff team compliance for safeguarding training was below the 90% target set by the trust.
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred, or discharged within four hours of arrival in the emergency department. The trust consistently failed to meet the standard and performed generally worse than the England average for the period August 2017 to July 2018.
- The trust reported that 31.2% of patients who required mental health services were treated within 60 minutes in July and August 2018. Patients attending requiring mental health input in July and August 2018, 63.3% were treated within four hours.
- From July 2017 to June 2018 the trust's monthly median total time in A&E for all patients was consistently higher than the England average, with a spike in December 2017 when the trust's monthly median total time in A&E for all patients was 232 minutes compared to the England average of 159 minutes.

Urgent and emergency services

- Reception staff were not trained in recognition of red flag signs and symptoms, which allow for timely escalation of critically unwell or injured patients who self-present to the emergency department.
- Audit and governance processes were not embedded within the department.
- There was a dedicated room within the ED for mental health assessments, which met most of the requirements of the Royal College of Emergency Medicine (RCEM) mental health tool kit for improving care in emergency departments, which states any assessment area needs to be safe for staff, and conducive to valid mental health assessment and importantly, the assessment room must be safe for both the patient and staff. However, the environment was not in line with all requirements of (RCEM), because the doors did not open both ways, which meant if a patient barricaded the room, staff would need to use force to enter the room.

However:

- Staff understood their responsibilities to identify and report incidents and safeguarding concerns.
- Staff from various teams worked well together as a team to monitor and improve patient care and outcomes.
- Patient feedback was positive, describing staff as 'kind and caring'.
- Staff described a developing positive culture within the emergency department, telling us they felt supported in their role.
- To improve mandatory training compliance the trust had employed a clinical facilitator to improve access to training for ED nursing staff.
- Staff maintained and checked resuscitation, sepsis, and airways trolleys daily, and we found these well maintained with no gaps in staff records.
- We reviewed the notes of nine children in relation to initial assessments, staff triaged the children within fifteen minutes of arrival including the assessment of pain complying with the standards for children and young people in emergency care settings set by the Royal College of Paediatrics and Child Health (RCPCH 2012).

Is the service safe?

Requires improvement ● → ←

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

- The service provided mandatory training in key skills but not everyone completed it. Staff told us that high levels of clinical demand meant that staff could not always be spared to attend training. The emergency department medical staff team compliance for mandatory training was below the 85% target set by the trust and none of the five members of eligible medical staff had completed medicine management training
- The emergency departmental staff team compliance for safeguarding adults training was below the 90% target set by the trust.
- Reception staff were not trained in recognition of red flag signs and symptoms, which allow for timely escalation of critically unwell or injured patients who self-present to the emergency department.
- There was a dedicated room within the ED for mental health assessments, which met most of the requirements of the Royal College of Emergency Medicine (RCEM) mental health tool kit for improving care in emergency departments,

Urgent and emergency services

which states any assessment area needs to be safe for staff, and conducive to valid mental health assessment and importantly, the assessment room must be safe for both the patient and staff. the environment was not in line with all requirements of (RCEM), because the doors did not open both ways, which meant if a patient barricaded the room, staff would need to use force to enter the room.

- The service did not always control infection risk well. The trust provided audit results of May, June and July 2018 at the time of our inspection. The ED did not meet the trust target for bedpan or commode audits for the three months reported. The ED did not meet the 95% trust target for cleaning of contaminated equipment in June or July 2018.

However:

- To improve mandatory training compliance the trust had employed a clinical facilitator to improve access to training for ED nursing staff.
- Staff understood their responsibilities to identify and report incidents and safeguarding concerns.
- Staff maintained standards of cleanliness and hygiene within the emergency department. Systems and processes generally effectively prevented and controlled the spread of infection.
- Staff maintained and checked equipment appropriately and the trust maintained a central record of equipment repairs and renewals. Staff checked resuscitation, sepsis, and airways trolleys daily, and we found these well maintained with no gaps in staff records.
- Staff consistently monitored and recorded medication fridge temperatures to ensure medicines were stored in a safe manner to protect their integrity.
- Patients arriving by ambulance had a dedicated route into the department, and ambulance staff reported to a streaming and triage process area.
- We reviewed the notes of nine children in relation to initial assessments and found that staff triaged the children within fifteen minutes, including pain scores. This was in line with national guidance.

Is the service effective?

Requires improvement ● → ←

Our rating of effective stayed the same. We rated it as requires improvement because:

- We reviewed ten policies and procedures on the trust intranet. not all policies were accessible to staff or were stored in the incorrect folder on the intranet.
- Managers monitored the effectiveness of care and treatment. there was limited evidence the trust use used the findings to improve care and treatment. The emergency department did not meet the Royal College of Emergency Medicine (RCEM) standards, they took part in the national audits but failed to use the results to drive improvements and improve outcomes, for example action plans were not monitored or followed up.
- Even though staff reported positive multidisciplinary team working across the department, the trust did not employ any mental health nurses at the time of our inspection and staff reported there were often delays in mental health patients accessing the necessary care due to delays in obtaining mental health specialist input.

However:

Urgent and emergency services

- Staff received regular appraisals. At the time of our inspection we requested updated data for appraisal compliance in the emergency department (ED). In August 2018, 94% of medical staff and 85% of nursing staff had received an appraisal against a trust target of 79%. During our inspection, staff assessed patient pain levels and provided pain relief in a timely manner.
- The emergency department worked effectively as part of a wider team and promoted effective multidisciplinary working with other specialities including physiotherapy, and occupational therapy
- Even though staff had not met the trust target for Mental Capacity Act training, the ED provided patients with information to manage their illness or condition and general health.
- Staff gave patients enough food and drink to meet their needs when safe to do so.
- We reviewed nine sets of paediatric notes, which demonstrated staff offered children pain relief within 20 minutes, if clinically required. We also observed that children were offered pain relief before interventions. This demonstrated compliance with the Royal College of Emergency Medicine management of pain in children (July 2013).

Is the service caring?

Good ● → ←

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

- Staff provided compassionate care to patients. Feedback from patients confirmed that staff had treated them well and with kindness and compassion.
- All the patients and relatives we spoke with told us that staff respected their privacy and dignity during their stay and that staff had been thoughtful in their approach and patients appreciated the way staff had cared for and treated them.
- Staff provided emotional support to patients to reduce their anxiety and distress as much as possible. The paediatric nurses used distraction techniques when supporting children.
- The emergency department (ED) staff communicated with and involved patients and relatives in the decisions about their care and treatment, whenever this was possible.
- The chaplaincy team provided emotional support 24 hours a day, seven days a week. All patients and visitors were encouraged to make use of chaplaincy facilities.

Is the service responsive?

Requires improvement ● → ←

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

- The Royal College of Emergency Medicine (RCEM) recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard between June 2017 to May 2018. The trust submitted no data for this metric from December 2017 to June 2018. From July to November 2017 the trust's performance for this metric was consistently worse than both the 60 minute standard and the England median. The median time from arrival to treatment in July 2018 this trust was 80 minutes.

Urgent and emergency services

- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred, or discharged within four hours of arrival in the emergency department. The trust consistently failed to meet the standard and performed generally worse than the England average for the period August 2017 to July 2018.
- The service took account of patients' individual needs, but was not always successful in meeting them especially for mental health patients. The trust reported that 31.2% of patients that required mental health services were treated within 60 minutes in July and August 2018. Patients attending requiring mental health input in July and August 2018, 63.3% were treated within four hours.
- Staff that we spoke with did not know of any examples of improvements or learning related to complaints.

However:

- During our inspection, we noted sufficient seating was available in all areas for patients and relatives. The reception areas were well equipped to provide food and drink as well as a dedicated phone line to enable patients to call a taxi service.
- The ED took account of patient's individual needs. Where possible staff made reasonable adjustments within the ED for patients, for example those living with a dementia, autism or a learning disability.
- From August 2017 to July 2018, the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was better than the England average in eight out of 12 months.
- Data supplied by the trust following inspection showed that from April 2017 to March 2018, the monthly median percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was generally below to the England average.

Is the service well-led?

Requires improvement ● → ←

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

- The emergency department (ED) did not have a clear strategy or vision.
- We observed little in terms of learning and innovation. It was apparent that the teams had been through a significant period of change and that the focus of the department had been to promote the safety of patients and appropriate staffing levels.
- The trust had problems providing accurate data on its performance for the period December 2017 to June 2018.

However:

- Staff worked together well and helped each other in an open, friendly, and professional atmosphere.
- The medical staff we spoke with regarded each other very highly, there was a level of mutual respect and challenge, and communication was effective in terms of sharing ideas and patient information.
- Senior managers that we spoke with during our inspection demonstrated they had a good understanding of performance across the department and gave examples of how performance was used to drive improvements across the service.
- The trust had a risk register and risks relating to the ED, most of the front-line staff knew the risks and their impact on the department.

Medical care (including older people's care)

Inadequate ● ↓

Key facts and figures

The trust provides a comprehensive medical service within an inpatient setting, 24 hours a day, seven days a week. Medical care at the trust comprises elements of both elective and unscheduled inpatient and outpatient work.

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All inpatient care is based at Broomfield Hospital site. Acute medicine is undertaken in the Emergency Village which comprises of an Acute Medical Unit (AMU), which is the primary route of admission and assessment for GP referred medical patients, and Emergency Short Stay (ESS) ward. The AMU comprises 12 assessment trolleys and 20 beds with the intention that length of stay should be less than 24 hours. The ESS consists of six ED observation beds, 12 frailty beds and the remainder is intended for up to 48-hour stays under acute medicine.

Other specialities include gastroenterology, with a contribution of consultant staff in the endoscopy suite, which falls under the medical division; cardiology, which includes an Angiography Suite and Cardiac Physiology Centre; outpatient dermatology and neurology, with a neurophysiology service on site; inpatient care of the elderly, stroke, endocrinology; and renal which includes inpatient and outpatient haemodialysis provision. The trust provides adult allergy and respiratory services including a small non-invasive ventilation (NIV) capability and outpatient lung function physiology. Each service manages general medical cases in addition to the specific medical specialities.

Medical care has 261 inpatient beds. The majority of the work is carried out at the Broomfield site with some outpatient clinics taking place at Braintree Community Hospital and St Peters Hospital Maldon. HIV services are based at Crompton Clinic in Chelmsford

(Source: Routine Provider Information Request (RPIR) AC1 - Acute Context)

During our inspection we visited Felsted, Baddow, Braxted, Writtle, and Goldhanger wards, AMU, ESS, Endoscopy, and the Discharge Lounge. We spoke with 33 members of staff including doctors of various grades, nurses, occupational therapists, pharmacy staff, administrative staff, cleaners and service leads; and six patients and relatives. We reviewed 18 sets of patient records and a range of other information before, during and after our inspection.

Summary of this service

A summary of our findings about this service appears in the overall summary.

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

- Staffing remained a challenge since our previous inspection. We were not assured that processes in place to ensure that temporary staff were competent to carry out roles were robust and the pressures on permanent staff were having an impact on their ability to deliver safe care. This included vacancies of up to 59.8% and a high reliance on agency nurses to fill gaps in rotas, with some wards frequently staffed only by agency nurses, especially at night.
- Patients' individualised care records were not completed or managed in a way that kept patients safe. Records were poor in their completion and clarity, including care plans not being completed, sepsis assessments incomplete and falls assessments not completed.
- There was discrepancy in how sepsis assessments and NEWS escalation were documented and staff could not rely on the notes to ascertain an accurate picture of the patient's risk.

Medical care (including older people's care)

- Medicines management processes in the service were not robust. We had concerns about the high numbers of medicines incidents; a lack of learning from medicines incidents; discrepancies between patient care plans and drug charts; a lack of clinical audits to monitor compliance with medicines policies and patient safety alerts; and ineffective systems and processes for monitoring controlled drugs.
- There was a lack of systems and processes for ensuring safe temperatures in medicines storage rooms. On Baddow ward the temperature range was recorded as outside safe levels for two months without evidence of clear actions taken. We were not assured that staff were aware of the pharmacy alert from May 2018 that any instance of temperatures out of range must be reported.
- Systems and processes for incident reporting and learning from incidents were not sufficiently robust.
- Medical staffing was not always meeting planned levels.
- We had concerns about the effectiveness of safeguarding training; for example, staff did not show awareness of female genital mutilation (FGM); and among medical staff training compliance was low (63%).
- There was low compliance in sepsis training for medical staff, ranging between 30% and 57%.
- Systems and processes were not effective to ensure consistent good practice regarding cleanliness and infection prevention and control (IPC) processes. For example, we found a 24-hour urine sample in the sluice room dated 31 May 2018 meaning it had been left there over three months.
- The call bell system on Goldhanger ward was not fit for purpose and there were no emergency call bells in bathrooms on the ward, which could pose a risk for responding to patients if needed. There was a plan to replace the system in January 2019.
- Patients at risk of mental health crises were not always assessed promptly.
- The local audit schedule was not comprehensive and did not cover all the areas of risk we found on inspection which the service should have been monitoring; for example, the service was not auditing their response times to patient call bells.
- The service did not perform well in the 2017 Lung Cancer Audit or National Audit of Inpatient Falls 2017, some indicators significantly lower than national aspirational standards.
- External multidisciplinary team (MDT) working was a frequent challenge for staff due to difficulties accessing and liaising with social services, community care services and mental health services.
- Patients' dignity was not always respected and there was not always a compassionate approach from staff. Although this appeared to be due to factors such as lack of clear support and leadership for staff, low staffing and capacity issues, as opposed to staff not wanting to care for patients, we were concerned about the impact on patients' experience of care.
- There was not always good communication from staff to ensure patients were fully involved in and understood decisions, although again this was primarily due to time and capacity pressures on staff, based on our observations and conversations with staff.
- There were some poor results in the friends and family test (FFT), notably for Baddow ward and Danbury ward, which both scored under 80% for patients who would recommend the service.
- Access and flow was a significant issue; for example, Writtle ward, which had initially been opened for contingency to help with winter pressures, had never been able to close afterwards as the pressures had continued, and there was no clear plan for contingency arrangements ahead of the next winter period.

Medical care (including older people's care)

- Discharges were not always done in a timely, safe or appropriate way and staff and patients reported a feeling of pressure to get patients discharged as quickly as possible, which was reflected in our own observations. This was worsened by difficulty in ensuring the appropriate community services or home care packages were in place; discharge lounge staff not always receiving a comprehensive handover to ensure the patient could be discharged safely; and low nurse staffing numbers impacting on discharge planning.
- Governance and risk management processes were not sufficiently robust to provide oversight of the service. For example, the concerns we identified in relation to records, documentation of sepsis pathways, reporting and learning from incidents, and medicines management were not being managed through the service's risk assurance framework, by having named leads and local controls and clear action plans.
- There was a lack of clear vision or strategy for medicine, largely due to staffing challenges meaning it was difficult to see past the "day to day" priorities and work of the service. In particular, there was no clear documented plan about how the service was going to manage the 'winter pressures' period.
- Nursing leads on the wards struggled to fulfil their managerial and support responsibilities due to staffing and capacity issues.
- There was frustration among medical staff about a decision earlier in 2018, on which they had not been consulted. The decision was to create a 'twilight shift' following a recommendation by an independent body, this led to the reduction of medical staff on both early and night shifts and had been unsuccessful. At the time of our inspection, the trust told us the rota was being revisited.
- Although staff were highly committed to their work, there was a feeling of stress and poor morale among many staff and a lack of sufficient systems to support staff, continuously engage them, and foster a positive culture.

However:

- The endoscopy unit was following clear systems and processes for effective infection prevention and control including the use of national guidance for decontamination of equipment.
- There was a thrombolysis nurse or junior doctor bleep holder available 24 hours a day.
- We saw evidence of embedded antimicrobial stewardship practices with regular multidisciplinary ward rounds and appropriate endorsements on drug charts.
- There was evidence of strong internal MDT working; for example, in board rounds all staff were given the opportunity to contribute.
- There were opportunities for staff to maintain and develop their competencies. Health care assistants were supported to commence their nurse training, and junior doctors said they felt well supported by consultants.
- There was sufficient consultant cover out of hours.
- There were effective processes in place to ensure smooth access and flow within endoscopy.
- There was an end of life care facilitator based on Baddow and Braxted wards to help meet the needs of these patients.
- Staff were supportive of each other and pulled together as a team despite high vacancies and other pressures impacting on them.

Is the service safe?

Inadequate  

Medical care (including older people's care)

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

- Nurse staffing levels were not always safe to ensure patient needs were met, with vacancies of up to 59.8%. Staff across wards including service leads confirmed this was their main risk. The service covered gaps as far as possible by transferring staff from other wards and using agency staff, but this meant staff were often not familiar with the ward. On all wards, staff felt pressured due to the acuity of the patients and staffing levels.
- The service relied on the competency checks from the agency rather than carrying out their own, which was a concern as staff, particularly in Emergency Short Stay ward, said there had been issues with some agency nurse competencies and behaviours, although there was reported improvement recently as some agency staff were long term and regular. It was also not in line with trust policy.
- Some wards, notably Writtle ward, Goldhanger (stroke step down) and the discharge lounge, were frequently staffed by non-permanent nursing staff or staff who had been moved from other areas, which staff reported was a concern as they did not provide the same ward leadership as substantive nurses and were not always familiar with the ward.
- Patients' individualised care records were not completed or managed in a way that kept patients safe. Records were poor in their completion and clarity, including care plans not being completed, sepsis assessments incomplete and falls assessments not completed. Records did not follow a consistent or clear order. Staff felt they could not always rely on the records.
- There was discrepancy in how sepsis assessments and deteriorating patient escalations were documented; in some notes they were included in paper records and on others they were done on the mobile online clinical care system, where the assessment was. Sepsis six pathways were not always completed or documented fully. We found inconsistent completion of care plans for prevention of falls, pressure ulcers, infection or other risks, increasing the risk of avoidable harms. Due to frequent moves of staff between wards and our concerns about record keeping, there was a risk to continuity of care and prompt response to deterioration if risk assessments were not clear to staff who were not already familiar with the patient.
- Medicines management processes in the service were not robust. Our concerns included high numbers of medicines incidents including two serious incidents in relation to medicines that were undergoing investigation at the time of our inspection; a lack of reporting and learning from medicines incidents; discrepancies between patient care plans and drug charts; and a lack of clinical audits to monitor compliance with medicines policies and patient safety alerts. There were also several reports of patients being transferred to the discharge lounge without their medications which was not in accordance with policy.
- Controlled drugs (CDs) were not always appropriately checked and documented.
- There were systems and processes for ensuring safe temperatures in medicines storage rooms. However, on Baddow ward the temperature range was recorded as outside safe levels for two months but, although it was escalated, it was not clear what actions were subsequently taken. We were not assured that staff were aware of the pharmacy alert from May 2018 that any instance of temperatures out of range must be reported.
- Our concerns around medicines management were increased because overall medicines issues such as those above were not identified on the trust risk register meaning there was a lack of oversight and monitoring of the issue.
- Systems and processes for incident reporting were not sufficiently robust. Although staff knew how to report an incident, we found instances where incidents had not been reported, such as the urine sample we found in the sluice room on Writtle ward, which was subsequently reported after we asked. Staff felt the high vacancies and use of agency staff contributed to incidents on wards; for example, on Goldhanger ward, there had been seven serious incidents from June to September 2018.

Medical care (including older people's care)

- Systems and processes for learning from incidents were not robust. Although there were forums in place for this, including namely ward meetings where sisters would share learning identified at weekly sisters' meetings, we were not assured this cascading process happened effectively and consistently. This was in part due to the high use of agency nurses who did not have the same familiarity; the frequent movement of staff between wards meaning they may not be aware of recent incidents that had happened on the ward to which they were moved; and low staffing levels and capacity pressures meaning staff did not always have the time to read updates in incident learning folders during their shift.
- Medical staffing was not always meeting planned levels, for example on Felsted ward and ESS.
- We had concerns about the effectiveness of safeguarding training in equipping staff with the knowledge required to consistently recognise and escalate safeguarding concerns; for example, staff did not show awareness of female genital mutilation (FGM); and among medical staff training compliance was low (63%).
- There was low compliance in sepsis training for medical staff, ranging between 30% and 57%.
- Systems and processes were not effective to ensure consistent good practice regarding cleanliness and infection prevention and control (IPC) processes. For example, we found a 24-hour urine sample in the sluice room dated 31 May 2018 meaning it had been left there over three months.
- There was a high prevalence of *C.Difficile* (eight incidences from June to August 2018) and the reasons for these had been investigated by the trust. Identified areas of learning had been incorporated into the trust wide IPC plan and corporate risk assurance framework. However, this was not included on the service risk assurance framework.
- There were some environmental and equipment related risks on Goldhanger ward, including the call bell system breaking down frequently and a lack of emergency call bells in bathrooms on the ward, which could pose a risk for responding to patients if needed. There was a plan to replace the call bell system in January 2019 as part of a proposed bed reconfiguration.
- There were insufficient (three) dedicated non-invasive ventilation (NIV) patient beds to meet patient needs. Although this was on the risk assurance framework, there was no evidence that the proposed mitigating actions had led to reduction in the risk.
- Staff felt patients at risk of mental health crises were not always assessed promptly, sometimes waiting up to a week for assessment this, which increased the risk to patients experiencing mental health difficulties.

However:

- The endoscopy unit was following clear systems and processes for effective infection prevention and control (IPC) including the use of national guidance for decontamination of equipment. Staff in the unit were aware of the IPC risks for the service and had mitigating controls in place.
- There had been improvement in the last six months in access to equipment such as pressure relieving mattresses as a protocol had been established for prompt ordering and receipt.
- Staff knew how to access the trust resuscitation team in the event of an urgent concern to patient risk and nursing staff said they could access medical staff promptly in the event of patient risk or deterioration.
- There was a thrombolysis nurse bleep holder available 24 hours a day; and a contingency plan, whereby a junior doctor would carry the bleep so there was always cover to respond promptly to patients experiencing thrombolysis.
- We saw evidence of embedded antimicrobial stewardship practice with regular multidisciplinary ward rounds and appropriate endorsements on drug charts.

Medical care (including older people's care)

Is the service effective?

Requires improvement ● ↓

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

- The local audit schedule was not comprehensive and did not cover all the areas of risk we found on inspection which meant there was a lack of sufficient monitoring around areas of concern; for example, the service was not auditing their response times to patient call bells, and their record keeping audit was infrequent and only used a very small sample.
- The service did not participate in the National Audit for Inflammatory Bowel Disease, due to capacity and information systems issues. This was recorded on the service's risk assurance framework.
- The service did not perform well in the 2017 Lung Cancer Audit; for example, the crude proportion of patients seen by a cancer nurse specialist was 76.2%, which did not meet the audit aspirational standard of 90%; and the proportion of fit patients with advanced NSCLC receiving systemic anti-cancer treatment was 25.7%, compared to a national average of 62%, which was significantly worse than expected and made the trust a negative outlier.
- The service did not perform well in the National Audit of Inpatient Falls 2017, with three out of seven indicators not meeting the national aspirational standards. The proportion of patients assessed for the presence or absence of delirium (if applicable) was particularly low at 27%. This did not meet the national aspirational standard of 100%. This was reflected in our concerns around poor record keeping and inconsistent risk assessments for patients.
- External multidisciplinary team (MDT) working was a frequent challenge for staff due to difficulties accessing and liaising with social services, community care services and mental health services.
- There was poor compliance with level two training in the mental capacity act (MCA), for both medical staff (19.5%) and nursing staff (28.6%), compared to a trust target of 90%, although staff we asked were aware of mental capacity principles.

However:

- There was evidence of strong internal MDT working; for example, in board rounds all staff were given the opportunity to contribute.
- There were opportunities for staff to maintain and develop their competencies. For example, an occupational therapist on ESS had recently undergone social services training; and HCAs were supported to commence their nurse training,
- Junior doctors said they felt well supported by consultants and foundation year one doctors (FY1s) were required to do an audit themselves by the end of 2018 to develop competencies.
- The trust consistently participated and performed well in the Sentinel Stroke National Audit Programme (SSNAP) with an overall SSNAP level of A, where A is best.
- There was sufficient consultant cover out of hours.
- Pain scores were clearly documented in the patient records we reviewed and patients said their pain was well managed. However, the service had documented on their risk assurance framework that on some occasions, Abbey pain scores were being poorly completed due to variable staff understanding and interpretation. There was a training programme in place to address this.

Medical care (including older people's care)

- We found staff to be aware of mental capacity and deprivation of liberty safeguards principles when we spoke with them.

Is the service caring?

Requires improvement ● ↓

Our rating of caring went down. We rated it as requires improvement because:

- Patients' dignity was not always respected. For example, on Braxted ward, a patient told us they had been in the same clothes for five days and had not been asked about a change of clothes. Staff did not always react appropriately and promptly when patients required assistance with personal care and maintaining their privacy and dignity, and we overheard an inappropriate comment made in relation to a patient who appeared to be in distress on Writtle ward.
- There was not always a compassionate approach. Although this appeared to be due to factors such as lack of clear support and leadership for staff, low staffing and capacity issues, as opposed to staff not wanting to care for patients, we were concerned about the impact on patients' experience of care. For example, a patient's family were very upset because staff had got the patient's name wrong on the 'This is Me' dementia information pack, and were then told "we can just cross it out".
- There was not always good communication from staff to ensure patients were fully involved in and understood decisions, although again this was due to time and capacity pressures on staff.
- There were some poor results in the friends and family test (FFT), notably for Baddow ward and Danbury ward, which both scored under 80% for patients who would recommend the service. Staff were patient-focused and wanted to provide compassionate care for patients.
- We saw examples of compassionate care, notably on Goldhanger ward and the stroke ward. On the stroke ward two patients told us they felt well cared for and involved in their care.

Is the service responsive?

Requires improvement ● ↓

Our rating of responsive went down. We rated it as requires improvement because:

- Access and flow was a significant issue; for example, Writtle ward, which had initially been opened for contingency to help with winter pressures, had never been able to close afterwards as the pressures had continued, and there was no clear plan for contingency arrangements ahead of the next winter period.
- Admission criteria was not always adhered to, due to lack of capacity, meaning patients were not always in the ward best suited for their needs, most notably on Writtle ward.
- Discharges were not always done in a timely or appropriate way and relatives we spoke with gave examples of where patients had been discharged before they were ready. Matrons and ward staff acknowledged there was a feeling of pressure to get patients discharged as quickly as possible, sometimes with insufficient regard given to the potential for readmission or the overall care of the patient. This matched concerns raised by care homes and other external organisations (58 incidents in the trust between November 2017 and April 2018) about inappropriate or unsafe discharges, including patients not being discharged with their medication, or failure to put in place follow up arrangements such as district nurse referral.

Medical care (including older people's care)

- Staff said there were difficulties in ensuring the appropriate community services or home care packages were in place which meant that patients requiring this often ended up staying longer even when they were medically fit for discharge, which in turn risked reducing their independence further.
- Discharge lounge staff did not always receive a comprehensive handover to ensure the patient could be discharged safely.
- Staff felt that low nurse staffing numbers contributed to the issues with timely discharge and flow through the service; for example, agency staff did not have access to the electronic system to keep the discharge planning process moving smoothly, and the frequent moves of staff between wards reduced continuity of care.
- Some wards were not being managed to provide the purpose for which they were intended. Patients were frequently staying overnight in the discharge lounge which was not in accordance with the discharge lounge policy, and on the emergency short stay (ESS) ward, patients were often staying over a week or two weeks on occasions, which was not in accordance with ESS flow and admission criteria (although sometimes it was done in the patient's best interests to avoid moving patients at the end of life).
- Access and flow within endoscopy ran more smoothly and in the event of cancellations, patients were rebooked in a timely manner.
- There had been improvement in RTT for oncology patients. Since February 2018, the average wait for patients' first appointment had been reduced from 22 days to 8.9 days as of September 2018. The service was aiming to reduce it further to seven days. There was a cancer performance recovery plan in place with a clear trajectory for improvement from July 2018 until March 2019.
- The service worked with the trust wide end of life care facilitator to help meet the needs of these patients.
- Ward staff could refer to the diabetes specialist nurse team for support in meeting the needs of patients with diabetes.
- There was a flagging system on the online mobile clinical care system for patients with learning disabilities.

Is the service well-led?

Inadequate ● ↓↓

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

- Governance processes were not sufficiently strong to provide oversight of the service. For example, there was no clear plan to improve on the significant concerns around record keeping, staffing levels, incident reporting and inappropriate discharges. Many of the areas of concern were not being audited, meaning there was a risk of concerns not being identified and acted on.
- Risk management and mitigation processes were not robust. We had concerns about the effective management of risk in the service due to the concerns we identified, for example in relation to records, documentation of sepsis pathways, reporting and learning from incidents, and medicines management. Leads did not always have oversight or ownership of risk, issues and performance in their speciality. These risks were not included on the 'risk assurance framework' for the service. This meant they were not being regularly overseen or assessed formally as risks; no staff member was named as accountable for managing and reviewing the risks; and no clear action plans were documented to work towards mitigation and improvement of these risks.

Medical care (including older people's care)

- The matrons felt there was a significant risk caused by the level of agency staff, and that this in turn led to other risks, such as substantive nurses not taking breaks during their night shift because of concerns about leaving the ward only staffed by agency nurses. We had concerns that there was no clear recovery plan, sufficient mitigation factors and improvement strategies to improve this.
- There was a lack of clear vision or strategy for medicine, largely due to staffing and capacity pressures being the main priorities. Matrons acknowledged that staffing challenges meant it was difficult to see past the “day to day” priorities and work of the service and it was a frustration that they had no capacity to focus on the development of both staff and the service.
- Nursing leads on the wards struggled to fulfil their managerial and support responsibilities due to low staffing which meant they worked clinically and were included in the staffing numbers most of the time and therefore could not always provide the level of support to their staff that they would have liked.
- There was frustration among medical staff about a decision earlier in 2018 to create a ‘twilight shift’ following a recommendation by an independent body, which led to the reduction of medical staff on both early and night shifts and had been unsuccessful. Medical staff had not been consulted on this and were not clear on the reasoning. The service was, at the time of our inspection, implementing plans to reverse this measure.
- There was mixed feedback about the visibility and support of the executive team on the wards.
- We were concerned that risk management was not effective. The risk register did not reflect all the risks we found on inspection, such as those around patient records, inappropriate discharges, medicines management, and learning from incidents.
- There was a lack of clear strategy to ensure the development, improvement and sustainability of the service. In particular, there was no clear plan about how the service was going to manage the ‘winter pressures’ period considering that they had experienced severe capacity issues over the summer and that Writtle ward, which had originally opened for contingency over the last winter, had never been able to close afterwards. Staff were supportive of each other and pulled together as a team despite high vacancies and other pressures impacting on them.

However

- Matrons and local ward leads were visible on the wards and were trying to boost and maintain morale despite the challenges in the service.
- Staff were highly committed to their work and the trust had systems in place to reward staff.
- There had been a recent ‘Wonder ward’ initiative on Goldhanger ward to identify and address factors of poor morale that could be improved. One of the initiatives implemented was a ‘star board’ on the ward, where staff could write down an appreciation or recognition of another member of staff. This had led to a boost in morale on the ward.

Surgery

Requires improvement  

Key facts and figures

Mid Essex Hospital Services NHS Trust provides elective and emergency surgical services to a local population, predominantly from the districts of Chelmsford, Maldon and Braintree. Surgery services include: general surgery; ear, nose and throat (ENT); trauma and orthopaedics; oral and maxillofacial surgery (OMFS); breast; ophthalmology; and urology.

Surgery takes place mainly at Broomfield Hospital, with some elective orthopaedic, ophthalmology and day case surgery carried out at Braintree Community Hospital. The trust serves as a hub for ENT and OMFS, working with neighbouring trusts. Urgent OMFS and ENT cases are seen in emergency clinics on Billericay ward.

Broomfield Hospital has 149 surgical inpatient beds located across nine wards and units.

From April 2017 to March 2018, the trust had 35,439 surgical admissions. Emergency admissions accounted for 12,956 admissions (36.6%), 17,214 (48.6%) were day cases, and the remaining 5,269 (14.9%) were elective.

this inspection, we visited the wards, operating theatres, recovery, day stay unit and interventional radiology. The trust's discharge lounge was inspected as part of the medicine core service, due to its governance arrangements. We spoke with eight patients, one relative and 32 members of staff including medical and nursing staff, healthcare assistants, nursing staff, therapy and domestic staff. We observed care and looked at 20 sets of medical records. We also looked at a wide range of documents including policies, standard operating procedures, meeting minutes, action plans, prescription charts, risk assessments and audit results. Before our inspection, we reviewed performance information from, and about, the trust.

Although the evidence in this report focuses on Broomfield Hospital, data for Braintree Community Hospital is included in analysis of national data sets where no site-level breakdown is available.

Summary of this service

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

- Training compliance targets were not met for the majority of modules, including training in safeguarding and the Mental Capacity Act.
- Staff did not always follow best practice in relation to infection prevention and control.
- Care and treatment records were not completed or managed in a way that kept patients safe. Records were poor in their completion and contained various incomplete risk assessments.
- Controlled drugs were not always appropriately managed, in line with trust policies.
- We were not assured that learning from incidents was consistently shared amongst wider teams. Changes made from never events were not embedded in clinical practice.
- The Day Surgery Unit regularly re-opened as an escalation area, impacting on the access and flow of the unit.
- The service has been unable to capture accurate referral to treatment (RTT) data since November 2017. Prior to this, RTT performance was consistently worse than the England average. In trauma and orthopaedics, and ophthalmology fewer than 50% of patients were admitted within 18 weeks of referral. The trust had not achieved the 62-day RTT cancer standard since October 2013.

Surgery

- Some medical staff displayed behaviours that prohibited a positive safety culture. As individual behaviours were identified as contributing factors to recent never events, we had concerns that, unless this changed, there would be a direct impact on patient safety. We were not assured that service risks were always effectively identified. Concerns identified during the inspection, including poor infection control, incomplete records and safety culture, had not been identified by the service as risks.

However:

- The service had effective processes in place to keep people safe and protected from abuse.
- The service had suitable premises and systems were in place to ensure equipment was maintained.
- Ward staffing levels and skill mix were planned and reviewed so that patient needs were met.
- Staff provided care and treatment in line with evidence-based practice and national guidelines.
- Information about the outcomes of patient care and treatment was routinely collected and monitored.
- Staff had the necessary skills, knowledge and experience to carry out their roles.
- We observed care was delivered and reviewed in a coordinated way across surgical wards and theatres.
- Staff provided compassionate care, treating patients with dignity and respect.
- Staff communicated with patients about their care and treatment in a way they could understand. Staff provided patients with relevant information, both verbal and written, so they could make informed decisions about their care and treatment.
- Staff planned and delivered services to meet individual needs. Enhanced support workers worked alongside nursing staff to support patients with complex needs.
- There were clear processes for staff to manage complaints and concerns.
- Service leaders had the capacity and capability to deliver high-quality, sustainable care. Staff spoke positively about their local leadership. They described feeling supported in their role.
- There were clear responsibilities, roles and systems of accountability to support good governance and management.
- The service collected performance data via quality dashboards, which provided the board with an overview of how the service was comparing to key quality indicators.

Is the service safe?

Requires improvement ● ↓

Our rating of safe went down. We rated it as requires improvement because:

- The service provided mandatory training in safety systems, processes and practices but training compliance targets were not met for the majority of modules. Not all staff had received safeguarding training, in-line with national guidance.
- Staff did not always follow best practice in relation to infection prevention and control. We found incidences where sharps and blood-stained gauze strips were not safely disposed of. Staff did not always comply with the Control of Substances Hazardous to Health Regulations, 2002.

Surgery

- Staff knew how to assess, monitor and manage patient risk but risk assessments were not accurately documented. We were also not assured that all aspects of The World Health Organisation's Five Steps to Safer Surgery checklist were consistently completed.
- In theatres, the trust was trialling reduced staffing levels for some local anaesthetic procedures, against national guidance.
- Care and treatment records were not completed or managed in a way that kept patients safe. Records were poor in their completion and contained various incomplete risk assessments.
- Controlled drugs were not always appropriately managed, in line with trust policies.
- Staff received feedback from incidents they reported but we were not assured that learning from incidents was consistently shared amongst wider teams. Changes made from never events were not embedded in clinical practice. Systems to report, record and investigate medicine incidents were not robust.

However:

- The service had effective processes in place to keep people safe and protected from abuse.
- The service had suitable premise and systems were in place to ensure equipment was maintained.
- Ward staffing levels and skill mix were planned and reviewed so that patient needs were met.
- Staff stored records in a secure way that ensured patient confidentiality.

Is the service effective?

Good ● → ←

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

- Staff provided care and treatment in line with evidence-based practice and national guidelines.
- Patients were provided with sufficient nutrition and hydration to meet their needs and improve their health.
- Staff assessed and managed patient pain well.
- Information about the outcomes of patient care and treatment was routinely collected and monitored.
- Staff had the necessary skills, knowledge and experience to carry out their roles. Appraisals and supervision took place to provide staff with support and monitor the effectiveness of the service.
- We observed care was delivered and reviewed in a coordinated way across surgical wards and theatres.
- Staff were working towards providing a seven-day service.
- The service supported people to live healthier lives.
- Consent to care and treatment was sought in line with legislation and guidance.

However:

- We were not assured that theatre and ward staff effectively shared information, specifically around never events.
- There was poor compliance with level two training in the mental capacity act (MCA), for both medical staff (20.9%) and nursing staff (10.7%), compared to a trust target of 90%.

Surgery

Is the service caring?

Good ● → ←

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

- Staff provided compassionate care, treating patients with dignity and respect.
- Patient feedback was consistently positive. The patients we spoke with said that staff were caring and considerate.
- Staff understood the importance of providing emotional support to patients and those close to them. We observed staff providing reassurance to anxious patients before their surgery.
- Staff communicated with patients about their care and treatment in a way they could understand. Staff provided patients with relevant information, both verbal and written, so they could make informed decisions about their care and treatment.

Is the service responsive?

Requires improvement ● ↓

Our rating of responsive went down. We rated it as requires improvement because:

- Staff on the Day Surgery Unit raised concerns that the unit regularly re-opened on a Sunday as an escalation area. Escalation patients impacted on the flow of the unit, as they all needed to be discharged by a doctor before the day's surgery list could begin.
- The service has been unable to capture accurate referral to treatment (RTT) data since November 2017. Prior to this, RTT performance was consistently worse than the England average. In trauma and orthopaedics, and ophthalmology fewer than 50% of patients were admitted within 18 weeks of referral.
- The trust had not achieved the 62-day RTT cancer standard since October 2013.

However:

- The service had introduced enhanced support workers to meet the needs of individual patients.

Is the service well-led?

Requires improvement ● ↓

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

- At a senior management level, there had been a lot of change and instability within the service.
- Some medical staff displayed behaviours that prohibited a positive safety culture. As individual behaviours were identified as contributing factors to recent never events, we had concerns that, unless this changed, there would be a direct impact on patient safety.
- We were not assured that service risks were always effectively identified. Concerns identified during the inspection, including poor infection control, incomplete records and safety culture, had not been identified by the service as risks.

Surgery

- Some staff felt their concerns were not listened to or escalated beyond their line manager.
- Information management systems and processes were not always effective.
- Service leaders had the capacity and capability to deliver high-quality, sustainable care. Staff spoke positively about their local leadership. They described feeling supported in their role.
- Service priorities aligned with the overall trust strategy, with quality and sustainability as the top priorities.
- The service was proactively trying to promote an open and honest culture where staff could raise concerns without fear of retribution.
- There were clear responsibilities, roles and systems of accountability to support good governance and management.
- The service collected performance data via quality dashboards, which provided the board with an overview of how the service was comparing to key quality indicators.
- Staff, patients and relatives were engaged and involved in the service, improving the care and treatment delivered.

Outstanding practice

- The service was expanding its use of robotics within urology and ENT, having already been a success in upper and lower gastrointestinal surgery. The use of robotics allows surgeons to perform complex procedures that may have been difficult or impossible to perform otherwise. They can also perform minimally invasive surgery, resulting in fewer complications.
- After trialling on Notley Ward, the service had rolled out enhanced support workers to work alongside nursing staff to support patients with complex needs. Enhanced support workers had completed additional training in dementia (Level 3), nutritional dementia and end of life care. They ensured appropriate adjustments were made for patients coming onto a ward

Areas for improvement

We found areas for improvement in this service. See the Areas for improvement section above.

Services for children and young people

Key facts and figures

Broomfield Hospital

The trust has 50 inpatient paediatric beds at Broomfield Hospital:

- E122 – Phoenix Ward: This is a general inpatient paediatric ward with 24 inpatient beds. It also includes a paediatric assessment unit with eight trolleys.
- Ward A406 – The neonatal unit: This ward has two intensive care beds, four high dependency beds and 10 special care cots for sick term - and preterm infants from 27 weeks gestation. Prior to 27 weeks gestation, babies are stabilised and transferred to a tertiary unit.
- Wizard Ward: This is a children's theatre day stay ward with 10 beds.

(Source: Routine Trust Provider Information Request (RPIR) – Sites tab)

Phoenix ward is a 24 bed inpatient, medical and surgical ward providing care for children who are admitted as an emergency or who require an overnight stay in hospital. The trust is also the hub for ENT, plastics, and maxillofacial surgery for the local region. The paediatric assessment unit is co-located on the ward providing a total of nine trollies/assessment beds/cots.

Wizard ward is a dedicated ward which provides planned day surgical facilities. The children's assessment unit facilitates care for children with a range of medical and surgical conditions. Children can be referred urgently by their GP or by accident and emergency to this unit and will be seen and assessed by a paediatrician or a suitable specialist.

The neonatal unit provides a total of 16 cots, two of which are intensive care cots; four are high dependency cots; with 10 special care cots for sick and premature babies who are admitted directly from the labour ward or from the community midwifery teams. There are also two rooms for parents who need to stay with their babies prior to discharge.

Children's outpatients provide additional outreach clinics located within the community hospitals. Visiting specialist teams from The Royal London, Royal Brompton and Great Ormond Street provide joint care clinics minimising the requirement for children to travel.

There is 24 hour provision of consultant paediatric rota cover across the service. In addition, there is a pathway for the access of children's mental health services which is provided outside of the acute trust. We completed an unannounced inspection between 11 to 13 September 2018. During the inspection, we visited all areas of the children's service, including Phoenix ward, Wizard Ward, the neonatal unit (NNU), Children's burn unit and the children's outpatients department.

During the inspection we spoke with four sets of parents and their children. We spoke with 38 members of staff; including registered nursing staff, nursery nurses, medical staff, play specialist, administrative staff, allied healthcare professionals and the divisional leads. We observed care, and reviewed 12 sets of patient medical records and nine prescription cards.

Summary of this service

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

Services for children and young people

- Systems and process that were in place to safeguard children and young people were not fully embedded and there were shortfalls in the system of engaging with local safeguarding processes.
- Safeguarding level three training compliance was low for medical staff.
- Medication management and oversight of the temperature requirements for medication storage was inconsistent across the service.
- Not all policies were consistently reviewed and updated in a timely manner.
- The service monitored the effectiveness of care and treatment through some local and national audits, however there was only limited evidence of formal action plans related to sharing the findings of the audit rather than changes to practice.
- There was a lack of vision and strategy, specifically for children and young people's services.
- There was lack of awareness by the service leads regarding the inconsistent systems and lack of robust governance systems to support children safeguarding

However

- Staff knew how to report incidents and there was evidence of sharing learning from incidents, which was shared with staff.
- The service controlled infection risk well. Staff used control measures, which were audited, to reduce the risk of infection. We consistently observed good hand hygiene and use of personal protective equipment such as aprons and gloves.
- Nurse staffing levels on NNU were meeting recommended levels and were sufficient to safely meet patients' needs. Medical staffing levels and skill mix were appropriate to meet patient needs.
- Staff had the appropriate skills and competencies to carry out their work and there were opportunities for staff to progress or develop additional competencies.
- Compassionate care was consistently observed and noted by patients and their families, and privacy and dignity were well highlighted throughout the service.
- There was good internal MDT working across the service. Nursing and medical teams worked well together as one team to best support children's needs.
- All parents and carers we spoke with were happy with the care of their child and all observations of staff interaction with patients and parents or relatives were compassionate and kind.
- The service had a strong local leadership team. Nursing and medical staff consistently reported good relationships with service leads and described managers as approachable and supportive.
- There was a positive, team-based culture across the service.
- Service leads were able to explain the key risks for the service.
- There was evidence of public and parental engagement with the service.

Is the service safe?

Requires improvement  

Services for children and young people

Our rating of safe went down. We rated it as requires improvement because:

- The processes that were in place to safeguard people from abuse were not robust, the service had an action plan to improve but new processes were yet to be embedded. Compliance with safeguarding training was not meeting the trust target rates of inspection the trust interim safeguarding transformation lead demonstrated that the systems and processes were not embedded and in some instances, use of systems could cause a lengthy delay in referrals being made. This meant that the task of making a referral could be delayed or omitted due to work pressures in the busy ward environment.
- Compliance by medical staff with safeguarding level three training was lower than the trust target of 90%, at 68.4%.
- Whilst we found medicines to be securely stored throughout the service, the checking of medication fridge and room temperatures was not consistent, with limited oversight or monitoring that appropriate actions were taken when required.

However:

- There had been no never events or serious incidents in the service from August 2017 to July 2018. Staff knew how to report incidents and there was evidence of learning from incidents, which was shared with staff.
- The environment was clean and staff practised good infection prevention and control (IPC) and hand hygiene procedures.
- Daily checks of the resuscitation trolleys were completed on the ward, NNU and children's outpatients and we saw that the contents matched the equipment checklist.
- The service had a sepsis assessment tool with a clear escalation flowchart, which was based on best practice and national guidance.

Is the service effective?

Good ● → ←

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

- Staff worked together to assess and plan ongoing care and treatment. Working relationships with other providers of specialist care and regional networks were established.
- Staff had access to learning and development courses to support them in their roles and regular appraisal.
- The service had effective pain management processes, including age appropriate pain assessment tools and nurse prescribers.
- An evidence-based nutritional care bundle was in place on the neonatal unit and dieticians were available for advice and guidance.

However:

- Policies reflected national guidance and information needed to deliver effective care and treatment however not all policies were consistently reviewed and updated in a timely manner.
- The service monitored the effectiveness of care and treatment through some local and national audits, however there was only limited evidence of formal action plans related to sharing the findings of the audit rather than changes to practice.

Services for children and young people

Is the service caring?

Good ● → ←

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

- We observed examples of staff delivering compassionate care to patients during our inspection.
- Patients and carers told us that they were treated with respect and were involved in decisions surrounding their care and treatment.
- Patients and their families were provided with emotional support through the integrated use of play therapists and a psychology team.
- Parents informed us that information was provided to their children in a way that they were able to understand.
- The trust performed about the same or better than other trusts in the CQC children and young people's survey 2016.

Is the service responsive?

Good ● → ←

Our rating of responsive stayed the same. We rated it as good because:

- The children's services were planned and provided in a way that met the needs of local people.
- Children and young people were involved in discussions regarding the service.
- The service provided children with education based on their individual needs and health.
- The service provided overnight facilities to family members to allow them to stay with their children who were receiving care. Breastfeeding mothers were provided with three meals per day.
- Phoenix ward provided a designated room for teenagers and a designated play room for children under the age of two.
- The service took account of patients' individual needs. They liaised with the appropriate services to provide appropriate treatment and to facilitate successful discharges.
- The service had good links with the learning disabilities specialist team to meet the needs of children with learning disabilities.
- The service had play specialists, who used distraction techniques to help reduce anxiety in children throughout their stay and whilst receiving treatment, including in the pre-operative stage before a child went into theatre.
- Staff could access an interpretation service for children and parents whose first language was not English. This included both phone and face-to-face interpretation options, and staff reported they were quick to respond.

Is the service well-led?

Requires improvement ● ↓

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

Services for children and young people

- There was a lack of vision and strategy, specifically for children and young people's services.
- There was lack of awareness by the service leads regarding the inconsistent systems and lack of robust governance systems to support children safeguarding.

However:

- The leadership structure of the service was established and all staff were clear about who had responsibility.
- Both nursing and medical staff consistently reported they had good relationships with service leads and described managers as approachable and supportive.
- There was a positive, team-based culture across the service.
- Service leads were able to explain the key risks for the service and this was reflected on the risk register. Each risk had an appropriate person allocated to overseeing it and appropriate actions in place to mitigate them as far as possible. They also had target risk levels to help drive improvement, and target dates for addressing the risks.

Outstanding practice

- Within the children's service there was innovative use of various techniques, such as sensory equipment and animal handling, for stimulation, distraction and comfort for children with many different needs.
- The trust funded staff in NNU to complete their post registration education (Qualified in Speciality).

Areas for improvement

We found areas for improvement in this service. See the Areas for improvement section above.

Outpatients

Requires improvement ●

Key facts and figures

The outpatient's services at Mid Essex Hospital Services NHS Trust covers several sites, which include Braintree Community Hospital, St Peter's Hospital, St Michael's and Broomfield Hospital. The trust covers a wide range of specialities such as ophthalmology, gynaecology, surgical and the St Andrews burns and plastics regional unit at Broomfield hospital.

The trust had 583,038 outpatient attendances from April 2017 to March 2018, with 513,783 of those seen at Broomfield Hospital. Outpatient appointments were available, Monday to Friday between 8.30 am to 5.00pm with regular evening and weekend clinics for certain specialities.

The last inspection in December 2016 highlighted concerns regarding: - Nursing staff shortages in the orthopaedic and fracture clinic and limited accessible information available.

During our inspection, we visited the outpatient department located in Broomfield Hospital atrium. We inspected and observed areas across main outpatients including, gynaecology, ophthalmology, Ear, Nose and Throat (ENT), phlebotomy, booking team and the St Andrews burns and plastics centre and no joined up working between clinics.

In addition to consultant-led clinics, there are nurse-led clinics across a range of specialities. We spoke with patients, relatives, and members of staff. During our inspection we spoke with 28 members of staff in total including nurses, healthcare assistants, receptionist staff, medical staff, service managers, bookings team administration assistants, and directors of nursing.

We observed interactions between patients and staff, and considered the environment.

We also reviewed national data and performance information about the trust, and a range of policies, procedures and other documents relating to the operation of the outpatient department. previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

Summary of this service

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

We rated it as requires improvement because:

- A high level of clinical demand meant that staff could not always be spared to attend mandatory training.
- Records were not always clear, up-to-date, and easily available to all staff providing care.
- There was a high reliance on bank staff.
- The storage of medicines related stationery did not always follow national guidelines.
- Patients could not always have timely access to initial assessments, test results, diagnoses or treatment.
- There was no separate formal strategy for outpatients and staff were not aware of the trust's strategy and values.
- The service did not always collect and use information well to support its activities.

Outpatients

Is the service safe?

Requires improvement ●

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings

We rated it as requires improvement because:

- A high level of clinical demand meant that staff could not always be spared to attend mandatory training.
- Records were not always clear, up-to-date, and easily available to all staff providing care.
- There was a high reliance on bank staff.
- The service did not always have enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.
- The service provided mandatory training in key skills but not everyone completed the training in time to meet the target.
- The storage of medicines related stationery did not always follow national guidelines.
- There were still areas for improvement to be made to ensure that learning from serious incidents was embedded in practice

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk, measures were used to prevent the spread of infection.
- The design and use of the treatment centre was suitable for purpose. The outpatient department environment was clear and uncluttered.
- Risks to adult patients were assessed, and their safety monitored and managed so they were supported to stay safe.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.

Is the service effective?

We do not rate the effective key question. We found that:

- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- Staff gave patients enough food and drink to meet their needs whilst in Outpatients
- Staff assessed and managed patients to see if they were in pain.
- Information about the outcomes of people's care and treatment was routinely collected and monitored. Patient follow up rates improved significantly from June 2017 to March 2018.
- The service made sure staff were competent for their roles.

Outpatients

- Staff in different teams, services and organisations were involved in assessing, planning and delivering care and treatment.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They understood how and when to assess whether a patient had the capacity to make decisions about their care.

Is the service caring?

Good ●

We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care.

Is the service responsive?

Requires improvement ●

We rated it as requires improvement because:

- Patients did not always have timely access to initial assessments, test results, diagnosis or treatment.

However:

- The service planned and provided services in a way that met the needs of local people.
- The service took account of patients' individual needs and was successful in meeting them.

Is the service well-led?

Requires improvement ●

We rated it as requires improvement because:

- There was no separate formal strategy for outpatients and staff were not aware of the trust's strategy and values.
- There was not a comprehensive audit process in place to identify areas for improvement and identify risks.
- The service did not always collect and use information well to support its activities.
- There was a need for systems that supported innovation.

However:

- The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. Matrons and managers were visible and supportive.
- The service was taking steps to engage with patients and staff to plan and manage appropriate services.

Outpatients

- The service had been involved in work which demonstrated a commitment to continuous improvement.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Diagnostic imaging

Requires improvement 

Key facts and figures

The main radiology department at the trust is located at Broomfield Hospital, offering diagnostic imaging services to emergency, GP, outpatient and inpatient referrals. All imaging modalities, with the exception of PET-CT, are provided. There are satellite units offering plain film and ultrasound services at Braintree Community Hospital and St Peter's Hospital in Maldon. The radiology department offers 24/7 cover for plain film, mobile and theatre radiography and CT. There is on site consultant radiologist cover seven days per week, with out of hours reporting covered by a tele-radiology service.

The department has training registrars from the East of England Radiology School, and student radiographers from both City University, London and the University of Suffolk, Ipswich.

(Source: Routine Provider Information Request (RPIR) - Acute context tab)

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings. The last inspection in 2016 reported concerns regarding the storage of contrast media and adherence to infection prevention and control audit in the x-ray department.

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

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust. During the inspection visit, the inspection team spoke to 24 members of staff, including radiologists, radiographers, radiology assistants, administrative staff, and managers. We spoke to 10 patients and relatives.

Summary of this service

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings.

We rated this service as requires improvement because:

- The service did not always have systems in place to ensure that staff were able to identify and respond appropriately to changing risks to people who used services.
- There were staff shortages and low mandatory training and appraisal rates.
- The service had not always ensured that checks on the environment and equipment were regularly carried out, or that cleaning was regularly carried out or documented.
- The service was not carrying out discrepancy audits to review the quality of reports and audit activity in 2017 had been limited.
- Patients were not always able to access diagnostic imaging services or receive imaging reports in a timely manner.
- The management of risk and performance was not always robust.

However,

- Storage of contrast media had improved since our last inspection
- Staff understood their roles and responsibilities in safeguarding and under the Mental Capacity Act.

Diagnostic imaging

- Patients gave consistently positive feedback about the care provided by staff.
- Staff described cooperative, supportive and appreciative relationships with colleagues.

Is the service safe?

Requires improvement



We rated safe as requires improvement because:

- The service did not always have systems in place to ensure that staff were able to identify and respond appropriately to changing risks to people who used services. Patient call bells were not always working or accessible to patients in diagnostic imaging areas. The service did not have a formal process in place for carrying out harm reviews when patients had experienced significant delays in their imaging or the reporting of their imaging.
- There was no specific training for non-radiology staff who were reporting images, known as auto-reporting. In addition, the service did not audit the reports these staff produced. There is a potential risk of harm to patients associated with this.
- There was a shortage of radiologist and radiographer staffing in diagnostic imaging.
- Systems and processes to maintain cleanliness and control infection were not always consistently implemented or documented.
- The service did not have appropriate systems in place for the management of consumable stock and checks on the environment and equipment were not always carried out consistently.
- There was low compliance in some areas of mandatory training, such as resuscitation training which had been completed by only 58.8% of radiologists and 53.8% of radiographers.
- Staff did not always understand their responsibility to record reporting discrepancies as incidents. Staff had failed to report two serious incidents when reporting discrepancies were identified; it was not until patient complaints were received that incident reports were submitted.
- We did not receive assurance that learning from serious incidents was always robust; there had been delays in implementing actions to discuss reporting discrepancies at discrepancy meetings. Staff were not always aware of serious incidents that had occurred in the department and were limited in examples that they could provide of changes to practice that had occurred as a result of incidents.
- Patient group directions for the administration of medication had not always been regularly reviewed.
- Contrast media and other medicines were stored appropriately. This was an improvement from our previous inspection.
- Staff knew how to raise a safeguarding concern and were able to provide examples of how they had responded appropriately when safeguarding concerns were identified.

Is the service effective?

We do not rate the effective key question. We found that:

Diagnostic imaging

- We were not assured that learning from discrepancy meetings was appropriately used to implement actions to improve the quality of reporting. The frequency of and attendance rates at discrepancy meetings was not in line with Royal College of Radiologist guidance.
- The diagnostic imaging service was not able to undertake a discrepancy audit for all imaging modalities due to the demand on services. This reduced the ability for the service to review the quality of reports and identify any potential reporting discrepancies.
- There were concerns about compliance with Ionising Radiation Medical Exposure Regulations IR(ME)R in areas outside of radiology. Whilst actions had been put in place to mitigate risk, concerns had been ongoing for five years and had not been resolved by the time of our inspection.
- Imaging equipment competency records for radiographers and sonographers had not been regularly reviewed. We were not provided with imaging equipment competency records for radiologists or surgeons.
- Audit activity had been limited in 2017 due to staff shortages as there was only one audit on the audit programme.
- Appraisal rates for radiographers and radiology assistants were low due to staff shortages.
- The service had been working towards Imaging Service Accreditation Scheme (ISAS) accreditation at the time of our last inspection but demand within the department and a potential merger with two local trusts had meant that work towards accreditation had not progressed.
- We were provided with limited evidence during our inspection that the diagnostic imaging service was following a trust-wide process to ensure that compliance with new or updated National Institute of Health and Care Excellence (NICE) guidance was regularly reviewed. However, after our inspection the trust provided evidence of the processes in place.

However,

- Multidisciplinary working in diagnostic imaging areas was effective.
- Staff understood their roles and responsibilities under the Mental Capacity Act 2005, and knew how to support patients who lacked the capacity to make decisions about their care.
- The service provided care and treatment based on national guidance and participated in NHS radiology benchmarking. This provided the opportunity to benchmark the department's practices and performance against other departments across the country.

Is the service caring?

Good ●

We rated caring as good because:

- We observed kind and caring interactions between patients and staff. Patients gave consistently positive feedback about the care provided by staff.
- Patients said that they felt able to discuss any concerns or worries with staff and staff were observed providing appropriate support to patients.
- The majority of patients said that staff communicated with them so that they understood their care and treatment. Staff were observed giving forecasts about what would be happening with patients' treatment, explaining post procedure information, providing after care advice, and answering patient questions.

Diagnostic imaging

However,

- The environment within the diagnostic imaging department meant that patients' privacy and dignity could not always be maintained.

Is the service responsive?

Requires improvement ●

We rated responsive as requires improvement because:

- From September 2017 to June 2018 the percentage of patients waiting more than six weeks to have a diagnostic test was consistently higher than the England average.
- There were significant reporting backlogs in diagnostic imaging. This meant that people did not have timely access to diagnostic results. Whilst actions were in place to reduce the backlog, we were not provided with a formal recovery plan.
- Information about individual needs was not always gathered and recorded appropriately.
- The service did not always meet the information and communication needs of people whose first language was not English as some staff used family members to translate, including for consenting to a procedure. In addition, there was no patient information displayed or leaflets available in any other language.
- Complaints were not always dealt with in a timely manner and there was limited evidence of changes implemented as a result of complaints.

However,

- Data for July 2018 showed that the percentage of patients waiting more than six weeks to see a clinician had significantly reduced, and the trust's performance was better than the national average in July 2018.
- The environment within diagnostic imaging was generally appropriate and patient centred and services offered some flexibility and choice.

Is the service well-led?

Inadequate ●

We rated well-led as inadequate because:

- There were not always robust arrangements for identifying, recording and managing risks. Some of the concerns identified during our inspection were not on the risk register, whilst other risks had remained on the register for a significant amount of time. Leaders had not always taken appropriate action to address or mitigate identified risks.
- Governance meeting minutes were sparse, with limited evidence of discussion amongst attendees regarding any areas of concern or actions that should be implemented to address concerns. Diagnostic imaging governance meetings did not review all relevant data on patient experience, or any performance data.
- The service did not always have effective processes to manage performance as there was a lack of defined key performance indicators (KPIs) for report turnaround times. Departmental leaders recognised reporting backlogs as one of the key challenges to quality and sustainability but did not have a clear documented plan to reduce backlogs.

Diagnostic imaging

- There was no separate formal strategy for diagnostic imaging as the service was focused on a potential merger with two local trusts. This could lead to a lack of focus on making improvements and developments within the service, outside of streamlining processes with the other trusts.
- Some staff felt that departmental leads were somewhat limited in their availability and accessibility and that progress within the department stalled or slowed whilst the service manager was away from work. Departmental leaders acknowledged that they had limited visibility in clinical areas due to their workload, and modality leads had limited time to provide leadership to staff in their area due to being required to work clinically.
- Staff were not aware of the trust's strategy or values and said that trust leaders were not visible in diagnostic imaging.
- The majority of staff said that morale was low in the diagnostic imaging service. Morale was being impacted by staffing levels and the ongoing increase in demand in the department.
- Service level agreements with third parties were not always being effectively monitored as we were not provided with evidence that regular meetings had been held in 2018 to review and discuss performance.
- A significant amount of information requested as part of our inspection was not provided and we therefore did not have assurance that the service collected, analysed and managed information appropriately.

However,

- Staff within diagnostic imaging described the leaders of the radiology department as approachable and supportive, and felt they could raise concerns with them.
- There was a mostly positive culture throughout the diagnostic imaging service, which was centred on the needs and experiences of patients, encouraged openness and honesty, and staff described cooperative, supportive and appreciative relationships with colleagues.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity

Regulation

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulated activity

Regulation

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Diagnostic and screening procedures

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury

Regulated activity

Regulation

Diagnostic and screening procedures

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Treatment of disease, disorder or injury

Regulated activity

Regulation

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Diagnostic and screening procedures

Maternity and midwifery services

This section is primarily information for the provider

Requirement notices

Surgical procedures

Treatment of disease, disorder or injury

Our inspection team

Fiona Allinson, Head of Hospital Inspections led this inspection.

The team included a CQC deputy chief inspector, two inspection managers, 10 inspectors and 10 specialist advisers.

Specialist advisers are experts in their field who we do not directly employ.