Mid Essex Hospital Services NHS Trust

Braintree Community Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Good
Surgery	Good
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Braintree Community Hospital is part of the Mid Essex Hospital Services NHS Trust (MEHT). Braintree Community Hospital was taken over by Mid Essex Hospital Services NHS Trust in August 2014. The trust provides surgical and outpatient services at Braintree Community Hospital, with endoscopy services and the inpatient ward being run by alternative providers.

We carried out this inspection as part of our commitment to inspect all NHS trusts in England. Our rationale for choosing this service was based upon its recent change over to Mid Essex Hospital Services NHS Trust. This was a scheduled and announced inspection, which took place on 27 November 2014.

Overall, we have found that the ratings and provision of care in each core service inspected at Braintree Community Hospital was good. The care provided to people in surgery and outpatients was good, services were effective, the staff were caring, and locally within Braintree, the services were well led. Overall, we have rated Braintree Community Hospital as a good service.

Our key findings were as follows:

- The staff working at Braintree Community Hospital were still transitioning into new working regimes under Mid Essex Hospital Services NHS Trust. This meant that there were changes to management, procedures, paperwork and booking systems, which were taking some time to adjust to.
- It was evident that throughout the hospital, the staff were caring, dedicated and passionate.
- The League of Friends volunteer group was a feature of the service, with support for the volunteers voiced in each department we visited.
- Patients, visitors and relatives were highly complementary about the catering service in the café area, with the quality of the food being praised.
- The hospital environment was modern and visibly clean throughout.
- There was ample parking on site, which was free for patients, which was positive.
- Staffing levels were sufficient, though there were notable shortages of nursing staff, on occasions, within outpatients and surgery. Recruitment to those vacant posts was underway.

However, there were also areas of poor practice where the trust needs to make improvements.

The trust should:

- Ensure that there are a sufficient number of nursing staff recruited and in post to provide services.
- Ensure that lessons are learned from incidents, serious incidents and complaints.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Surgery	Good	Services were provided in a very clean and hygienic environment, in line with recognised guidance, which helped protect patients from the risk of infection, including hospital-acquired infections. Overall services were safe; however there was a lack of learning from incidents which occurred across the trust, with no system in place to facilitate learning from incidents and complaints which needed improving. We saw staff who were caring; the patients we spoke with complimented staff on their caring approach and professionalism. We saw that appropriate equipment checks and maintenance were carried out. Most of the staff we spoke with felt supported by their managers. Staff training and appraisals were carried out to ensure that staff were competent and had knowledge of best practice to effectively care for and treat patients. However, the trust had taken over part of the building in April 2014; many of the staff had still not had their final terms and conditions, including salary banding completed.
Outpatients and diagnostic imaging	Good	Patients were treated with dignity and respect by caring and motivated staff. Patients spoke positively about staff, and felt well informed about their care and the procedures being undertaken. The services we inspected were very clean, and the environment was well maintained. There was a clear process for reporting and investigating incidents. Diagnostic imaging services had an excellent feedback mechanism to staff, to keep them informed of incidents submitted and the outcomes of investigations, including lessons to be learnt. Good communication was evident across the departments on other sites within the trust. There was a shortage of key staff, in particular qualified nursing staff for outpatients. There was a strong team spirit and good multidisciplinary working across all services. The hospital was adhering to recognised best practice, including nationally-recognised guidance from NICE and Royal College guidelines. Staff aimed to deal with complaints efficiently, and they told us that they

Summary of findings

would always try and deal with a complaint immediately, where possible. There was good local leadership and a positive culture within the services. Feedback from patients was very positive.

Good

Braintree Community Hospital

Detailed findings

Services we looked at
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Detailed findings

Background to Braintree Community Hospital

Braintree Community Hospital is a community hospital which is operated by Mid Essex Hospital Services NHS Trust. The trust provides outpatient and surgery services. The inpatient area is run by a community trust, and the endoscopy services are run separately.

Our inspection team

Our inspection team was led by:

Chair: Professor Bob Pearson, Medical Director, Central Manchester Hospitals Trust.

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

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

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

How we carried out this inspection

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

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

The announced inspection visit took place at Braintree Community Hospital on 27 November 2014.

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

We held a listening event for people who used the service on 25 November 2014, when people shared their views and experiences of using the services. We also held a dedicated focus group for the Braintree Pensioners Action Group in Braintree, to listen to their experience of using the service, as they were involved in the campaign to open a community hospital in the area. Some people who were unable to attend the listening event shared their experiences with us via email or by telephone.

During the inspection we spoke with a range of staff in the hospital, including nurses, doctors, administrative and clerical staff, and radiographers and pharmacists. We also spoke with staff individually as requested. We talked with patients and staff attending for surgery and for outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

Detailed findings

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

Facts and data about Braintree Community Hospital

Braintree Community Hospital (MEHT Services) overview:

Beds: 0 inpatient beds

Activity Summary:

Activity type	2013-14
Outpatient attendances	73,405

Population Served:

- According to the 2011 census 96.6% of the population of the borough of Braintree is White and the highest ethnic minorities are Asian and mixed/multiple ethnic group, both with 1.3%.
- Braintree is ranked by Public Health England as better than the England average for most categories of assessment, including deprivation, children living in poverty, teenage pregnancy rate, and life expectancies of males and females. However, it is rated worse than the England average for road injuries and deaths, and homelessness.

Deprivation:

- Braintree ranks 210th out of 326 local authorities on the deprivation scale.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Notes

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

Surgery

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

Information about the service

Braintree Community Hospital is part of Mid Essex Hospital Services NHS Trust (MEHT). It is located in a small town, Braintree, approximately 12 miles from the main hospital in Chelmsford. The community hospital was taken over by the trust in April 2014. The hospital undertakes X-rays and other diagnostic tests, rehabilitation, endoscopy and day surgery for patients over 16 years of age only. There were two theatres, which were under-utilised, and three recovery bays. Adjacent was a dedicated day unit.

The rest of the hospital, including a small inpatient unit, is owned and run by another organisation, so did not form part of our inspection. However, there are shared facilities, including utilities, maintenance and public areas.

The hospital clearly has its own identity within the trust, and staff and patients enjoy working there and using the services it provides. Feedback from patients shows that they appreciate having a small and dedicated hospital that serves the local communities.

We inspected the day surgery unit and operating theatre.

We talked with four patients, one relative and ten staff, including nurses, health care assistants, operating department practitioners, doctors, receptionists and senior managers. We observed care and treatment, and looked at four care records.

Summary of findings

Services in the surgical department were safe. Services were provided in a clean and hygienic environment in line with recognised guidance, which helped protect patients from the risk of infection, including hospital-acquired infections. However there was a lack of learning from incidents which occurred across the trust, with no system in place to facilitate learning from incidents and complaints which needed improving. We saw that appropriate equipment checks and maintenance were carried out.

Due to the low risk nature of the surgery undertaken here, there were few reports of incidents at this site, particularly as the unit was managed by the main Broomfield Hospital operating department. However, we reviewed four of the seven incidents logged on the hospital's electronic system since April, and despite them stating 'all staff made aware', when we asked, staff were not aware of these incidents taking place, or of any learning from them. There was little data on the safety of the day surgery unit at Braintree, such as audits. We saw two patients undergoing pre-operative checklists, which were thorough.

We saw staff who were caring; the patients we spoke with complimented staff on their caring approach and professionalism. The patients we spoke with appreciated being treated in a small unit, where they perceived that the waiting time was much shorter. There

Surgery

was a calm atmosphere. Staff training and appraisals were carried out to ensure that staff were competent, and had knowledge of best practice to effectively care for and treat patients.

Are surgery services safe?

Good

The day unit and operating theatres were clean, modern and bright. Medicines management systems were found to be safe.

Patients told us that they felt safe, and we observed some good practice surrounding surgical check lists, including one incidence of the staff building a good rapport with the patient.

There was a lack of learning from incidents at all levels. For example, senior nursing staff were not aware of recent 'never events' that had happened at Broomfield Hospital, even if they were within the same specialty or related to their practice, such as wrong site surgery. On the day of our inspection, we looked in a patient's medical record and found an operating note, which had been completed incorrectly; the patient had had lesions removed on the right side, yet the surgeon's notes stated that lesions on the left side had been removed. The correct surgery had taken place and we have been informed by the trust that the consultant has since corrected the notes.

Incidents

- The main trust had reported five 'never events' (a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers) within the main site at Broomfield Hospital, between April-October 2014. All but one of these 'never events' related to wrong site surgery.
- A root cause analysis was done for each, and although the causes for the wrong site being operated on were all slightly different, it was clear during our inspection that there had been no robust system of learning, trust-wide, to prevent future occurrences.
- Staff were all aware of how to use the trust's electronic recording system. We reviewed four of the seven incidents that had taken place between April 2014 and October 2014. There were a mixed category of incidents reported, with no particular identifiable trend.
- We found that many incidents were awaiting investigation. This meant that incidents were not

investigated, lessons learnt and closed in a timely manner; three incidents in particular, surrounding patient safety, in April, May and September 2014, had not been closed.

- They related to incorrect eye drops being administered, a patient arriving into the operating theatre with no identification label, and two patient's documents being mixed up because they had the same first name. All the learning outcomes for these incidents recorded on the electronic reporting system stated that 'all staff were made aware'.
- Braintree Community Hospital staff had recently started joining the meetings with Broomfield Hospital staff at which complaints, incidents and learning actions were disseminated. The first of these meetings was held in November 2014.

Cleanliness, infection control and hygiene

- The hospital was visibly clean. The operating theatre was extremely clean. Cleaning was carried out by an external cleaning company. Staff told us that any perceived shortfalls with cleanliness were rectified immediately, once they had been noticed and reported.
- We saw daily and weekly cleaning schedules, and audits of cleanliness.
- Infection rates were negligible. Patients who were at risk of having an MRSA infection were pre- admitted at Broomfield Hospital.
- We observed that staff were using appropriate equipment and clothing in the operating theatre. Gloves and aprons were worn on the day unit as appropriate. Hand hygiene gel dispensers were available at the entrances to the day unit and beside each bay; staff were observed using these. None of the gel dispensers we tested were empty.
- We observed a nurse wash her hands before they examined a patient's eye following cataract surgery. We noted that all the clinical staff we saw were adhering to the trust's 'bare below the elbow' policy, and were wearing minimal jewellery.

Environment and equipment

- Braintree Community Hospital is purpose-built. It was bright and modern with a contemporary appearance. The day unit and the adjacent waiting area were tranquil and calm.
- No decontamination work took place at Braintree Community Hospital. There was an agreement in place whereby instruments were decontaminated and sterilised at a nearby hospital, which was not owned by MEHT. However, recently, some sets of instruments had been sent to another hospital and, because this hospital did not have an acceptable traceability system, 43 sets of instruments had been 'quarantined' whilst a high level investigation took place. This had caused some operational difficulties, particularly with orthopaedic surgery. This was because having so many sets of instruments out of circulation had significantly reduced the number of sets available.
- There was a regular daily delivery service between the two sites. The instruments and instrument trays belonging to Braintree Community Hospital were marked in a way that identified them.
- Security of the unit was good. The day unit was locked, and visitors were required to use an intercom, and to identify themselves upon arrival before they were given access. Staff entered the unit by means of a swipe card that was unique to them.
- Signage was clear; however, there were no signs in other languages, or for example, to assist those with a sensory disability.
- The day unit consisted of 10 bays. They were separated into two areas, and were adjusted to either a male or female 'side', depending on the ratio of male and female patients for that particular session. This meant that male and female patients were separated from each other.
- There was a bay at the end of the unit, which was slightly separate from the rest of the unit. The nurse in charge told us that this was used for patients who required a quieter area, such as if they were nervous. There was a separate area for patients undergoing ophthalmic surgery, with comfortable reclining chairs. Bathroom facilities were sufficient.
- Storage areas, both in the day unit and the operating theatres, were clean and well organised. There was minimal equipment stored in corridors. Equipment that was stored, was covered.
- We checked resuscitation equipment and the 'difficult intubation' trolley. We found that equipment was checked daily, and the trolleys were sealed once the equipment had been checked. All were clean and in

good working order. Emergency equipment was standardised with Broomfield Hospital. Medicines used for resuscitation, and consumable items, such as syringes and needles, were all in date.

Medicines

- Fridges were locked and daily temperature recordings were within the normal range. Controlled drugs were locked away appropriately, registers had the required entries, and staff checked stock balances at least daily.
- Medicines were available to meet the needs of patients. For example, there was a small stock of eye drops, as the unit undertook some ophthalmic surgery. Staff said that they knew how to report errors and incidents; however, there was little feedback to individual staff once they had reported an error. We found no evidence that lessons were learnt in order to prevent similar errors.
- Patients were told how to take their medicines at home before they left hospital. The nurses undertook this task. We observed a patient being discharged from the day unit, and saw that the nurse explained their post-operative medicines, and ensured that the patient understood the written information.

Records

- We reviewed four patient records in the day unit and in the operating theatre. We noted that appropriate assessments had been completed accurately, such as venous thromboembolism (VTE) risk assessments. In all cases, the preoperative checklist was consulted, which included the patients past history and any inerrant risks associated with co-morbidities.
- The medical notes we saw were completed thoroughly, and were mostly legible. However, in one case, we noticed that a patient had undergone surgery for the removal of two lesions on their right side. The GP referral letter, the outpatient record - when the patient had been seen by the consultant surgeon some two months earlier, and the electronic discharge summary - completed by the scrub nurse, confirmed this. However, the operating record, completed by the operating surgeon, not the original consultant, stated that the lesions had been removed from the left side of the patient. This meant that the operation record was incorrect. We brought this immediately to the attention of the nurse in charge, as the surgeon was operating on another patient.
- Nursing and medical notes were in a paper format, apart from discharge summaries. The patient's complete records were kept at the bedside, and were taken to the operating theatre. Notes were returned to the main records store at Broomfield Hospital.
- There was a drive to co-ordinate all the records, so that they were the same as those at Broomfield Hospital.

Safeguarding

- Safeguarding training for adults, Levels 1 and 2, had been undertaken by most staff working at Braintree Community Hospital. For new staff this training was part of their induction.
- Staff we spoke with were able to show us a good understanding and awareness of the trust's safeguarding processes, and how they would report any concerns.
- We were told that any decisions would be made with the input of people who could speak on behalf of the patient if the patient did not have capacity to make their own decision. During the handover of a patient from the day unit to the operating theatre, we saw the nurse discreetly bringing to the attention of the theatre nurse that the patient had a history of dementia. This ensured that the theatre staff were aware that the patient may need further explanations and support.

Mandatory training

- The trust's target was that 75% of staff should have completed mandatory training. We saw from trust records that the majority of training for staff in mandatory subjects was up to date. All staff who had transferred from the hospital's previous provider had received a full trust induction, and were up to date with the trust's mandatory training.

Assessing and responding to patient risk

- We reviewed the case notes of four patients and found that, in general, these reflected their needs. They had appropriate risk assessments, and consent had been taken for the proposed surgery.
- The trust had implemented use of early warning scores, such as the national early warning system (NEWS),

which had been introduced at Braintree Community Hospital when the trust took over the site in April 2014. It was used effectively to identify and assess deteriorating patients. NEWS is a mechanism for calculating certain indicators to judge whether or not a patient is deteriorating clinically, and if so, whether further or new intervention is required. This includes simple physiological observations of the patient's respiratory rate, oxygen saturation, temperature, blood pressure, pulse rate, urine output and level of consciousness. A higher score triggers further intervention from a senior nurse or doctor to ensure that any changes in a patient's status are managed immediately.

- Patients were pre-admitted at both Braintree Community Hospital and Broomfield Hospital for assessment. Some pre-admissions, for example for patients undergoing procedures requiring a local anaesthetic, were completed by telephone. Only patients who were deemed to be low risk for surgery, were operated on at Braintree Community Hospital. High risk patients had their operations done at Broomfield Hospital, where access to facilities that may be required in an emergency, were more readily available.
- If a patient deteriorated following surgery at Braintree Community Hospital, they were cared for by the anaesthetist or nurses until a transfer to Broomfield Hospital could be arranged. The transfer was done via a 999 ambulance, and in the absence of a surgical assessment unit, patients were admitted to A&E.
- We saw a flow chart in the operating theatre and in the day unit, to confirm this process. The nurse in charge told us that this was a rare event, and had happened only four times in the past two years, and only once since the trust had taken over the service in April 2014.
- If a patient became suddenly and seriously unwell, such as with a cardiac arrest, there was always someone on site with current advanced life support skills. All other clinical staff had intermediate life support training. This meant that cardio-pulmonary resuscitation (CPR) could commence; the patient could have their airway secured, and appropriate first line medication given, whilst waiting for the 999 ambulance to arrive and transfer the patient to Broomfield Hospital.
- We found that World Health Organization (WHO) safety checklists were completed thoroughly in the operating theatre. Compliance was audited via a band 7 nurse at Broomfield Hospital. Any incomplete forms were discussed with the member of staff involved. This included medical staff.

Nursing staffing

- The department was led by a band 7 nurse, who reported to the theatre manager at Broomfield Hospital. The day unit coordinator reported to the band 7 theatre nurse.
- The unit used very few bank staff; most of the shifts were filled by the unit's own staff. There was one member of staff from an agency who was used regularly. They confirmed to us that they had received a full induction to the department. Three operating [JW1] department practitioners (ODPs) from Broomfield Hospital had received an induction, so that they could transfer easily to Braintree Community Hospital should the need arise.
- There were four vacancies between the two departments, which were in the process of being advertised.
- The unit opened at 7am. It usually closed at 6pm, although there was an operating list that continued later, until 8pm, on one day a week. Staff worked long days to cover lists. Very occasionally, they were required to stay later if a patient required a longer recovery time. The nurse in charge told us that this was very rare.
- On the day of our inspection, the staff skill mix was suitable to support the patients in their care safely.

Surgical staffing

- There were no surgical patients staying overnight, so there was no on-call doctor.
- The surgeons and anaesthetists visited from Broomfield Hospital, and held both outpatient clinics and operating lists at Braintree Community Hospital.

Major incident awareness and training

- Senior staff we spoke with were aware of the trust procedures for any major incidents. However, junior staff were less responsive, and said that they would defer to whoever was in charge.

Surgery

Are surgery services effective?

Good

Audits were undertaken as part of the trust's auditing programme, such as audits of transfers into the trust following surgery, for patients who had experienced complications, or required an unexpected overnight stay. This would identify whether late operating was being undertaken, or if unsuitable patients were being operated on. However, as the trust had taken over Braintree Community Hospital in April 2014, there was insufficient data to be meaningful at this stage.

Patients told us that they were comfortable following their procedures.

Staff demonstrated a broad understanding of the Mental Health Act, and what to do if a patient was unable to consent.

Evidence-based care and treatment

- We saw that guidance was produced for pre-operative assessments in line with best practice, including the NICE (National Institute for Health and Care Excellence) and the Association of Anaesthetists of Great Britain and Ireland guidelines. This meant that patients could be assured that appropriate assessments would be carried out to ensure they were medically fit for their operation.
- All patients completed a pre-assessment medical questionnaire, which broadly indicated if they had any existing conditions that increased risk to them if surgery was undertaken. Most patients attended for pre-assessment a few days prior to their expected surgery.
- Pre-assessment took place either at Broomfield Hospital or at Braintree Community Hospital. However, the pre-assessment protocols were in their initial stages at Braintree Community Hospital, with no dedicated staff in place to run them. Patients undergoing the orthopaedic, plastic, ophthalmic or gynaecological surgery, attended pre-assessment within those particular departments at Broomfield Hospital.

Pain relief

- All the surgery undertaken at Braintree Community Hospital was of a minor nature. At the time of our inspection there were two operating lists going on, with all the operations taking place under local anaesthetic. We looked at four patients' medication charts and saw that they had pain relief prescribed if they required it.

Nutrition and hydration

- On the day of our inspection, patients were having their surgery done under local anaesthetic only. We saw that they were able to eat and drink up until they went into the operating theatre, and we heard nurses offering them hot drinks. Following surgery, we saw that patients were offered a choice of hot and cold drinks and a selection of sandwiches before they went home.
- For patients undergoing general anaesthetic, the unit followed guidance from the Royal College of Anaesthetists with regards to pre-operative fasting. Patients were offered food and drink following their procedure, as appropriate to their condition. All patients had to drink and have a small snack before they were allowed to go home.

Patient outcomes

- As the trust had only recently taken over Braintree Community Hospital, there was no data with regard to patient outcomes.
- The nurse in charge told us that there had been no returns for theatre because, for example, a patient was bleeding excessively post-operatively.

Competent staff

- There was a comprehensive induction for new staff. This included both a trust-wide induction and a local indication. Staff told us that as they had been transferred from another company to Mid Essex Hospital Services NHS Trust in April 2014, all had undergone the trust's induction. All said that their induction had been beneficial.
- Staff we spoke with reported that they had appraisals where they could discuss their work. All the staff we spoke with confirmed that they had received an appraisal. There were two staff appraisals outstanding for the operating theatre; however, those staff concerned were away on long-term absence.
- None of the staff we spoke with had received a review of their appraisal, and there was no formal supervision in place. However, there was awareness that the trust had only recently taken over most of the current staff from the previous employer.

Surgery

- Doctors had their appraisals completed according to General Medical Council Guidelines.

Multidisciplinary working

- The nurse in charge of the day unit told us that communicating essential information was straightforward within the unit, as it was so small. The theatre manager from Broomfield Hospital, who had operational responsibility for the unit, visited regularly. Weekly operational meetings were held in Broomfield Hospital, to which the senior staff were invited. The staff worked well with the doctors and anaesthetists, seeking advice about particular patients if, for example, the patient had an existing condition, or required pre-operative tests.
- We saw evidence of excellent multidisciplinary working between the nursing, theatre and medical staff in the day unit and operating department. This was particularly evident when a patient was checked into the operating theatre for their surgery.

Access to information

- There were a large number of information leaflets about a number of procedures, and what to expect, which were an important part of the preparation of patients for surgery. These included the risks and benefits of certain procedures, wound care, and types of anaesthetic. Some leaflets were obviously professionally printed, whilst others were photocopied.
- However, none of the leaflets we saw in the trust were available in different languages, or different formats, such as in an easy-to-read format for someone with a learning disability.
- Patients were advised what to do should they require advice when the unit was closed out of hours and at weekends.
- The ophthalmic department had a nurse on-call up until 10pm Monday to Friday, in case patients were worried or concerned. After 10pm, calls were diverted to the on-call doctor at Broomfield Hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

- Patients were able to give their consent when they were mentally and physically able. Staff acted in accordance with the law when treating an unconscious patient, or in an emergency. Staff we spoke with said that they understood and acted in accordance with the Mental Capacity Act 2005. Staff had received training in aspects of the Mental Capacity Act 2005.
- Both junior doctors and nurses we spoke with were able to tell us about the requirements for consent when a patient lacked the capacity to make the decision for themselves. However, it was rare for patients who lacked capacity to be treated at Braintree Community Hospital. Such patients lacking capacity were usually treated at Broomfield Hospital.

Are surgery services caring?

Good

During our time spent on the surgical wards, we observed positive interactions and caring behaviours between staff members and patients. Patients were very positive about the care they had received. It was clear that patients appreciated being treated in a small, calm unit near to their home. Patients were treated with privacy and dignity.

Compassionate care

- Staff practiced and understood the principles of delivering compassionate care to patients.
- The patients had very positive views about their care. They told us, “you couldn’t make it any better. No long delays. Everything is excellent”. Another said, “I’m extremely happy with my experience”.
- We observed care being delivered where patients’ privacy and dignity was preserved. Nurses and health care assistants were talking to patients with kindness and compassion. We observed the curtains being closed when any patient received personal care.

Understanding and involvement of patients and those close to them

- All the patients, and one relative that we spoke with, told us that they had received suitable explanations and understood what was happening with their care.
- Patients told us that staff had given them the advantages and disadvantages of any proposed treatment options, including the risks and benefits. One told us, “I can’t fault it. The staff are extremely helpful and approachable. Everything was explained, my questions were answered. A big thank you to everyone”.

Surgery

Emotional support

- Patients told us they felt that the calm environment helped them to feel relaxed. We observed a minor operation taking place; one of the staff held the patient's hand and chatted to them during their procedure. This helped to put the patient at their ease.

Are surgery services responsive?

Good

The trust overall did not meet the national 18-week maximum referral to treatment (RTT) waiting standards for general surgery and orthopaedics. However, it did meet this target for other types of surgery, including plastic surgery and ophthalmic surgery, much of which was done at Braintree Community Hospital. The Department of Health monitors the number of elective surgery cancellations; this is an indication of the management, efficiency and quality of care. Although the trust overall had a higher than the national average number of patients whose operation was cancelled, and who were not treated within 28 days, no surgery was cancelled at Braintree Community Hospital. It was clear that there was capacity to undertake more surgery there. One member of staff told us, "I wish it was busier".

All patients who were to undergo planned surgery were pre-assessed, either face-to-face, or by telephone.

Service planning and delivery to meet the needs of local people

- We saw that on every operating list, as well as the patient's essential details, and the proposed operation, the breach date was included. A breach date indicates the date when a patient would breach the 18 week waiting target for undergoing activity which would end the RTT period. A senior member of staff told us that the breach date was included so that immediate decisions could be made, should an operating list need to be curtailed. They told us that sometimes breach dates were a priority over the patient's clinical need. However, lists were never cancelled at Braintree Community Hospital, unless there were unforeseen circumstances, such as a surgeon being unwell.
- It was evident that patients liked the unit at Braintree Community Hospital. It was calm and peaceful. Patients appreciated being treated near to their home, and not having long waits or concerns about parking.
- It was clear that the unit was under-utilised. However, it had only been run by the trust for a number of months, and its use was still being reasoned and developed. One member of staff told us, "you probably won't ever hear hospital staff say this, but I wish we were busier".

Access and flow

- The longer theatre lists were sometime 'staggered.' This was so that patients did not all arrive together and then have a long wait for their surgery, if, for example, they were last on the list.
- We found that theatre sessions started and ended on time. However, there was one weekly list which finished late. This was being monitored.

Meeting people's individual needs

- The areas that the trust served had a very low population who spoke English as a second language. The trust used a recognised translation service, should this be required. However, staff told us that they often used patient's relatives to provide translation services for their loved ones, but staff acknowledged that this was not ideal due to safeguarding concerns.
- The pre-assessment was held in private to allow for questions to be asked. Post-operative information was given at the pre-assessment stage, so that patients had the opportunity to consider the information. We spoke with a patient who said that they appreciated the opportunity to ask questions and have their fears allayed.
- Any patients who were deemed unsuitable for day care in a small unit, such as if their co-existing conditions increased the risk of complications, were referred back to Broomfield Hospital. This meant that patients who could have been at risk, had their procedure undertaken in a hospital that would meet their more complex needs.
- The nurse in charge told us that occasionally, patients were booked late, and then any pre-operative tests needed to be expedited. However, this was a rarity. No emergency or urgent procedures were undertaken in the day unit: every procedure was pre-planned.

Learning from complaints and concerns

Surgery

- Informal concerns or complaints were dealt with by the staff on duty, and the nurse in charge either took responsibility to address these, or passed them onto someone more senior, who was present in the hospital two to three days each week. The complaint was then passed to the relevant person in the hospital to respond fully.
- Outcomes and actions from complaints were not disseminated to staff in a robust manner, which meant that there was lack of learning. Staff told us that they were usually not aware if a complaint had been raised, unless they found out informally.
- In the day care unit, we saw a pile of paper patient satisfaction surveys. These had been completed by patients, but had not yet been collated or taken note of. However, the operational lead manager told us that these had been superseded by cards, which were shorter and easier for patients to complete; use of these was just being implemented at the time of our inspection.

Are surgery services well-led?

Good

Most staff said that they felt supported at local level. Some staff had seen the CEO and the chief nurse when they visited the unit. Staff told us that the consultants were mostly very approachable. Most staff members we spoke with told us that they did not receive feedback from complaints or incidents that they had reported or that related to the area in which they worked. This meant that learning from complaints and incidents was not always effectively communicated by the management teams.

Audits were in their initial stages, as the trust had only taken over the hospital in April 2014. Therefore, audit cycles had not been completed.

Vision and strategy for this service

- Most of the staff we spoke with, even those who were senior, were unaware of the hospital's vision or strategy, although some could tell us what the hospital's values were: 'We care, we excel, we innovate. Always.'
- As the hospital was such a recent addition to the trust's portfolio, staff were aware that more day surgery would be moved from the main site, ophthalmology being a recent addition. However, they were also aware that this was a massive change for the trust as a whole, and they knew that this would not happen 'overnight'.

Governance, risk management and quality measurement

- Patients were risk assessed, and if they were not fit enough to have their surgery in a small unit, they were operated on at the main site, at Broomfield Hospital.
- The unit had a good management structure in place, which reflected the needs of the department. Support and senior leadership was provided from the main site at Broomfield Hospital.
- Governance meetings were held monthly and shared with Broomfield Hospital. However, essential information from these meetings was inconsistently and mostly poorly disseminated downwards to more junior staff.

Leadership of service

- The leadership in the unit was generally viewed as positive and effective by the staff we spoke with. All staff we spoke with on the unit were very positive about the teams they worked in.
- There was a lack of learning throughout the surgical directorate and the trust with regards to incidents, such as with regards to 'never events' and critical incidents.
- Most staff members we spoke with told us that they did not receive feedback from complaints or incidents that they had reported or that related to the area in which they worked. This meant that learning from complaints and incidents was not always effectively communicated by the senior management teams.
- Some of the staff at Braintree Community Hospital had worked there for several years when it was owned by another organisation, whilst some had been transferred from the main site at Broomfield Hospital. Some worked exclusively at Braintree Community Hospital, whilst others worked between the two sites.
- Some staff told us that arrangements to have their terms and conditions transferred from the previous company to the trust had not been completed. For example, although their salary had remained the same, under a transfer agreement, 'Transfer of Undertakings (Protection of Employment) Regulations 2006' (TUPE), the trust had not yet finalised their NHS banding, which

was the source of some frustration. Others expressed their concern about travel time between the two sites and the consultation that was underway regarding longer working days.

Culture within the service

- The hospital had some members of staff who had worked for the trust for many years; others were new to the trust, although not to the hospital. Most said that they were proud to work there and wanted to do their very best to ensure that patients got the best care.
- Many told us how much they loved their jobs and the people they worked with. All staff said that despite the upheavals of new ownership, they enjoyed working at Braintree Community Hospital, the pace was not as frenetic as at Broomfield Hospital, and they felt they could give more individualised care to their patients. Furthermore, the team was beginning to gel and work as one.
- Staff told us that the managers were all open to suggestions for improvements, and that there was an open culture with regards to change and improvement across the service.

Public and staff engagement

- The hospital had a small café, which was used by staff, patients and visitors. People came in from outside to have lunch there. One visitor told us, "we can get free parking and a main meal is £3.50. It's really tasty and great value".
- The trust had over 400 volunteers working for them, some of which worked at Braintree Community Hospital carrying out tasks such as directing people to the right department.

Innovation, improvement and sustainability

- We saw good evidence of team and multidisciplinary team working in most areas that we inspected. This was apparent in working taking place across the day unit and in the operating theatre.
- The operating department had worked to standardise all documentation, so it reflected that which was used at Broomfield Hospital. This made it easier for cross-site working and audit.
- All staff were keen to ensure that more patients were diverted to Braintree Community Hospital, so that the hospital's facilities were optimised for the good of the patients.

Outpatients and diagnostic imaging

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

Information about the service

Braintree Community Hospital has an outpatients department that provides outpatient services across a range of specialties, including orthopaedics, ophthalmology and dermatology. It also has a diagnostic imaging department that provides plain film X-ray and ultrasound.

We visited the general outpatient's area and observed an ophthalmology clinic. We also visited the diagnostic imaging department. We spoke with eight patients and a wide range of staff, including nurses, health care assistants, medical staff and radiographers.

Summary of findings

Patients were treated with dignity and respect by caring and motivated staff. Patients spoke positively about staff, and felt well informed about their care and the procedures being undertaken. The services we inspected were very clean and the environment was well maintained. There was a clear process for reporting and investigating incidents.

Good communication was evident across the departments on other sites within the trust. There was a shortage of key staff, in particular qualified nursing staff for outpatients. There was a strong team spirit and good multidisciplinary working across all services.

Patients and relatives commented positively on the care provided by all the outpatients' staff. Patients within the diagnostic imaging department on both sites felt that the care from the staff was excellent.

The hospital was adhering to recognised national guidelines, including nationally-recognised guidance from NICE, and Royal College guidelines. Staff aimed to deal with complaints efficiently, and they told us that they would always try and deal with a complaint immediately where possible. Patients were happy about the choice of location for outpatients and diagnostic imaging, and felt that Braintree Community Hospital offered great services.

Outpatients and diagnostic imaging

There was good local leadership The managers of the services we inspected had a vision for the future of the services. The staff in all departments felt supported, and said that management and senior staff were approachable.

Are outpatient and diagnostic imaging services safe?

Good

There was a clear process for reporting and investigating incidents. Diagnostic imaging services had an excellent feedback mechanism for staff, to keep them informed of incidents submitted and the outcomes of investigations, including lessons to be learnt. Good communication was evident across the departments on other sites within the trust. There was a shortage of key staff, in particular, qualified nursing staff for outpatients. There was a strong team spirit and good multidisciplinary working across all services.

There were policies and procedures in place in relation to consent and the Deprivation of Liberty Safeguards (DoLS). All staff we spoke with understood how to obtain informed consent. Safety measures were in place for consenting to diagnostic imaging procedures. Good safeguarding procedures were found consistently across the services, and at a trust-wide level.

Incidents

- Incidents were reported via the trust's electronic reporting system.
- All the staff we spoke with told us that they knew how to report incidents, including 'near misses'. Staff in both outpatients and diagnostic imaging were supported by senior staff to use the online reporting system.
- We looked at a sample of reported incidents within the last three months, and saw that these were managed in accordance with the trust's incident reporting and management policies. Staff were able to tell us how the system worked, and what kind of incidents they would report.

Cleanliness, infection control and hygiene

- All the outpatient and diagnostic imaging areas we visited were found to be exceptionally clean.
- We noted that the staff in clinical areas observed 'bare below the elbow' guidance, and adhered to the hospital's control and prevention of infection guidance. We observed good hand-washing technique in the outpatients department.

Outpatients and diagnostic imaging

- All staff we spoke with had completed infection control training.
- There was an ample supply of alcohol hand gel.
- Infection prevention and control policies were accessible to all staff via the intranet, and staff we spoke with knew how to find them.
- We reviewed the Hand Hygiene Observational Audit Tool, and the Cleaning and Decontamination of Clinical Equipment Audit Tool, in the outpatients and diagnostic imaging departments. No issues or concerns were identified.

Environment and equipment

- Equipment in all the departments was regularly serviced, tested and appropriately cleaned. The diagnostic imaging equipment was maintained via a maintenance contract.
- We saw labelling on equipment to demonstrate that testing had been completed and on which date.
- We looked at a sample of resuscitation equipment across the departments. All the required checks had been completed and signed off. We did not find any gaps in the records.

Medicines

- Medicines were not used within the diagnostic imaging department.
- The majority of outpatient clinics we visited did not store medicines. Where medicines were kept in a clinic, they were stored securely. We noted that the temperature of one clinic fridge was monitored on a daily basis. There were no temperature recordings of any concern.
- Competences were being developed for health care assistants to administer eye drops in ophthalmology clinics.

Records

- There did not appear to be any issue with patient records in the outpatient clinics. The notes we looked at were in good order.
- We did not see any breaches of confidentiality of patient information during our visits to all the departments.
- Staff told us that some information, such as X-rays, were accessed electronically.
- Patient X-ray reports were sent electronically to the GPs.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

- Staff reported that advance notice of people with special needs was provided through the booking system.
- Staff had developed a letter for patients attending with dementia, who were coming from a care home, to ensure that the relevant information was sent in at the time of the patient's appointment.
- We observed consent being given prior to an X-ray examination. A full identification checklist was completed prior to the X-ray being taken. Staff confirmed that this was standard practice for all patients.

Safeguarding

- The patients we spoke with said that they felt safe within the outpatients and diagnostic imaging departments.
- The staff we spoke with had completed the relevant safeguarding training for their role. They told us that they knew how to raise any safeguarding concerns.
- The trust had a safeguarding policy in place that could be accessed by staff.

Mandatory training

- Staff said that they were up to date with their mandatory training, and the training records we looked at confirmed this.
- Staff felt that the training was very good.
- Staff were supported to use the e-learning system.

Assessing and responding to patient risk

- Diagnostic imaging staff at Braintree Community Hospital showed us the nurse call stations in the X-ray rooms and the reception area. These alerted other staff that help was required. The call station was also linked to the emergency team to attend if required. Staff said that they were also able to access medical support from the rapid assessment unit which was adjacent to the diagnostic imaging department.
- Staff were present in clinic rooms and waiting areas, and were able to respond to patients who appeared unwell and who might need assistance.

Staffing

Outpatients and diagnostic imaging

- Senior nursing staff described how staff arrangements were planned to meet the requirements of the outpatient clinics. There was a shortage of qualified nursing staff, particularly in ophthalmology, to meet the skill mix requirements of the team.
- Diagnostic imaging had the required number of staff to meet the demands of the service.
- A comprehensive induction programme was offered to all staff.
- Administrative staff in diagnostic imaging covered all trust sites, as required.

Are outpatient and diagnostic imaging services effective?

We report on effectiveness for outpatients and diagnostic imaging below. However, we are not currently confident that overall, CQC is able to collect enough evidence to give a rating for effectiveness in this area. We found that the hospital was adhering to recognised national guidelines, including nationally-recognised guidance, such as NICE and Royal College guidelines.

The DNA ('did not attend') percentage was below the England average. Outpatient and diagnostic imaging services at Braintree Community Hospital occurred on five days each week.

Evidence-based care and treatment

- We saw that trust policies were based on, and developed to include, nationally-recognised guidance, including NICE and Royal College guidelines.
- One example was given by diagnostic imaging staff at Braintree Community Hospital, where new guidelines had been issued by the orthopaedic consultant, when receiving X-ray requests for teenagers with scoliosis. The staff member confirmed that these guidelines were routinely followed within the service.
- All staff were aware of how to access trust policies and procedures. The majority of these were found on the trust intranet, which was accessible by staff.

Patient outcomes

- The majority of patients we spoke with during the inspection were positive about attending the outpatient services. Patients at Braintree Community Hospital, in both the outpatients and diagnostic imaging departments, could not speak highly enough of their experience. One person said, “I actually enjoy coming here as I just know I am being looked after really well”.
- The trust follow-up to new patient ratio was below the England average. This indicated that the patients were being effectively managed to reduce repeated attendance.
- The DNA ('did not attend') percentage was below the England average for the trust overall, demonstrating that good systems were in place to enable attendance at the clinics where possible.
- The hospital ran a continuous patient experience survey that patients were encouraged to complete following their visit. We saw that the feedback cards and collection points were clearly visible. We observed one patient using the feedback card. They said that they were extremely likely to recommend the service to friends and family if they needed similar care or treatment.

Competent staff

- Staff told us that they had all received an annual appraisal. The majority said that they found it helpful in identifying further training needs to support them in their roles. One member of staff told us that they had just started a new training course following their appraisal.
- One new member of staff told us they had just completed the trust induction programme and a full departmental induction. They felt they had been better equipped to understand the trust and to do their job well.

Multidisciplinary working

- The radiology staff described how they worked closely together to achieve the best outcomes for the patients. They worked with the rapid assessment unit staff, and regularly contacted GP practices to ensure the smooth running of the service.
- The administrative staff in both outpatients and diagnostic imaging commented on how well everyone worked together. Patients we spoke with were very positive about the team working well together, and the positive communications they received during their appointments.

Seven-day services

Outpatients and diagnostic imaging

- Diagnostic imaging provided a walk-in service from 9am-6pm, Monday to Friday.
- Outpatient services operated a five day a week service, with extra clinics arranged in the evenings and at weekends, when required.

Are outpatient and diagnostic imaging services caring?

Good

Patients and relatives commented positively on the care provided by all the outpatients' staff. Patients within the diagnostic imaging department on both sites felt that the care from the staff was excellent.

We saw that patients were treated politely and respectfully at all times during their visit to the hospital.

Compassionate care

- We observed a wide range of staff of differing professions and grades, interacting and speaking with patients in a caring, friendly and kind manner.
- All staff treated patients with dignity and respect.
- The environment allowed confidential conversations to be held between staff and patients. We did not observe staff talking about patients in the corridors.
- There were sufficient staff in all the services to ensure that a chaperone was available for intimate examinations, or when requested.
- We saw that staff listened to patients well, and responded to any questions.
- One patient said, "we get the best care at this hospital".
- All staff we spoke with took great pride in their work. Many staff had worked at the hospital for many years. They demonstrated caring, professional attitudes.

Patient understanding and involvement

- We spoke with three patients regarding the information they received in relation to their care and treatment. All the patients we spoke with were aware of why they were attending the service, and felt sufficient information had been given.
- One patient had been attending the outpatient ophthalmology clinic for a long time. They told us that they were confident in the service, and "I have the correct information to manage my eye condition".

Emotional support

- Information was displayed throughout the hospital and in the waiting areas, about any support services that might be appropriate. There were good networks and support services run in the community.
- Staff approached the patients with a caring and supportive attitude.

Are outpatient and diagnostic imaging services responsive?

Good

We found that patients in outpatients and diagnostic imaging were seen by staff who were polite and respectful, and who wanted the best outcome for the patient's visit.

Patients shared positive views about the medical staff, nurses and allied health professionals they saw in the services. They felt that their needs had been met.

Patients were happy about the choice of location for outpatients and diagnostic imaging, and felt that Braintree Community Hospital offered great services.

Staff aimed to deal with complaints efficiently, and they told us that they would always try and deal with a complaint immediately where possible. Staff in diagnostic imaging told us that there had not been a complaint made against the service at any time.

Service planning and delivery to meet the needs of local people

- Diagnostic imaging at Braintree Community Hospital recently changed to a walk-in service for plain film X-ray. The service was open Monday to Friday, from 9am-6pm. The staff managed the flow of patients well. The patients we spoke with were extremely satisfied with the service, and felt it met their needs.
- We saw that where possible, and if clinically appropriate, patients could choose their location for attendance at appointments. One patient we spoke with chose to attend Braintree Community Hospital for their orthopaedic post-operative review, as it was closer to home.

Access and flow

Outpatients and diagnostic imaging

- The trust was meeting almost all of its referral to treatment times (RTT) according to figures submitted from April 2013 to June 2014.
- Waiting times for diagnostic tests were below the England average.
- The outpatient department was steadily busy on the day of our visit. However, staff and patients told us that there were no delays in being seen for appointments. We observed a good flow of patients in and out of the departments.
- The administrative staff in the diagnostic imaging department advised us that the average patient waiting time for an X-ray was about 10 minutes. We observed patients waiting for no more than 10 minutes to have their X-ray taken.

Meeting people's individual needs

- The services we inspected used a telephone interpreter service for other languages. This was easily accessible to use.
- Staff across the service had looked at ways to meet the individual needs of patients with learning difficulties.

Learning from complaints and concerns

- Information about the Patient Advice and Liaison Service (PALS) was clearly visible across the services.
- Staff we spoke with were all aware of the complaints procedure, and were confident in dealing with complaints if they arose.
- Staff within the diagnostic imaging department told us that they had never received a complaint.

Are outpatient and diagnostic imaging services well-led?

Good

The managers of the services we inspected had a vision for the future of the services. The staff in all departments felt supported, and said that management and senior staff were approachable.

The change of management at Braintree Community Hospital had been handled well, and staff felt encouraged for the future direction of the hospital.

Most staff felt that the senior executive team were more visible now, and there was a good relationship with the chief executive.

Vision and strategy for this service

- The managers of the services demonstrated a strong vision for the future of their services. They were aware of the challenges faced, but had plans in place to develop services and staff.
- The managers of the outpatients and diagnostic imaging services showed that they had managed the joining of services to Broomfield Hospital well. The staff felt supported in the process.
- We heard from many differing staff across the services that the chief executive had an 'open door' policy and was often visible at the hospital.

Governance, risk management and quality measurement

- The Friends and Family Test had been implemented in outpatients. There was limited feedback available during the inspection. Patients and relatives we spoke with were very happy with the service.
- There was no clinical director in post for the outpatients department at the time of the inspection. Clinical governance meetings had commenced in August 2014 for this department.
- Diagnostic imaging had dedicated staff employed for clinical governance across the service. Roles included monitoring all incidents and near misses, reporting back lessons learnt to the staff, attending a monthly radiation protection advisory group, auditing referrals, and undertaking a full range of risk assessments.
- A radiology induction programme had been introduced for all doctors working within the trust. This covered learning from all reportable CQC incidents, identification checks, and referral criteria. Feedback from this course was very positive.
- Complaints and compliments were investigated, and staff were involved in any service improvements that had been identified.

Leadership of service

- We saw good evidence of leadership across the services. Staff reported that the managers were approachable and had time for them even though the services were busy.

Outpatients and diagnostic imaging

- At the allied health professional focus group, staff were positive about their teams, and were pleased to have an opportunity to share the good work they were engaged with.

Culture within the service

- We spent time during the inspection observing the staff and the flow through the services. We saw that staff treated patients with respect and took pride in their work. We felt that the staff had the patient's best interests at the forefront of their day-to-day interactions.
- We saw staff interacting with their managers during the inspection, and saw that this was done in a positive and friendly manner. Staff were very enthusiastic about working in the department. One member of staff said, “I love working here”.

Public and staff engagement

- Staff we spoke with felt engaged with the trust-wide improvements.
- There was some concern from staff and the public we spoke to at the listening event that the hospital would lose its community feel.

Innovation, improvement and sustainability

- Both outpatients and diagnostic imaging had put processes in place to ‘grow their own staff' in the face of national shortages for some professions. This had been welcomed by staff, and was a good example of innovation to improve and sustain the services.
- One member of staff in diagnostic imaging told us about an innovative idea to ensure that identification checks, for patients coming for examinations from care homes, were done thoroughly.
- We saw good examples at a department level, of innovative changes, such as an example of a two week wait referral form in a different colour to enable easy identification.

Outstanding practice and areas for improvement

Outstanding practice

Areas for improvement

Action the hospital MUST take to improve

Action the hospital SHOULD take to improve

- Ensure that there are a sufficient number of nursing staff recruited and in post to provide services.
- Ensure that lessons are learned from incidents, serious incidents and complaints.
- Ensure that learning from incidents and complaints is shared across all trust hospital sites.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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