Care Quality Commission

Mid Essex Hospital Services NHS Trust

Broomfield Hospital

Quality Report

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

Ratings

Overall rating for this hospital	**Requires improvement**
Urgent and emergency services	Inadequate
Medical care	Requires improvement
Surgery	Requires improvement
Specialist burns and plastic services	Requires improvement
Critical care	Good
Maternity and gynaecology	Requires improvement
Services for children and young people	Good
End of life care	Requires improvement
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Broomfield Hospital is part of the Mid Essex Hospital Services NHS Trust (MEHT). Broomfield Hospital is an acute district general hospital and it is the only hospital location within Mid Essex Hospital Services NHS Trust to provide accident and emergency (A&E) services. Broomfield Hospital also provides a county-wide plastics, head and neck and upper gastrointestinal (GI) surgical centre to a population of 3.4 million, and an internationally-recognised burns service in the St Andrew's Centre within Broomfield Hospital that serves a population of 9.8 million.

Broomfield Hospital is an acute hospital providing accident and emergency (A&E), medical care, surgery, critical care, maternity and gynaecology, children and young peoples services, end of life care, and outpatient and diagnostic services, which are the eight core services always inspected by the Care Quality Commission (CQC) as part of its new approach to hospital inspection. In addition to these eight core services, the hospital provides a regional centre for burns and plastic surgery. We have therefore included these as an additional core service on this scheduled inspection.

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 aspirations to become a foundation trust, but also due to risks that had arisen around the non achievement of the four hour target in A&E, and also an increased number of whistleblowing and safeguarding concerns received by the Commission.

This was a scheduled and announced inspection, which took place between 26 and 28 November 2014 and on 6 December 2014 we conducted an unannounced inspection of the service. In addition, on 05 February 2015 we returned and carried out a focused unannounced inspection of the Emergency and Assessment Unit (EAU) and took enforcement action, on 26 March 2015 we returned to ensure that systems were in place to protect people from avoidable harm.

Overall, we have found that the ratings and provision of care in each core service varied greatly. The trust was a caring organisation throughout, and staff we observed in the majority were passionate about their work and caring towards patients. We found that the burns service was providing excellent care, with some of the best outcomes for patients with severe burns in the country, and the results were competitive with burns centres worldwide. Generally, we found the critical care and services for children and young people good, with improvements needed in medical care, surgery, end of life care and outpatient and diagnostic services. We found examples of poor care and practice in urgent and emergency services which we have rated as inadequate, and also in maternity and gynaecology and specialist burns and plastic services which required improvement. During our inspection of Broomfield Hospital EAU on 5 February 2015 we found that the safety of the emergency assessment unit (EAU) was inadequate but this did not impact on the rating for urgent and emergency services which was already rated as inadequate. However the rating for leadership within urgent and emergency services changed from requires improvement in November 2014 to inadequate. This is because the leadership of the unit did not act to ensure that appropriate and registered staff were responsible for the direct care of patients on the EAU. The leadership of the service failed to act on concerns raised by staff and the senior management team failed to have effective governance and assurances processes in place to monitor the work and roles of the staff working in adaptation posts whilst they were awaiting registration. Overall, we have rated Broomfield Hospital as a requires improvement service as whilst there are two inadequate ratings for the safe domain this only relates to one core service. We have identified areas where improvements are required.

- It was evident that throughout the organisation staff were passionate, dedicated and cared about the work they delivered.
- The service has had an unstable few years with management changes and this had impacted on service flows, confidence and stability. The service is on a journey to improving the services provided and this will take some time to embed throughout.

Summary of findings

- There were significant staffing shortages particularly for qualified nurses throughout the hospital but there was a plan in place to recruit over 200 additional nurses, though it is recognised by the trust that skill mix would remain a challenge for some time.
- The emergency department like all throughout England in November was under pressure from a high volume of attendances.
- The flow of the emergency department, staff vacancy, skill mix and triage did have an impact on the care patients received which in some cases was poor. Care in the emergency department did not always adhere to NICE guidelines, particularly around head injuries and sepsis.
- The care of patients with mental health concerns fell below the expected standard of care.
- There was no clear pathway or plan for patients who were receiving care at the end of their life. The development and implementation of this plan was required following the removal of the Liverpool Care Pathway in 2014.
- The trauma service within plastic surgery particularly on Mayflower was disorganised and impacted directly on patient care and safety when the ward became overcrowded with patients.
- Significant concerns were raised around Writtle ward and their high use of non-trust staff and case mix of medical outliers and women with gynaecological and early stage pregnancy concerns.
- There were significant waiting lists in place for patients who require a follow up outpatient appointment (over 24,000 at the time of inspection across all specialties). There was no risk assessment process in place for those patients to ensure that a longer wait was acceptable.
- Improvements were required in terms of the reporting and learning from incidents.
- Governance structures at departmental level across the emergency department, medical care, specialist plastic surgery, maternity and gynaecology and end of life care were not robust and were in significant need of improvement.
- The Burns service was outstanding and there innovative developments and plans the service had. Their patient outcomes also show that they are one of the best burns centres in the world. We commend them for the work that they are undertaking and their achievements to date.

We saw several areas of outstanding practice including:

- The caring and responsive approach shown by the chaplaincy and the services provided to bereaved families by staff in the mortuary were outstanding. Staff within both services went beyond the call of duty to support families, particularly those bereaved of children and babies.
- The burns service was outstanding with innovative and pioneering approaches to care delivery and outcomes for people with burns which had been reflected in national research papers.
- Outcomes for patients with serious burns was comparable among the best in the world and were consistently exceptional. This was evidenced through a cohort study undertaken by St Andrew's in 2012.
- Pathways for breast reconstruction and hand therapy were outstanding.
- The trust's abscess rate following an epidural was 0% as compared to the national average of 8% which was an excellent outcome for patients.
- The 'trigger and response team' team were an exceptional team supporting acutely unwell patients throughout the hospital. The team were recognised throughout the hospital as being very responsive.
- The mortuary team were innovative and passionate about providing a good patient experience at the end of life.
- Individual specialist staff in the trust including the learning disability nurse, specialist nurse for dementia care and the manual handling advisor were identified as being outstanding and highly responsive to patient and staff needs.
- The nurse-led peripherally inserted central catheters (PICC) was developed within the critical care service without initial funding, it has seen great success and improved patient outcomes.
- There were outstanding examples of local leadership and innovation in the intensive care unit.

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

Importantly, the trust must:

Summary of findings

- Ensure that only registered nurses are included in the nursing numbers and ensure that staffing numbers are maintained on the EAU by suitably qualified and registered staff.
- Ensure that incidents are appropriately reported and investigated on the EAU.
- Ensure that the adaptation staff working in the hospital are provided with support, supervision and competency training as well as mentor support.
- Improve governance and assurance processes around the use of adaption staff throughout the hospital to ensure that they work within the scope of their role.
- Immediately improve inpatient deterioration recognition across all inpatient areas, particularly on Writtle Ward.
- Immediately work to reduce the number of patients who are on a waiting list for a follow-up outpatient appointment.
- Reduce the number of hospital-acquired pressure ulcers.
- Ensure medicines are administered in a timely way, especially for patients receiving intravenous antibiotics and time critical medicines.
- Ensure care documentation, including care plans and risk assessments, are undertaken in a timely way, accurately, are fully completed, and reviewed when required.
- Ensure that nursing handovers are robust and identify patients at risk.
- Ensure that there are sufficient and appropriately skilled nursing and medical staff on duty at all times to meet patients' needs in a timely manner.
- Ensure nurses have the appropriate/specific skills to care for all the patients in their ward areas.
- Improve treatment times for patients with prostate cancer to ensure a higher percentage of patients receive their required treatment within 62 days.
- Improve governance systems to include formalised and minuted mortality and morbidity meetings across the directorates.
- Ensure that systems for providing staff with feedback on incidents, and sharing learning from incidents, are embedded throughout the trust.
- Develop a strategy for the improvement and delivery of end of life care.
- Improve staff training and awareness on mental health, so that the provision and care for patients in urgent and emergency services with mental health conditions improves.
- Ensure patients with mental health concerns are risk assessed on arrival at the emergency department.
- Review staffing levels on the reception desk in the emergency department.
- Ensure that patients are referred to in a dignified and respectful way, and not as bed numbers, particularly on Danbury Ward.
- Ensure all items of equipment that require annual service and maintenance are maintained on time.
- Ensure patient prescription charts for medicines are signed when medicines are administered, particularly in the emergency department and emergency assessment unit.
- Ensure medicines cupboards are kept secure at all times.
- Ensure that intravenous (IV) fluids are stored securely to minimise the risk of tampering.
- Improve staff knowledge and understanding of what constitutes a safeguarding referral for adults.
- Ensure that all safeguard referrals for adults in the emergency department are completed and actioned in a timely way.
- Work to improve safety, and reduce incidents with a serious impact, on the labour ward.
- Reduce the number of elective surgeries, including elective caesarean cancellations.
- Improve hand washing techniques, and infection control practices and techniques, in the emergency department, emergency assessment unit and on Writtle Ward.
- Ensure that only clinically appropriate patients are admitted to Writtle Ward, also ensuring that the medical outliers criteria for Writtle Ward is not breached.
- Review the decision to lift the birth cap on the maternity service, and determine a safe way to manage the increase in the number of women attending in labour.

Summary of findings

- Improve the standard of 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms completion throughout the trust.
- Implement an approved end of life care plan and pathway for patients.
- Review the pathology referral system to ensure that all referrals are managed safely.
- Review the need for a dedicated link co-ordinator for the health team at HMP Chelmsford, to co-ordinate prisoner visits.
- Improve governance arrangements and quality assurance, particularly in incident reporting, risk registers and incident investigations.

In addition the trust should:

- Ensure quality dashboard data is consistent across the directorate and is in a format that is easily accessible to patients and relatives.
- Provide day rooms for care of the elderly wards.
- Decrease the number of agency and bank staff by improving recruitment and retention of nursing staff. This would improve access to training.
- Work and balance staff skill mix across areas to ensure skilled experienced staff are on duty where possible.
- Improve the incident reporting culture for staff trust wide to increase the number of incidents reported overall.
- Review staffing and management structures for end of life care.
- Ensure that recruitment plans, to increase the amount of permanent burns nurses, are agreed and actioned to ensure that the high usage of agency and bank staff is reduced.
- Ensure that there is a paediatric trained registered nurse, consultant and anaesthetist available at all times within the Burns service.
- Review Burns specific policies and procedures to ensure that there is evidence of regular review and ratification.
- Review mechanisms for using feedback from patients, so that there are opportunities for reviewing and improving service quality.
- Improve patient confidentiality throughout the wards particularly when staff are discussing patient care.
- Ensure that cardiac monitor alarms are not muted without ensuring that patient is safe.
- Ensure that staff are provided with feedback and informed of learning from incidents.
- Ensure that patients with mental health concerns are appropriately observed and monitored.
- Ensure the corridor within the emergency department which leads from the ambulance doors and the resuscitation area is kept clear of obstructions at all times.
- Improve shift and nursing handovers in the emergency department to ensure all staff are informed of the required information.
- Safely plan and increase consultant cover in the emergency department from 11 to 16 hours per day as recommended by The Royal College of Emergency Medicine.
- Improve patient care within the emergency department around sepsis and head injuries in line with Royal College of Emergency Medicine guidelines.
- Improve implementation of the escalation protocol in the emergency department.
- Improve ambulance handover times within the emergency department.
- Improve local staff engagement throughout all services within the hospital.
- Safely work to reduce the number of emergency caesareans performed in maternity.
- Consider reviewing the case mix on Danbury ward to ensure those receiving oncology and end of life care are with an appropriate patient group.
- Consider reviewing nursing shift lengths to minimise the number of 13.5 hour shifts staff undertake.
- Improve audit and evidence based care and treatment in maternity services.
- Provide formal team meetings in the maternity and gynaecology wards for staff.
- Review cultural concerns and alleged bullying culture by management within the maternity service.

Summary of findings

- Improve 18-week maximum referral to treatment (RTT) waiting standards for general surgery and trauma and orthopaedics.
- Review executive and non-executive leadership arrangements for end of life care to drive the end of life care agenda through the trust.
- Improve the incident reporting culture trust-wide.
- Develop a maternity specific trigger list to ensure robust reporting measures.
- Improve the culture and leadership on EAU.
- Improve the incident reporting culture relating to safe staffing levels.

On the basis of the findings at Broomfield Hospital from our comprehensive and focused inspections the Care Quality Commission has used its enforcement powers to impose an urgent condition on the trust's registration to ensure that patients receive care from suitably qualified and registered nurses in the EAU. The Care Quality Commission has also issued the trust with a warning notice in relation to care and welfare concerns identified for patients receiving care at Broomfield Hospital. These can be viewed in the enforcement section of this report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Inadequate 	The emergency department (ED) and emergency assessment unit (EAU) at Broomfield Hospital were inadequate with regards to being safe. We saw that staffing levels were not sufficient to provide safe care to patients, particularly in the emergency assessment unit. Staff consistently had poor awareness and practice of infection prevention and control, wearing gloves and aprons whilst walking around the departments. Appropriate care was not always provided to people with deteriorating conditions, or those with mental health concerns. The service was not always effective. There was a low return of audits on sepsis and pain. Guidance on specific conditions, such as the stroke and sepsis pathway, was not always followed. We found that the ED and EAU were providing a caring service. Services were not responsive and we rated this inadequate. The EAU and ED had surges of activity which they struggled to cope with, due to space, bed availability, and low staffing levels. There were regular occurrences of ambulances stacking and waiting to handover within the department, delaying the ambulance handover. The leadership within the ED and EAU required improvement because leadership processes and governance systems were not embedded. We also found that the service did not promote staff openness and a blame culture was evident. In February 2015 the emergency assessment unit (EAU) at Broomfield Hospital was inadequate with regards to being safe. We saw that staffing levels were not sufficient to provide safe care to patients with three registered nurses on duty. We found that on the EAU pre-registration staff awaiting registration with the Nursing and Midwifery Council (NMC) working in nurse uniform, with 'registered nurse' ID badges, working with responsibility with for patient caseloads without NMC registration. When we returned on 26 March 2015 we found that that the trust had taken appropriate action. The unit was appropriately staffed with qualified

registered nurses and there were new arrangements in place to ensure that pre-registration nurses were well supported and working in supernumerary roles.

Medical care

Requires improvement

We found that the medical services required improvement. There were high levels of pressure ulcers, although numbers of patients having a fall were reducing. We found variable record keeping with regard to people's care planning and observations. The use of medical and nurse agency staff was high. Nursing handovers did not always highlight patients at risk. Care was generally provided in line with national best practice guidelines. The trust had been meeting national targets for the treatment of women with breast cancer.

There was evidence of progress towards providing seven day a week therapy services for the care of the elderly, although this was not yet in place. Nurses did not always have the skills to care for patients with particular needs. Caring was good. This was because the staff included patients in conversations, responded to patient's needs, and displayed a caring culture across the directorate. The trust had not introduced specific care pathways for patients with dementia.

Surgery

Requires improvement

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, we were concerned that patient records were not stored securely, that there were gaps in nursing shifts because there was an ineffective bank and agency booking system in place, and we observed a lack of learning from reported incidents and complaints.

Consultant surgeons worked a seven day on-call rota, which meant that as well as their own work, they built up a large number of emergency patients over a week that required treatment and reviews. To facilitate this, the emergency team 'borrowed' junior doctors from other teams, reducing their continuity of training and practice. We saw staff who were caring; the patients we spoke with complimented staff on their caring approach and professionalism. Shortages of beds resulted in some

patients being admitted to an inappropriate environment. Patients' operations were sometimes cancelled or delayed due to lack of capacity. However, the hospital had put some processes in place to attempt to minimise this.
The trust has a recruitment programme; however, staff reported to us that there were delays recruiting and replacing staff. 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. A clinical governance framework was also in place.

Specialist burns and plastic services

Requires improvement

We found that there was a very different service provided to the plastic surgery patients and the burns patients. The burns patients received an exceptionally good service whilst the plastic surgery patients received a service which was concerning in terms of safety and responsiveness. We have reported them as a single service as this is how the trust identifies them however where necessary we have separated our findings for the individual services.
In the burns service there were a sufficient amount of qualified nurses and doctors on duty at all times. We found that actions were taken to address known risks to ensure patient safety. However in the plastic surgery service we found that the service did not respond appropriately to risk levels in the service or for individuals. There was an unacceptable level of thematic serious incidents and 'never events', whereby the service was slow to react and failed to implement necessary changes in a timely way. Staff across all disciplines in plastic surgery told us that the trauma service provision was unsafe. Action plans were in place to improve this service; however, action required had not taken place as planned.
There were also significant gaps in the checking history of emergency equipment , non-compliance with national standards in terms of infection control, and some environments were not fit-for purpose. Compliance with mandatory training required improvement. There were also substantial

Summary of findings

nurse and junior doctor shortages in some areas, with high use of agency and bank nursing staff. Significant changes had been made to the plastic surgery service provision without due regard to the impact on people's safety and staff's wellbeing. We found that nursing staff on the ward did not always have the time to complete patient's risk assessments and care plans accurately or fully. This meant that vital risk assessments, including pre-operative assessments in some areas, were not being undertaken safely, nor in line with evidence-based care and treatment. We observed instances where this put patients at risk of harm. We did, however, see examples of outstanding practice with regard to patient pathways for breast reconstruction and hand therapy.

In the burns service there was a truly holistic and patient-centred approach to assessing, planning and delivering care and treatment to people who used the service. There was evidence of innovative and pioneering approaches to care delivery, and outcomes for people using the service were outstanding, and had been reflected in national research papers. The plastic surgery service was not so effective. We found that the monitoring of some patient's outcomes of care and treatment required improvement; we found that mortality and morbidity meetings were not occurring, and return to theatre and length of stay rates were not monitored. There was, however, evidence of robust local auditing, which monitored success rates of breast reconstruction and free-flap surgery.

Feedback from people who used the burns service, and those close to them, was consistently positive about the way staff treated people. The plastic surgery service used the Friends and Family Test (FFT) on Billericay and Stock Ward. We were concerned that this test was not used consistently throughout the service. In the plastics outpatient department staff did not always see people's dignity as a priority.

People could access the burns service in a seamless and timely way. People's individual needs and preferences were central to the planning and delivery of tailored services. There were innovative approaches to provide integrated person-centred pathways of care, which involved other service

providers. However in the plastic surgery service there was minimal effort made to plan and deliver services based upon needs analysis. People were frequently and consistently not able to access the emergency plastics service in a timely way for an initial assessment, diagnosis or treatment, and people experienced unacceptable waits for this service.

The burns service had a clear vision and credible strategy to deliver high-quality care which promoted good outcomes for burns patients. The governance arrangements ensured that staff were clear about their responsibilities, and quality and performance were regularly considered. In the plastic surgery service whilst we found outstanding examples of leadership across all ward levels, we found other areas, particularly at senior manager level, that required improvement. This was because the plastics service strategy was not underpinned by detailed, realistic objectives and plans. Also, the arrangements for governance and performance management at senior management level did not always operate effectively. Leaders at local level did have the necessary experience, knowledge and capability to lead effectively; however, they were not supported to do so due to financial and service specific restraints. We saw numerous examples of outstanding practice throughout the service which demonstrated innovation and development in plastic surgery nationally.

Critical care

Good

We found that the critical care service was safe, effective, caring and responsive to meet the needs of patients and relatives, and the service was well-led, with strong local leadership of the units. Medical staffing levels were in line with national guidance, Core Standards for Intensive Care Units 2013, with factors such as case mix, patient turnover and ratios of trainees considered. Nursing staffing establishment levels and skill mix were adequate across both units. The management at service level were clear about their roles and vision for the service. Staff morale was high, and a supportive environment was in place, with robust competency and training packages, small team allocations, and close working with the wider multidisciplinary team (MDT).

Summary of findings

Maternity and gynaecology

Requires improvement

We found that the current safety arrangements in maternity and gynaecology services were inadequate. It was clear that there was under-reporting of incidents, such as unplanned readmissions and staffing issues at times. The current level of supervisor of midwives investigations, and number of serious incidences, especially on the labour ward over 2014, was higher than expected for the size of the trust. Training for the unwell patient was being actioned; however, we had concerns during the inspection on Writtle Ward, where there were delays in escalation of concerns regarding a deteriorating patient at night and prompt treatment, which could put the patient at risk. We saw that there was a consistently high usage of agency and bank staff on labour wards and especially on Writtle (gynaecology) Ward over the past year, where over 50% of staff were, on occasions, agency. Agency staff, including locums, did not receive a signed off induction to evidence familiarity and knowledge of core risk practices within the units. Changes were made to services, such as the removal of the birthing cap over 12 months ago which allowed access to women out of the area, resulting a potentially negative impact on people's needs.

The admission criteria for medical outliers on Writtle (gynaecology) Ward was being continually breached. This did not meet people's needs and was inappropriate.

Services for children and young people

Good

There were arrangements in place to implement good practice, learning from any untoward incidents, and an open culture to encourage a focus on patient safety and risk management practices. There were effective arrangements to identify and manage risk, and keep patients safe. We saw good examples of care being provided, with a compassionate and dignified approach.

National guidance was being implemented, and monitoring systems to measure performance were in place. The number of staff receiving mandatory training and appraisals was high. The children and young people's service understood the different needs of the communities it serves, and acted on these to plan and design services. The paediatric

Summary of findings

department encouraged children, their relatives, and those close to them, to provide feedback about their care, and were keen to learn from experience, concerns and complaints.

End of life care	**Requires improvement**		We found that overall, the service required improvement, due to there being no board member with end of life care responsibility, and poor communication within the service. We also found that access to the service was poor. We found that improvements were required regarding safety, access to the service, and in responding to patient's needs. End of life care for patients was supported by a specialist palliative care team. Since the phasing out of the Liverpool Care Pathway, the trust did not follow a specific end of life care pathway. There were inconsistencies in the completion of 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms. It was not always clear whether discussions with the patient and their representative had taken place. The caring and responsive approach shown by the chaplaincy, and the services provided to bereaved families by staff in the mortuary, were outstanding. Staff within both services went beyond the call of duty to support families, particularly those bereaved of children and babies.
Outpatients and diagnostic imaging	**Requires improvement**		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 clean; however some areas were in need of refurbishment. 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. There was a shortage of key staff, in particular, qualified nursing staff for outpatients, ultra sonographers, consultant musculoskeletal radiologists and consultant ophthalmologists. We found concerns within the outpatient clinics about the length of time patients were waiting for appointments. There was also a decline in the percentage of patients waiting less than 62 days from urgent GP referral to first definitive treatment for all cancers in the first quarter of 2014. There was

Summary of findings

good local leadership, and a positive culture within the services. Pathology services felt that there was a lack of senior clinical leadership to drive the service forward. Sexual health services were outstanding, and demonstrated a patient-focused culture. Feedback from their patient satisfaction survey was excellent.

Requires improvement

Broomfield Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Surgery; Specialist burns and plastic services; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging

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Detailed findings

Background to Broomfield Hospital

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

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

Our inspection team

Our inspection team was led by:

Chair: 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, palliative medicine 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 between the 26 and 28 November 2014, with a subsequent unannounced inspection on 6 December 2014. On 5 February 2015 we also visited the Emergency and Assessment Unit (EAU) to carry out a focused unannounced inspection, on 26 March 2015 we returned to EAU to follow up on our concerns.

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 on 25 November 2014, when people shared their views and experiences of

Broomfield Hospital. 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, junior doctors, consultants, administrative and clerical staff, radiologists, radiographers and pharmacists. We also spoke with staff individually as requested. We carried out unannounced

Detailed findings

visits on Saturday 6 December 2014 to the accident and emergency department, maternity services, Danbury Ward and the emergency assessment unit. During these unannounced visits we spoke with staff, patients and relatives.

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

HM Prison Chelmsford is located within the city centre of Chelmsford, Essex and is a Category B men's prison and Young Offenders Institution. The prison is operated by Her Majesty's Prison Service and houses 745 prisoners, as of July 2014. The main acute healthcare service that supports this prison is Mid Essex Hospital Services NHS Trust. We went to HM Prison Chelmsford on 28 November 2014 to meet with a group of prisoners who had recent experiences of using Broomfield Hospital. We would like to thank HM Prison Chelmsford and the community service team, PROVIDE, for supporting the organisation of this dedicated patient experience group and providing us with valuable feedback.

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

Facts and data about Broomfield Hospital

Broomfield Hospital overview:

Beds: 635

- 546 general and acute
- 56 maternity
- 20 intensive care
- 13 high dependency

Activity Summary:

Activity type 2013-14

Inpatient admissions 85,981

Outpatient attendances 593,103

Accident & emergency (attendances) 81,220

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%. 93.9% of the borough of Chelmsford is White, and the highest ethnic minority is Asian at 2.9%. The borough of Maldon is 98.1% White and the highest ethnic minorities are Asian and mixed/multiple ethnic group, both with 0.8%

Deprivation:

- Chelmsford ranks 298th out of 326 local authorities for deprivation, Maldon ranks 230th out of 326, and Braintree ranks 210th out of 326 local authorities.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Good	Inadequate	Inadequate	Inadequate
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Specialist burns and plastic services	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Inadequate	Requires improvement	Requires improvement
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	N/A	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Inadequate	Requires improvement	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic imaging.
2. We have rated safety overall as Requires Improvement as whilst two areas were rated as inadequate only one of these services is a core service. The other are is limited to the plastic surgery service.

Urgent and emergency services

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

Information about the service

The emergency department (ED) at Broomfield Hospital is located within the PFI wing of the hospital that was purpose-built and opened in 2010.The ED at Broomfield Hospital provides a 24-hour, seven day a week service to the local area. The department saw around 81,000 patients between April 2013 and March 2014.

Patients present to the department either by walking in via the reception, or arriving by ambulance. The department had facilities for assessment, treatment of minor and major injuries, a resuscitation area and a children's ED service. The emergency department is a member of a regional trauma network.

Our inspection included two days in the emergency department and emergency assessment unit (EAU) as part of an announced inspection. During our inspection, we spoke with clinical and nursing leads for the department. We spoke with six members of the medical team (at various levels of seniority), and eight members of the nursing team, including the lead nurses with responsibilities in safeguarding, infection prevention and control, tissue viability and mental health.

We also spoke with nine patients and undertook general observations within all areas of the department. We reviewed the medication administration and patient records for patients in the emergency department.

Prior to this inspection we were aware of concerns identified during an unannounced responsive inspection undertaken in August 2014, where concerns were identified, including the department not fully complying with standards for Children and Young People in Emergency Care Settings 2012. The department did not enable a safe environment in which to monitor deteriorating patients or those with a mental health condition who required observation. Lessons learned from incidents were not always taking place, and where lessons were shared, these were not embedded. The care provided to mental health patients within the department was suboptimal and placed patients at serious risk of harm. Following the inspection we asked the trust to take action to ensure improvements were made.

Urgent and emergency services

Summary of findings

The emergency department (ED) and emergency assessment unit (EAU) at Broomfield Hospital was inadequate with regards to being safe, responsive and well led.

We looked at equipment which was clean, but found that some equipment was not maintained to the manufacturer's recommendations, with service labels highlighting that a service was due. Medication was not always recorded within patient notes and prescription charts. Medicines were not stored appropriately, with drug cupboards found unlocked.

We observed that at times, co-ordination became disorganised and caused frustration within the teams in the emergency department. Lack of communication, especially when the department was under pressure, was a recurring theme which had an impact on patient flow, including ambulance handovers.

The department was very busy at times, and patients arriving by ambulance could be held for a significant amount of time within the ambulance waiting area, whereby cohorting of patients within this area was a recurring theme. There was a senior member of nursing staff who was designated as a shift co-ordinator. However, we observed that this designated person would often be counted upon within the nursing team, and focus on demands within the department would often be lost.

The care provided to mental health patients within the department was suboptimal, and we observed patients with mental health needs waiting in the same area as medical patients and children, within the ambulance waiting area. Patients with mental health needs were identified to nursing staff by the ambulance crews, and we observed on two occasions that these needs were ignored.

There were substantial nurse vacancies within the emergency assessment unit. The EAU was reliant on agency and bank staff to maintain safe staffing levels. We observed during our inspection that agency nurses working within EAU were unsure of standard operating procedures, and did not have the full skillset, with substantiated staff having to spend a considerable amount of time explaining these procedures.

We looked at staff training records, and all staff had received mandatory training, including safeguarding adults and children. Mental capacity assessments were being undertaken appropriately, and staff demonstrated knowledge around the trust's policy and procedures.

We saw that staff took the time to listen to patients, and explain to them what was wrong and any treatment required. Patients told us that they had all their questions answered and felt involved in making decisions about their care.

Staff were not always clear on the risks and areas in the emergency department that needed improvements. We saw that completed incident reports did not have a clear 'lessons learnt' approach. Staff spoken to told us that they felt engaged with the ED managers to make changes to improve the quality of service. Staff we spoke with felt that the service had improved in recent months.

In February 2015 the emergency assessment unit (EAU) at Broomfield Hospital was inadequate with regards to being safe. We saw that staffing levels were not sufficient to provide safe care to patients with three registered nurses on duty. We found that on the EAU pre-registration staff awaiting registration with the Nursing and Midwifery Council (NMC) working in nurse uniform, with 'registered nurse' ID badges, working with responsibility with for patient caseloads without NMC registration. When we returned on 26 March 2015 we found that that the trust had taken appropriate action. The unit was appropriately staffed with qualified registered nurses and there were new arrangements in place to ensure that pre-registration nurses were well supported and working in supernumerary roles.

Urgent and emergency services

Are urgent and emergency services safe?

Inadequate

The systems in place to protect patients and maintain their safety were not always used within the patient pathways available. We saw that staffing levels were not sufficient to provide safe care to patients within the treatment areas, and in particular, the emergency assessment unit. Staff consistently had poor awareness and practice of infection prevention and control, wearing gloves and aprons whilst walking around the departments.

We identified concerns about the level and experience of staffing throughout the department. We spoke with members of staff about the availability of experienced nurses within the ED and EAU, and we were told that there are not enough nurses with specific skills. For example, we observed a nurse who was unable to perform a 12 lead electrocardiogram (ECG).

The department had a waiting area for patients who walked into the department requiring treatment. We found that the waiting area was cold. There was no information displayed advising people what to do should their condition worsen, such as if they developed chest pain. The reception staff were positioned behind a glass barrier, and during our inspection we observed that the reception staffing levels at times were very low, and the demand on reception was unmanageable.

There were areas within the emergency department that did not have an appropriate environment, and provided a risk to people with mental health concerns receiving care and treatment.

Training records identified that 13% of staff were still awaiting to complete infection prevention and control and mental capacity training. We saw that all other subjects had a trajectory for completion. We spoke with a senior member of staff who was unsure of the mandatory training requirements and in particular mental capacity. Dementia care was not well understood by staff. We looked at eight patient care records and found numerous sections not completed.

On 05 February 2015 we revisited EAU following concerns raised to us about staffing. We found that there were insufficient numbers of registered nurses on duty and of the seven staff on duty that day, listed as 'registered nurses', only two were registered with the Nursing and Midwifery Council (NMC). We raised our concerns immediately to the person in charge and the Chief Executive Officer for immediate action to be taken to resolve the concerns identified. On 26 March 2015 we returned to check if improvements had been made. We were assured that EAU was staffed appropriately with qualified registered nurses with a sufficient number of nursing staff on duty at all times. There were new arrangements in place to ensure that pre-registration nurses were well supported and supernumerary.

Incidents

- The trust reported seven serious incidents (SI), relating specifically to the emergency department, to the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (STEIS), between March 2013 and October 2014. They included two incidents relating to delayed diagnosis, one incident reported as suboptimal care of the deteriorating patient, one incident involving the safeguarding of a vulnerable adult, and three following premature discharge.
- We asked staff if they reported incidents and had knowledge of the reporting system. Staff told us that they reported incidents when they could find the time, via the hospital internal reporting system (Datix), but not all staff who reported incidents received feedback on outcome and closure on incidents they personally reported.
- We spoke with senior nursing staff about evidence of learning from incidents. We identified a lack of learning following incidents at the inspection in August 2014. The trust had since put in place a serious incident learning initiative. However at this inspection staff we spoke with could still not provide us with an example of a change of practice or evidence from learning from incidents.
- During our inspection we pathway tracked a serious incident that had been investigated earlier in the year, with regard to mental health awareness and care provided to patients with mental health conditions. We found that staff were not following procedures to risk assess, care for, or treat patients with a mental health condition.
- The mental health treatment room did not meet fully meet the needs of a person with mental health concerns. We found that the room had not been

correctly assessed for ligature points and found an identifiable ligature point within the room. The room had a second door which was insecure and exited onto a main hospital corridor. We spoke with a senior nurse and asked if the room was monitored when occupied. We were told that it wasn't and due to staffing levels patients were often left in the room on their own whilst waiting for assessment. Whilst we note patients are free to leave there was no mechanism for identifying when the patient has left the room.

Cleanliness, infection control and hygiene

- During our inspection we observed some instances where staff did not use personal protective equipment appropriately. For example four staff were witnessed to not be wearing gloves or aprons where required. We observed during our inspection that three doctor's and two nurses did not wash their hands between patients or used hand sanitizer.
- We observed a member of staff, who was providing patient care, leave the patient and walk around the department wearing gloves and an apron, before returning to the same patient wearing the same gloves and apron.
- We also observed doctors wearing the same examination gloves post patient care, and then writing within the patient notes. We informed a manager about this during our inspection, and were told that staff were spoken to and advice provided on best practice with regards to infection prevention and control (IPC).
- We noted during our inspection that there were hand-cleaning stations within treatment areas. Hand sanitiser was found at each door entrance, and within corridors throughout the emergency department and emergency assessment unit, and the containers were full.
- We observed ambulance staff remove dirty linen and clean ambulance stretchers, within the same area in which patients were handed over, and within patient treatment cubicles.
- We looked at all areas of the department during our inspection and found them to be clean.
- Clinical waste bins were available, but not all sections were completed by the person who assembled the clinical waste bin; such as the date when the bin was assembled and the name of the person who assembled the bin.
- In the emergency assessment unit (EAU) we observed that IPC procedures were not followed. We found a patient within a side room that had signs outside advising staff that they required IPC protective equipment. However, we checked the notes of the patient and found that they did not have any infection, and the signs were from the previous patient who had occupied the room. Therefore, incorrect information around infection status was being displayed; however records showed us that the room had been cleaned between patients.

Environment and equipment

- During our inspection we found that the main access corridor through the emergency department was used to store beds and equipment. This was the same corridor used by ambulance staff taking patients along to the resuscitation area. We were told that this was a 'one off', but we witnessed this on three occasions over the two days of our inspection. On one occasion this caused problems with a patient being resuscitated by ambulance staff en route to the resuscitation area.
- The emergency department had a designated children's department, which had a secure access and flow through the department. The children's emergency department had a specific waiting room, which was appropriately decorated and equipped for children waiting to be seen. This had improved from our previous inspection on 19 August 2014.
- There was a designated ambulance handover area, which was often used to cohort ambulances waiting to handover above a 15 minute waiting time. Ambulance crews alerted hospital staff that they were waiting to handover patients by pressing a buzzer, which sounded in the major's area. This was not always heard, and there was no assurance that the triage nurse was aware of ambulances waiting, as the ambulance handover area was not visible from the major's area, and was behind double doors at the end of a corridor.
- Resuscitation equipment was available and clearly identified. Equipment trollies followed a system that adopted airway, breathing and circulation management approach within each resuscitation bay.
- We looked at emergency resuscitation trolleys within the department and found the trollies within the children's emergency department and resuscitation areas had been checked daily and this was consistent across the children and adult departments.

- Ambulance crews waiting to handover a patient had no ability to handover confidential information. The ambulance handover area was inadequate in these aspects whereby members of the public and other patients could be in this area and hear confidential information. We observed this on numerous occasions during our inspection and this was not challenged by the triage nurse taking the handover.
- We looked at various pieces of equipment across all areas within the A&E department. We found inconsistency with regards to scheduled servicing with some pieces of equipment being a year out of date from the recommended service. The equipment included: blood pressure machines, a suction unit, electro cardiogram monitor and suction catheters. This was identified through the trusts internal service stickers on each piece of equipment.
- We noticed during our inspection a planned development area to enhance the amount of bed spaces. Construction work was taking place and we found that ED patient records were also being kept in the same room. The room had a door which went onto a main corridor within the ED department for which members of the public had free access, The door was consistently kept unlocked which created an insecure environment to store confidential records.
- The emergency department had a designated ambulatory care bay in a separate area away from the major's treatment area. This was within a new area known as the medical assessment zone (MAZ). The MAZ was usually overseen by a nurse from the A&E department.

Medicines

- During our inspection we checked the records and stock of medication, including controlled drugs, and found correct and concise records, with appropriate daily checks carried out by qualified staff permitted to perform this task.
- We looked at patient prescription charts, which were not completed fully and signed by the prescriber. For example, we saw one patient record where the patient had an intravenous prescription for 500mls of sodium chloride in the ED, and when they were later transferred to EAU, a further 1000mls of sodium chloride was administered with no prescription. We informed the trust of this error.
- Medicine cupboards were observed throughout the inspection to be left open and insecure, and medicines could not be found. For example, Lignocaine could not be found within an open drug cupboard in a suture room. We brought this to the attention of a senior nurse, who took appropriate action immediately.
- Intravenous fluids were stored in an open public area within the major's treatment area, which permitted anyone to have access. This meant that the IV fluids were not stored securely to minimise the risk of tampering.

Records

- It had been identified on a previous inspection that the storage of records was not secure within the ED. We followed up on this concern during our announced inspection, and found that records were still not stored securely and safe. For example, records were found within an area where workmen were carrying out construction work. Medical notes were located on work surfaces within the reception area, with other hospital staff and ambulance crews having access.
- We looked at 20 sets of accident and emergency clinical notes during our inspection. All of the notes we looked at were inconsistent as regards completion. Nine sets of notes did not have completed observations taken with regular re-assessments recorded. One set of notes only had the ambulance service observations, and no further observations had been taken by the emergency department upon admission of the patient to the emergency department.
- During our inspection we observed that accident and emergency notes were difficult to find within the documentation, because notes were not defined between clinical observations and nursing and medical notes; therefore doctors and nurses were looking for the same notes at the same time.
- We found within five sets of patient notes that not all risk assessments were undertaken in the department. For example, MRSA screening was not always completed, sepsis bundle flow charts were not completed, and prevention of pressure damage care plans were not completed.

Safeguarding

- Staff were clear and could describe the procedure to be followed if there was a concern about a child. If there were concerns regarding child welfare, the emergency department would discuss it with the safeguarding lead.
- Not all staff we spoke to had knowledge of what constitutes a safeguarding referral for an adult, and we saw that not all adult safeguarding referrals are followed up. We asked what service the department offers, or actions it takes to support people that attend the ED on a regular basis. There is no support network in place to manage or support these people.
- We looked at a safeguarding referral which was not completed fully. We spoke with three nurses around the completion of records and referrals, and we were told that it takes an "awful amount of time", and they told us that it would be better if the referral records were electronic.
- We looked at training records and saw that nursing staff had undergone mandatory safeguarding training to an appropriate level. Compliance of training for safeguarding adults and children level 1 was 98%.
- We spoke with staff, including nurses, doctors, reception and housekeeping staff, who understood their responsibilities, and they were aware of the trusts safeguarding policies and procedures.

Mandatory training

- We were provided with records of mandatory and supplementary training for staff with varied compliance across the multi-disciplinary teams. Records demonstrated that 13% of staff were still required to complete areas of training which included infection prevention control and mental capacity assessment.
- Records demonstrated that the department provided training within many different areas, which included basic life support - adult training, basic life support – paediatric training, infection control (including hand hygiene), information governance, manual handling (patient) and risk management.
- Mandatory training was provided in different formats, including face-to-face classroom training and e-learning (e-learning is electronic learning, via a computer system), although staff told us that there was limited time allowed to complete extra training.
- We spoke with varied grades of doctors and were told that the induction they were provided with was adequate. One doctor told us that they had received limited information around the management of a myocardial infarction (MI) (a myocardial infarction is medical terminology for a heart attack).

Management of deteriorating patients

- We observed that the department operates a triage system of patients presenting to the department, either by themselves or via ambulance, and are seen in priority, dependent on their condition.
- There was a system in place whereby patients who walked in to the department presented at the reception desk, and the receptionist would make a decision as to whether the patient was within one of two categories, either injured or illness. We observed during our evening inspection, when only one receptionist was on duty, and the department was busy with ambulances and walk-in patients waiting to book in, that a decision was made with a patient presenting to be directed within the illness pathway. However, this patient was septic and was told to take a seat. This was not observed by the receptionist (due to their lack of any clinical qualification) and the patient deteriorated whilst waiting. We immediately brought this to the attention of nursing and medical staff to ensure that the patient was treated promptly.
- We had to bring the care of two patients to the attention of the nurse-in-charge during our inspection, as the patients were not receiving the appropriate care or early intervention as recommended by national guidelines, from bodies such as the National Institute for Health and Care Excellence (NICE) and the College of Emergency Medicine (CEM).
- These included a patient with a head injury who was discharged without having been correctly assessed. We bought this to the attention of a consultant who took immediate action.
- We also witnessed a child patient who was presented at the department with queried sepsis. We saw that the patient was 'streamed' as having an illness and told to wait in the waiting room. We noted that 45 minutes later the child was still in the waiting room and their condition had deteriorated. We immediately bought this to the attention of nursing staff.
- Patients arriving as a priority (blue light) call are transferred immediately through to the resuscitation area. Such calls are phoned through in advance (pre-alert), so that an appropriate team are alerted and

prepared for their arrival. We looked at a pre-alert form with regards to a pre-alert that occurred during our inspection, and found that the form had been completed fully, with any clinical observations recorded, estimated time of arrival of the ambulance to the emergency department, and who took the details over the telephone from the ambulance service.

- We visited both the emergency department and emergency assessment unit between the hours of 10pm and midnight during our inspection, and found both departments under extreme pressure with lack of nursing and reception staff. We noted the ED's inability to triage and take handover from ambulances, with seven ambulances waiting to handover, with the longest waiting 1 hour 45 minutes.
- Our intelligence monitoring tool reviews ambulance waiting times to hand over patients to the care of the emergency department and in December (which covers that period during our inspection) this was rated as an elevated risk. This meant that target times were not being met and that patients were at potential harm from not being assessed by a member of the medical team in a timely manner.
- We found that nursing handovers were not always comprehensive and thorough, we observed three nurse handovers and found elements of general safety as well as patient-specific information missing from the handover. For example, a patient's previous medical history which was significant to their current condition was not included, for another patient their relevant mental health need was not acknowledged and we saw that agency nurses had little information passed to them.
- The shift handover was carried out around a board in the majors department. This area is a busy thoroughfare and staff interrupted the handover process to ask questions. Key staff were involved in the handover process. The trust states that a handover between staff caring for patients occurs at the patients bedside, we did not see this occurring.

Nursing staffing

- Information provided by the managers within the ED and EAU demonstrated that the establishment for the emergency assessment unit was not operating at the required whole time equivalents (WTE), with a number of qualified nurse posts vacant. Senior staff acknowledged that they were not meeting the national guidelines on their staffing needs, and they were actively recruiting.
- We looked at nursing rotas and saw that the emergency department was adequately staffed, with support from bank and agency. However, the emergency assessment unit was often short-staffed on a daily basis, and was reliant on the use of agency nurses who were not familiar with the EAU and patients of high acuity.
- The emergency department had a sufficient number of nurses with specific paediatric qualifications working within the paediatric ED. When they were on shift they would be assigned to the paediatric service within the emergency department, and would be supported with other nurses. The children's emergency department saw around 17,000 children per year.
- We were told that there was no paediatric lead within the children's service provided in the emergency department, although a clinician within the department did have a sub specialty in paediatric emergency care.
- The emergency assessment unit is very reliant on bank and agency staff, which can pose a risk to safety through lack of consistency and unfamiliarity with the department. However, these staff should have received local induction prior to starting their shift, but the competency was varied dependent on which nursing agencies were used.

Medical staffing

- The department currently operates below the England average of whole time equivalent (WTE) consultants employed within a rota. From the rotas we examined we noted that there were four full-time consultants employed at the time of our inspection. The College of Emergency Medicine (CEM) requirements list that 10 full-time consultants would be needed for a service of this size. The trust is currently recruiting consultants in emergency medicine, and we recognise that there is a national shortage of ED consultants.
- Consultant grade doctors are present in the department for eleven hours each day between the hours of 8am and 7pm. Emergency departments should have consultant cover for sixteen hours each day, and the current consultant rota did not support this, and was very reliant on the goodwill of the current consultants in post, which was evident.

- There are middle grade doctors and junior doctors on duty overnight, with an on-call consultant system.
- There was a shortage of senior grade doctors within the department, which inhibited the ability of the service to make definitive decisions around patient care, admissions and discharges.
- The department regularly employed locum middle grade doctors. When we reviewed the rota, we noted that the same doctors were consistently in use. Doctors had received the trust induction programme, and were familiar with the department and protocols.

Inspection of EAU - February and March 2015

Incidents

- We examined incident records provided by the trust. During the period that the unregistered health professionals 'pre-registration staff' had been working on the wards in a 'Registered nurse' capacity here were numerous incidents relating to the safety of patients including pressure ulcers, medication errors and deteriorating patients.

Medicines

- During the inspection we observed that the 08:00hrs medication round was completed at 11:25hrs and controlled drugs had not been provided or checked.
- We were told by a staff member that at 11:35am the IV antibiotics from night shift and 8 am were not administered due to the lack of qualified competent nurses to administer them. We checked the medicines charts on the ward which confirmed what we were told. This meant that patients were not receiving their medicines in a timely manner.
- Another staff member told us that two weeks prior to our inspection they knew that thought they would have to give medicines on a medication round on their own due to a shortage of staff. They said that the medicines could not be given by them and informed us that patients did not receive their medication. They told us that the night staff were aware and did not report this or administer the medication.
- We observed a 'pre-registration' staff member who was on duty working on the unit as a nurse without NMC registration handling drug prescription charts and IV fluids and drawing up drugs then taking them for administration to a patient. We spoke with staff member about this and they told us that they handled IV fluids and put them up on patients, they told us that they were on their own when administering IV fluids and connecting to a patient unobserved.
- We reviewed the drug chart and observed that the staff member had signed to say they had administered the medicine without supervision of one of the ward sisters. We checked the competency workbook for this person and found it to be blank. We immediately raised this to the attention of the sister in charge.
- Another pre-registration staff member we spoke with informed us of their concerns that when it is busy they believe medication and IV fluids are compromised and not administered to patients.

Nursing staff

- On arrival at the ward we identified that the white board stated that there were seven staff nurses on duty for the morning shift and eight staff nurses were listed to work during the afternoon. We examined the rotas for the ward and found that there were seven nurses listed to work in the morning and eight nurses working in the afternoon.
- Of those seven nurses on duty in the morning, we identified that there was; one registered nurse on duty, one nurse shift coordinator and five nurses who were not registered with the Nursing and Midwifery Council (NMC). There was a third registered nurse on the unit who was scheduled on the rota to work on a supernumerary day but supported the ward clinically due to the clinical demands of the unit.
- Four of these five nurses were overseas recruits who had trained as nurses overseas and were awaiting registration with the NMC. One member of staff was a newly qualified nurse awaiting their registration to be confirmed.
- The Band 8a lead nurse was on the ward but was based in the office for the duration of our inspection and did not work on the ward during our inspection.
- We viewed the patient allocation board where nurses were allocated to patient bays and were listed for patients and relatives to know who their named nurse was. We found that the following members of staff were all allocated as the nurses for patient bays with a case load of six patients each which was not appropriate and unsafe for the staff and the patients.
- The rotas examined specified all five members of staff as 'RN' which means registered nurse. These members of

staff were included as 'registered nurses' in the overall registered nursing number for the ward. This meant that on duty at the time of our inspection there were three registered nurses for 35 patients during the morning and four registered nurses in the afternoon.

- We were informed by a staff member, "We only have five staff nurses qualified for longer than two years." They also told us that they had eight sisters and two permanent night staff and three day staff qualified longer than two years. Twelve members of staff are new from overseas staff and 10 have not got their PIN numbers.
- Two inspectors observed the rota and this accurately reflected what we were told. This number of staff is insufficient and meant that patients were placed at risk of harm due to insufficient skilled and competent nurse staffing numbers.
- We observed that one sister on EAU was supervising the members of staff who had not received their registration PIN numbers from the NMC. This meant that they were supervising four people whilst carrying a case load of 18 patients. This demonstrated that there were insufficient numbers of registered staff on duty.
- We spoke with four members of staff who were working without NMC registration on the EAU. Staff member A informed us that they were looking after six patients and a HCA was reporting to them. They had received their induction to the trust and on arrival to work on the ward took a case load of patients. However they told us that they were not expected to receive their Registration and PIN number from the NMC until July 2015. Therefore this means that the trust was employing them and expecting them to work as nurses before the registration body, the NMC, had deemed them suitable and had registered them as nurses.
- We reviewed the job descriptions for band 4 'Associated Practitioners' also known as pre-registration staff in place at the trust. When assessed as competent the staff who did not have registration with the NMC whilst having competency pack had not been assessed to do so. On review of the competency packs held by these staff we found that in all cases these were blank.
- At inspection we found that the associate practitioners were acting outside of their job description in assessing and implementing programmes of care. One staff member informed us that they had received training in cannulation and blood taking and was cannulating without supervision stating, "sometimes we are so busy that I do it on my own". We examined their competency assessment and found that it was blank and had not been signed off.
- Of the five nurses that were on the unit working without NMC registration all were wearing nurses uniform and wearing trust identification badges which said 'Registered nurse'. One staff member we spoke with told us, "I think this is dangerous, we are accountable for this."
- We viewed the vacancy rates for the ward which identified that the registered nurse vacancy rate was 40% though active recruitment was on going.
- The turnover rate was very high with fourteen staff left the ward in December 2014 alone. There had been no review or analysis as to why there was a such a high turnover of staff on the ward. This meant that the hospital was not learning lessons on why staff were frequently leaving.
- When we visited in March 2015 we were assured that EAU was staffed appropriately with registered nurses with a sufficient number of nursing and support staff on duty at all times. We examined staffing rotas for the past four weeks and spoke with staff which confirmed our findings have been consistent.
- The notice boards for the public clearly stated who the patient's registered nurse, health care assistant and pre-registration nurse was on duty each day.
- There were arrangements in place to block book agency staff for a period of six months. These staff were being trained in trust practices for intravenous drug administration and equipment use and there were new competencies being implemented which required sign off before these staff undertook such duties.
- There were new arrangements in place to ensure that pre-registration nurses were well supported and supernumerary. This included new titles for nurses awaiting registration with the NMC, they were called "pre-registration nurses" which was printed on their badges, and their uniforms had been changed from nurse uniforms to health care assistant uniforms with red piping on the arms to identify them as pre-registered nursing staff. We observed that there was now a robust mentorship and training programme in place which included induction, specific training and competency frameworks. Rotas also confirmed that these nurses spent at least 40% of their time with their allocated mentor.

Urgent and emergency services

- We spoke with senior managers, nurses and HCAs and staff told us that EAU felt safer since appropriate staff were on duty and that patient care had improved as a result.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

The emergency department used a combination of the National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines to determine the treatment they provided. Local policies were written in line with this, and were updated as national guidance changed. However, there was a low percentage return of College of Emergency Medicine (CEM) audits that met requirements, and in particular, of the audit returns for sepsis and pain.

The emergency department used evidence-based guidelines – for example, there were a number of care pathways in the department for patients with specific conditions to follow, such as the stroke and sepsis pathway. However, these were not always followed or implemented at the appropriate early recognition time.

We spoke with doctors and nurses about the implementation of National Institute for Health and Care Excellence (NICE) guidelines. They told us that as NICE guidance was issued, they made sure that any new policy, which was relevant to the ED, was implemented, and that staff were aware of the requirements.

Nursing and medical staff did not always have the information and support they needed to deliver effective care and treatment to people who use the emergency department services. The mental health nurses provide a service from 7am to 7pm, with an office in the department, there are good working relationship with the mental health trust with regular monthly meetings at a senior level. However during the inspection we did not witness any mental health nurses in the department despite patients being admitted with mental health problems.

Use of National Guidelines

- Departmental policies were easily accessible; staff we spoke with were aware of these policies and informed us that they were used. There were a range of emergency department protocols available, which were specific to the ED.
- Further trust guidelines and policies were followed within the emergency department, such as sepsis and needle stick injury procedures. We looked at four treatment plans which were based on the National Institute for Health and Care Excellence (NICE) guidelines, but the emergency department had not followed the guidance; for example, a patient with a head injury did not have any neuro-observations taken within the required timeframe.
- We found reference to the College of Emergency Medicine (CEM) standards, and spoke with medical staff, who demonstrated knowledge of these standards.

Care plans and pathway

- We spoke with staff who were knowledgeable about the care pathways available to patients, and the appropriateness of each pathways benefit.
- There was a clear protocol for staff to follow with regards to the management of stroke, fractured neck of femur, and sepsis. The department had introduced the 'Sepsis Six' interventions to treat patients. Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis.
- We looked at recent audit data, which demonstrated that the emergency department was not performing at the required target levels. For example, 57% of septic patients had a full set of observations and a pain score within 15 minutes of arrival. The required CEM standard is 95%.
- Nurses at the ED at Broomfield Hospital did obtain blood cultures from patients who were query septic, and they were not reliant on doctors obtaining these blood samples. This meant that the process within the care pathway, to administer and treat with antibiotics, should be positive. The return of data within the CEM audit demonstrated that 36% of patients were administered antibiotics in the ED within one hour, and 100% of patients were administered antibiotics in the ED before leaving in 2013.
- We looked at seven patient care plans within the EAU and 11 emergency department patient notes during our inspection. We found a consistency within both the care plans and notes, of sections not completed and

observations not recorded. For example, one care plan did not have section 14 (prevention of pressure damage) completed, and the patient had known pressure ulcers on admission. Another care plan did not have any infection status assessment completed.
- We also saw ED notes with no neurological observations recorded on a patient with a head injury. We immediately bought this to the attention of nursing staff.

Nutrition and hydration

- Food and drinks were available for patients upon request. Patients would have to find a nurse to ask and request if they could have something.
- We spoke to five patients on the emergency assessment unit, who told us that they were offered food and drink at regular times, and water was always available.
- The ED had a breakfast bar available, with hot and cold drinks. We observed during our inspection that sandwich rounds took place at lunchtime and again in the evening.

Outcomes for the department

- During our inspection in August 2014 we identified concerns in relation to the care and outcome of patients who attended the department with a mental health concern. During this inspection we found that improvements to care of people with mental health concerns had not improved to a compliant standard.
- We spoke with emergency department staff, who were unable to tell us about the arrangements for dealing with admitting people who required treatment under the Mental Health Act 1983 (revised 2007). During our visit, a person was admitted with mental health needs, and we pathway tracked the outcome for this patient and found paperwork not fully completed, including a safeguarding referral. We bought this to the attention of trust management.
- We spoke with senior staff, who told us that a recognised assessment tool for people with mental health issues was not being used. We did not see that specific outcome measures were being used in relation to people with mental health issues.
- We looked at internal audits which took place, and could not see evidence that the results had been used to assess the effectiveness of the department.
- The department holds monthly clinical governance meetings, where mortality and morbidity is one item on a regular agenda. Both clinical and nursing staff attend these meetings.

Competent staff

- In assessing nursing staff, 86% of appraisals of nursing grades were undertaken, and staff spoke positively about the process and stated that it was of benefit. An appraisal is a personal development review of staff's performance objectives, and a process for determining staff development needs. This rate is lower than expected, and evidenced that improvements in staff support are required.
- We were not provided with details of the appraisals of medical grade staff which were undertaken.
- We spoke with nursing staff, who told us that they felt that the mandatory training was delivered and kept them up to date, but the clinical supervision could be better and was thought of when the need arose rather than on a regular basis.
- We saw records that demonstrated that not all medical and nursing staff were revalidated in basic, intermediate and advanced life support.
- One doctor told us that they could access training to make sure that they were up to date with their current practice, but had to complete this in their own time due to pressures within the department.
- Non clinical staff told us that they received the mandatory training for their role, but had not received any training about how to stream patients. Non-clinical reception staff were responsible for streaming patients by using a list provided by the A&E consultants as to whether patients had an injury or illness when they booked in. We found that this streaming of patients was not always effective.
- We spoke with various qualified nurses and health care assistants, who told us that their professional development was supported by management within the emergency department and emergency assessment unit.

Multidisciplinary team working and working with others

- We witnessed multidisciplinary team (MDT) working within the ED. During our inspection a trauma alert

happened within the local area, with an injured person attending the ED via the ambulance service. An alert was made to the ED and the correct teams were in place when the patient arrived.
- We observed that there was a medical and nursing team leader within the resuscitation area when required.
- We witnessed within the major's treatment area that staff did not work together in a way to assess and plan on-going care and treatment in a timely way, when people were due to move between teams or departments, including referral, discharge and transition.
- Staff we spoke with were not always aware of the protocols to follow, and who to contact with regard to key personnel within external teams.
- We saw that the ambulance service had recently placed a hospital ambulance liaison officer (HALO) into the department, to assist with the delayed ambulance handover process, which was consistently not being met by the trust. The HALO was integrated within the department team. However, the ambulance service moved the HALO to another trust for a period of time, and we saw ambulance handover delays increase during this period, due to the trust not monitoring handover performance.
- The trust wide pain service was involved in discharge planning and admission avoidance in the emergency department.

Seven-day services

- There was a consultant out-of-hour's service provided via an on-call system.
- The emergency department offered all services where required seven days a week.
- We were told by senior staff within the A&E department that external support services are limited out of hours, and it often proves difficult at weekends, which in turn, has an effect on patient discharges and care packages.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Not all staff were aware of the need to assess whether a patient had a temporary or permanent loss of capacity. We observed nursing and medical staff gaining consent from patients prior to any care or procedure being carried out.
- We spoke to people who used the service, and one person told us "I was sent in by my GP and staff have explained everything to me and asked if it is ok before carrying out any tests on me".
- Staff reported receiving training on the Mental Capacity Act 2005 within safeguarding training. Staff explained their systems for assessing people's mental capacity to give consent regarding treatment. We examined the training records, which showed that 98% of staff had received this training. This supported what we were told.
- We spoke with staff working within the children's emergency department, who were able to explain and reference assessing children as 'Gillick competent'.

Are urgent and emergency services caring?

Good

Urgent and emergency services required improvement to ensure that all patients received a caring service. Whilst we witnessed compassionate care we saw that some patients did not receive the emotional support that they required. We witnessed a patient living with dementia not being supported by care staff and we saw that due to pressures within the department that care staff were unable to spend time with patients that they required to fully understand what was happening to them. We also witnessed that confidentiality was not always maintained for patients.

During our inspection, we did find Friends and Family Test questionnaires out in view within the treatment and reception areas, and we found two posters in the waiting room displaying different information to the public about Friends and Family Test results. There were two systems available for people to use to access the Friends and Family Tests. A paper questionnaire was available, together with a 'voting box' system for people to use, with a small plastic disk provided by reception staff for patients and relatives to drop into a corresponding box of their choice.

We were witness to episodes of nursing and medical interaction during our visit, with feedback from individual patients and relatives. Some patients we spoke to were complimentary about the care that they had received during their attendance at the emergency service.

Compassionate care

Urgent and emergency services

- During our inspection we saw that staff responded in a timely manner to patients who requested help or required assistance. For example, we saw that call bells were answered in a timely manner and within five minutes.
- Staff we spoke with demonstrated an understanding of the need to recognise cultural, social and religious individual needs of patients. However, we did not find documentation available for people offering advice in different languages.
- We saw that staff tried to respect the confidentiality required around patients and relatives when communicating, ensuring that personal information was protected, but we noted that this was difficult to achieve within the designated ambulance handover area.
- The trust can be seen to be submitting data for the Friends and Family Test (FFT). FFT is an important feedback tool that supports the principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. The FFT highlights both good and poor patient experience. The Friends and Family Test score for the emergency department was displayed with two results on posters in the public waiting room.
- The Friends and Family Test results were scoring 'about the same' as other trusts. We looked at two questions within the FFT, which were, 'While you were in the ED, how much information about your condition or treatment was given to you?' - the trust scored 7.8 out of a maximum of 10 and 'Were you given enough privacy when being examined or treated in the ED?' - the trust scored 9.2 out of a maximum of 10.
- In the A&E survey the trust scored about the same as other trusts in England in respect of the caring questions.

Patient involvement in care

- We spoke with four people who were patients in the department, and one of the patients told us that they felt informed about their patient journey and that staff were responsive. Another patient informed us that they were aware of what was going on, and this eased their worries.
- We observed the majority of staff explaining to patients if there was going to be a delay in seeing a doctor, what the reason for that delay was, and how long they would have to wait to be seen.

Emotional support

- We witnessed staff providing patients and relatives with emotional support where staff demonstrated they understood what the impact of treatment had on a person's wellbeing. For example, a trauma patient was bought in by ambulance to the resuscitation area. We saw that support was offered to the parents of the patient and staff explained the assessments and treatment taking place which at times needed to be rapid for the patients needs.
- Staff tried to support patients and their relatives as much as they could in the time they had; however, staff were very busy during our inspection, and were therefore unable to spend a lot of time with people. Patients and relatives thought that the staff were helpful if they were approached. This was more evident within the emergency assessment unit.
- We saw one patient living with dementia being cared for by a porter rather than care staff. Despite this person being in obvious distress the care staff walked passed leaving the porter to reassure the patient.
- We witnessed a patient experience from their transition from the care of the ambulance service over to the accident and emergency staff. This was carried out without taking into consideration the patients respect and dignity when moving from the ambulance trolley to the ED's trolley.
- We saw that people's independence was respected, enabling them to manage their own health, care and wellbeing where possible.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Inadequate

Urgent and emergency services were not responsive, and we rated this inadequate. The emergency assessment unit and the emergency department had surges of activity, which occurred on a regular and potentially anticipatory

basis. The department struggled to cope with capacity issues, and the surges of activity, due to space, bed availability and low staffing levels. The ED takes a reactive approach in managing high surge activity and busy periods, rather than a proactive approach. The hospital was not meeting the national target of four hours to treatment at only 87% of patients achieving this target during the period of our inspection.

The trust escalation protocol was sufficient; however the ED does not provide a safe response when demand reached an identified level. For example, patients had to wait a significant amount of time above fifteen minutes within the ambulance triage area having observations taken, and a dynamic triage did not take place with care provided once a handover had taken place between the ambulance service and the ED.

There were regular occurrences of ambulances stacking and waiting to handover within the department, delaying the ambulance handover.

Patients who had been in ED overnight told us that they were not routinely checked upon. One person who had been admitted to the department overnight had not had any further assessments until they were transferred to the ward the following day.

Meeting the needs of all people

- The emergency department has an escalation policy, which was developed by the management team. We were told that the escalation policy was put in place to be followed when the department was experiencing long delays in ambulance handovers, patients being transferred to a ward, and when there was a lack of available beds within the hospital to admit patients. The policy details what steps of implementation to take, such as a colour coding escalation classification of green, amber and red with the response required from the department, site management team, manager on-call.
- We observed that during periods of demand the department struggled to cope. There was a lack of clear co-ordination within teams, which inhibited the flow through the department to be safely maintained. We witnessed delays in the implementation of the escalation protocol.
- The hospital was not meeting the national target of four hours to treatment at only 87% of patients achieving this target during the period of our inspection.
- The department did not coordinate and deliver care which took account of people with complex needs. For example, we saw within the emergency assessment unit that a patient with dementia was being provided care by portering staff. The portering staff did not have the required training and understanding of the environment that impacted on the patients care requirements and in the correct environment. We witnessed two nurses walk pass the patient and porter and not intervene. We immediately bought this to the attention of senior nurses who then supported the patient with their needs.
- Despite the recent improvements with the medical assessment zone, the department had limited space, which restricted the growth of services delivered in line with a growing population. For example, the waiting room within the EAU did not match the size of the rest of the department. The service offered an ambulatory care service and this often utilised hospital beds during our inspection, rather than ED trolleys, due to patients requiring beds overnight. This then affected the ambulatory spaces available the following day and delayed patient care.
- We saw an electronic noticeboard in the waiting area advising people that there was currently a wait to be seen; however, we observed that the actual wait for some patients was longer than that which was displayed.
- We spoke with staff about the services available and asked whether they provided people who use the ED services with further information, or offer to opportunity to ask questions about the care and treatment. There are leaflets available within the department for people to take.

Access and maintaining flow through the department

- The department operates a triage system of patients presenting to the department, either by themselves or via ambulance, and they are seen in priority dependent on their condition.
- The trust is performing below the England average with regards to handover of patient care from the ambulance crew to the accident and emergency department. Between November 2013 and March 2014 there were 1,042 patients who waited over 30 minutes to have their care handed over to nursing staff.

Urgent and emergency services

- There is an internal 'live' electronic system of evaluating and managing the patient flow through the department to assist with bed demand across the hospital. The department was reliant on working with the paper systems in use.
- The department was frequently affected by capacity and demand throughout the hospital, with beds not being available in the wards when required to treat patients who were admitted to the hospital. This led to patients having to wait longer than would be expected for a bed in the ED.

Complaints handling (for this service) and learning from feedback

- The emergency department and emergency assessment unit advocates the Patient Advice and Liaison Service (PALS), which is available throughout the hospital.
- There was limited information available for patients on how to make a complaint and how to access the Patient Advice and Liaison Service.
- All concerns raised were investigated, and there was a centralised recording tool in place to identify any trends emerging. The number of formal written complaints for ED during the 12 month period between 1 September 2013 and 31 August 2014, was 53, with 30 being upheld or partly upheld, 20 not being upheld, and three outcomes yet to be concluded. The top three reported complaints concerned 'all aspects of clinical treatment', 'communication' and 'attitude of staff'.
- Within the EAU, the number of formal written complaints during the 12 month period between 1 September 2013 and 31 August 2014, was 22, with 14 being upheld or partly upheld, four not being upheld, and four outcomes yet to be concluded. The top reported complaints concerned 'all aspects of clinical treatment', 'communication', 'discharge arrangements' and 'attitude of staff'
- We looked at two complaints and saw that both were analysed at the root cause.
- We asked staff whether they received information about complaints and concerns. They told us that they were not regularly informed about them. They told us that lessons did not seem to be learned and were not discussed with two-way feedback.

Are urgent and emergency services well-led?

Inadequate

The leadership within the emergency department (ED) and emergency assessment unit (EAU) was rated as inadequate. We found that the service had been through many changes in both the ED and the EAU, which are now led by clinical managers. However, the leadership needs to be sufficiently embedded to ensure that patient experience and flow through the department continues to be improved. We were informed that the management changes that had happened universally throughout the departments, had created an insecure feeling which had affected staff and morale. The department was not engaged in the wider trust and staff did not feel listened to.

We returned to the Emergency Admissions Unit (EAU) in February 2015 and found that this was a significant issue (for details please read our inspection report from February 2015). On this occasion we found that staff had reported concerns locally but these had not been escalated which put patients at potential risk of harm. We took urgent enforcement action in this area.

At our inspection in March 2015 we found that appropriate changes were being implemented to address our concerns about staffing and the lack of governance and assurance processes relating to pre-registered nurses. Staff told us that subsequent to these new changes; the unit felt safer, patient care had improved and staff felt able to raise concerns.

Vision and strategy for this service

- Not all staff that we spoke with were knowledgeable about the trust's vision and journey. They were not always aware of the problems associated with the priorities for the department.
- Information was not always available to all staff in different formats about the trust's vision and strategy. There was limited information provided with updates on any changes or amendments to the department's priorities and performance against those priorities.
- The trust had a lack of vision in the promotion of best practice across the ED.
- The future vision of both the EAU and the ED was not embedded within all the teams, and was not well described by all members of staff.

Urgent and emergency services

Public and staff involvement and engagement

- Staff in the ED did not feel engaged outside of the department, and demonstrated little awareness of the various initiatives taking place across the trust. One member of staff told us that they just did not have time to get involved in things when they were working.
- Out of the eight members of nursing staff we spoke to, five members of staff felt they were not listened to with regards to improving the department. For example, when they made suggestions to the trust about how to improve the department.
- During our inspection we did not see any information available in the waiting area for people who use the services to encourage participation and involvement. This would allow people to get actively engaged, so that their views were reflected in the planning and delivery of services provided within the emergency department.

Governance, risk management and quality measurement

- Monthly departmental meetings are held within the management teams. We were provided with minutes of the previous meetings. We were not provided with assurance that risks are well managed within both the ED and EAU. Managers were aware of the risks identified, but there was not a robust timeline of actions to address each risk. This meant that quality in risk management could not be measured against trust-wide risks.
- There was a set agenda for each departmental meeting, with certain standing items, such as incidents, complaints, risk, staffing and training.
- A quality dashboard was not displayed within the emergency department. However, the emergency assessment unit had this information displayed for patients and relatives to see within the entrance. This meant that people who used the ED service and staff were not aware of the department's performance around the care being received or delivered.
- We spoke with three staff members about quality indicators, and there was a lack of knowledge, with some staff unable to provide an example of a quality clinical indicator or a performance indicator. This meant that staff were not aware whether the clinical care provided was of a good quality and measurable against national figures.
- We viewed the risk assessments undertaken for the ED and EAU, and found that they had been reviewed just prior to our inspection. However, we noted that they had not been reviewed since 2011 on subjects such as fire and security, which demonstrated that risk management was not routinely reviewed within each department.
- The corporate risk register examined only contained two risks relating to the ED; these concerned meeting the four hour target, and the availability of junior and middle grade doctors. There was a local risk register which detailed lower level risks; however, we identified significant risks that could have been graded at the level required for the corporate risk register; these included ambulance handovers, which should be on the corporate risk register.

Leadership of service

- There was an departmental team, which was respected. The team was led by the senior nurses, and we saw that nursing teams were led by a band 7 sister/charge nurse, who had responsibility for shift management of staff, mentoring and development.
- Staff told us that the nursing leadership in the department was good.
- Clinical leadership was limited, with the low number of substantiated consultants available. We did see that the permanent consultants were passionate about the department, and that there was very much an open door policy in place throughout all disciplines.
- Staff told us that they did not feel supported by the senior executive trust management team. They told us that when the ED was under pressure, the department did not always receive the support and leadership it needed from a trust-wide perspective to ensure patient care and flow was maintained.
- Staff told us that they only saw senior executive management when the departments were using the escalation protocol, when there were no beds, or when the four hour target was not being met. We were informed by staff of examples where they were confronted by senior managers and executives as to why patients had breached their four hour pathway in ED. Staff told us that this style of leadership affected their morale and caused them worry.

- We were told and we saw that the capacity of leadership had been improved, with the introduction of further nurse leaders in both the emergency department and the emergency assessment unit.

Innovation, learning and improvement

- We did not see evidence of staff innovation, either on an individual or team basis, which was put into practice and owned by the department.
- We spoke with a senior manager within the trust about how lessons learned from incidents were disseminated across the trust. They told us that they would expect senior staff to pass this information to the rest of the team, but they said there was no formal mechanism in place to check that this was happening. This meant that the culture did not centre on the needs and experience of the people who use the services.

Culture within the department

- Most staff told us that within the department, there was a sense of team working. They thought that the team pulled together in difficult times, and supported each other. Some staff told us that they felt under pressure to meet targets, and were made to feel as though they had failed to do their job correctly by senior trust managers, if targets were not met.
- There were no mechanisms in place to support staff other than formal routes with regards to stress management. This meant that there was not a strong emphasis on promoting the safety and wellbeing of staff.
- During our inspection we saw that the staff were willing to go above and beyond the call of duty, and were dedicated, passionate and caring towards their patients; however, they were not supported, and in some instances, felt blamed for target performance issues, which affected their morale.
- We spoke with staff of various grades within the departments in clinical and non-clinical roles, and they told us that the culture within the trust did not encourage openness and honesty, and there is very much a 'blame culture'.

Inspection of EAU in February and March 2015

Governance, risk management and quality measurement

- Following the inspection we requested information from the trust in relation to safe staffing levels and the roles of the pre-registration staff including how it will be ensured that this will not happen again.
- We established that there were no clear governance or assurance processes in place around the roles of the pre-registration staff related to their training, competencies and roles within each area. This meant that they or the commission could not be assured that no unregistered staff was working outside the scope of their role elsewhere in the hospital.
- The trust was continuing the investigate whether or not that any of the adaptation staff were involved in these incidents whilst providing direct nursing care. The trust acknowledged that if there were incidents which may have involved the staff and that they may be required to execute their duty of candour responsibilities to inform patients.
- The quality of risk management and incident investigation on the unit was weak as it had failed to identify in each case the role of involvement of the adaption staff.

Leadership and Culture

- In February 2015 we saw that the registered nursing staff on duty were passionate, dedicated and hard working. They went above and beyond the call of duty to ensure that patients were safe however they were they were not supported and were affected by the staffing situation they were faced with on shift. This affected their morale.
- We spoke with all the pre-registration staff on duty about their roles on the ward. The staff told us that they worked and did what they could to help recognising how busy the ward was. Most told us that they felt pressure to undertake the work even without NMC registration.
- There was a ‘blame culture’ and a negative culture on the unit. Three staff members we spoke with informed us that they had consistently raised the concerns regarding the unregistered nursing staff working on the unit, including through the raising of incident forms, but that their concerns were not listened to by the management team.

Urgent and emergency services

- We were informed post inspection by the Chief Nurse that they had spoken with staff about the culture on the unit and staff explained their concerns. The Chief Nurse informed us that they were going to work on this with the staff.
- At our follow up inspection on 26 March 2015 we spoke with senior managers, nurses and HCAs and all reported that whilst the concerns we raised at our last inspection had been very difficult for the team initially, it had a positive impact which meant that staff felt better supported and the unit felt safer.
- A new senior manager had been temporarily positioned on EAU to support the changes implemented following our last inspection. Staff that we spoke with spoke highly of this additional support and told us that they felt they could raise concerns if needed. We were assured that the culture on EAU had started to change for the better.
- The management team for the unit recognised that the work they were undertaking now for pre-registration staff should have been done without CQC having to enforce it but the processes and procedures for this staff group were now clear to all staff.

Medical care (including older people's care)

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

Information about the service

At the time of our inspection, Broomfield Hospital has 270 beds within the medical directorate, providing care for a wide range of medical conditions. These include stroke, respiratory, cardiology, renal, oncology and diabetes.

During our inspection, we visited six medical wards, two of which were elderly care wards. We also visited patients who were being looked after by medical consultants, but due to lack of capacity on the medical wards, were accommodated on other wards in the hospital; these patients are called 'outliers'. On the evening of our second day of inspection there were 34 medical outliers across seven wards. Senior personnel in the trust informed us that there were generally between 30 and 50 outliers each day.

We spoke with a wide range of staff, including all grades of nursing staff, healthcare assistants, occupational and physiotherapists, consultants, middle grade and junior doctors, pharmacists and porter/security staff. We also spoke with patients receiving care, and some of their relatives, as well as looking at medical and nursing records and drug charts.

Before, during and following our inspection we reviewed information sent to us from the trust.

Summary of findings

We found the medical services required improvement. There were high levels of pressure ulcers, although the numbers of patients having a fall was reducing. Incidents were reported, although feedback was variable across the directorate, and ward safety quality dashboards were not consistent, or easy for patients and visitors to understand. The storage of medicines was satisfactory, although medicine administration did not always take place, and documentation of medicine administration was not always undertaken in accordance with trust guidelines. We found variable record keeping with regard to people's care planning and observations. The use of medical and nurse agency staff was high. Nursing handovers did not always highlight patients at risk.

Care was generally provided in line with national best practice guidelines. The trust had been meeting national targets for the treatment of women with breast cancer. Cardiac monitoring equipment was not being used appropriately on one ward, which put patients at potential risk.

There was evidence of progress to providing seven day a week therapy services for the care of the elderly, although this was not yet in place. Nurses did not always have the skills to care for patients with particular needs. Middle grade nursing staff were working towards achieving a leadership qualification, although this had

Medical care (including older people's care)

not yet been completed. More emphasis had been placed on training nursing staff; barriers to this were the high nurse vacancy rates, and availability of training courses in general.

Caring was good. This was because the staff included patients in conversations, responded to patient's needs, and displayed a caring culture across the directorate. Despite being busy, staff found the time to talk with patients, sharing a joke when appropriate. Patients and relatives were treated with respect by staff who provided emotional support when necessary. Patient confidentiality was not always adhered to.

The number of medical outliers was regularly high, and the use of additional wards for medical patients had yet to be implemented. Day rooms on care of the elderly wards were not available. Specific care pathways for patients with dementia had not been introduced.

Local and trust leadership had changed in recent months, leading to more engagement from both sides. The NHS staff survey 2013 showed staff unable to contribute towards improvement, and communication between senior management and staff was poor. No formalised mortality and morbidity meetings were in place at medical directorate level. In the majority of cases, local ward leadership was good, and staff felt supported. Training for nursing staff was receiving a much higher priority, although it was often difficult to access because of nurse shortages.

Are medical care services safe?

Requires improvement

We found the medical services required improvement with regard to safety. We found that care on Danbury and Baddow wards particularly required improvement s to ensure that patients were not put a potential risk of harm through shortages of staff and provision of appropriate care. The hospital had high levels of pressure ulcers, which included those inherited pressure ulcers occurring prior to admission to hospital. The number of patients having a fall was reducing. Incidents were reported, although feedback was variable across the directorate, and ward safety quality dashboards were not consistent, or easy for patients and visitors to understand. The storage of medicines was satisfactory, although time-critical medicine administration did not always take place, and documentation of medicine administration was not always undertaken appropriately, following trust guidelines. We found variable record keeping with regard to people's care planning and observations. The use of medical and nurse agency staff was high. Nursing handovers did not always highlight patients at risk.

Incidents

- All staff, including bank and agency staff, were able to input incidents on the trust's electronic reporting Datix system.
- Staff we spoke with on the majority of the wards we visited stated that they reported incidents, such as the lack of staff and details of patient falls, and were encouraged to do so.
- Two members of staff informed us that they did not always report a shortage of staff, as they did not have sufficient time to do it during their shift.
- None of the medical staff we spoke to had raised an incident on the hospital's Datix system since August 2014, although they were aware of how to do so.
- A total of 36 medicine-related incidents had occurred in the medical services between April and August 2014. This was the second highest reporting area in the hospital.
- A total of 52 serious incidents had been reported in the medical directorate for the year 2013/14. The serious

incidents were reports under the National Framework for Reporting and Learning from Serious Incidents requiring Investigation, developed by the National Patient Safety Agency (NPSA).
- Of these serious incidents, 28 related to pressure ulcers at grade three or above, this included patients who are admitted to the hospital with pressure ulcers and 14 related to falls.
- The trust was using Hi-Low beds for patients who had been risk assessed as requiring such a bed because of their risk of falls.
- Data received prior to inspection showed that the rates of pressure ulcers and falls within the medical directorate since September 2013 had continued to fall, with falls being particularly low, and incidence of pressure ulcers although falling remained high.
- Staff opinions differed on whether they had been given feedback on incidents that had been raised on the Datix system.
- We saw the agenda for one ward meeting. The agenda for 4 September 2014 showed clearly that discussion took place regarding the Datix reports; a list of all Datix reports in a two month period was given with the agenda. The highest number of incidents related to falls and pressure ulcers.
- We also saw two sets of ward meeting minutes for a second ward, one dated 8 October 2014 and the other 29 October 2014. Neither of the documents identified any discussions on Datix reporting or feedback on issues raised.
- We saw the root cause analysis (RCA) investigation for two serious incidents that had occurred in 2014. Both identified the learning points from the incidents, and included either an action plan with dates for actions to be completed, or actions taken. However, this did not include how the outcomes of those actions were to be monitored.
- We were informed that formal departmental mortality and morbidity meetings were not currently being undertaken. However, respiratory and cardiology mortality and morbidity meetings were undertaken on a monthly basis, but were not comprehensive in content.

Safety thermometer

- In July 2014, the trust reported that 4% of patients had a pressure ulcer, compared with 4.5% nationally.This was the best performance during the last 12 months. Although data in August showed an increase to 6%, overall there was a definite downward trend.
- In July, the trust reported that no patients had had a fall with harm compared to 0.7% nationally. Just over 1% of patients had a urinary tract infection with a catheter compared to 0.8% nationally. This was an improvement on the previous six months data.
- All medical wards we visited had evidence of capturing information relating to patient safety, such as incidents of pressure ulcers, venous thromboembolism (VTE) assessments, and adherence of staff to the trust's hand hygiene policy.
- Other elements in the audit included commode cleanliness, staffing levels and appraisal rates.
- It was acknowledged by a senior member of staff that the audit information gathered across the wards in the medical directorate was not standardised; this was being taken forward.
- Staff were aware of the audits, but did not always have feedback or discussion on the results. Ward meeting minutes did not always evidence that they were discussed.

Cleanliness, infection control and hygiene

- Ward areas we visited were visibly clean and free from odours.
- Personal protective equipment, such as gloves and plastic aprons, were available in all areas for staff to use, and we saw them being used in accordance with trust policy.
- All wards had antibacterial gel dispensers at their entrances and near patient bedside areas. Appropriate signage regarding hand washing was visible.
- Staff were seen to use antibacterial hand gel routinely in the course of their duties.
- All wards we visited had facilities for isolating patients with infectious diseases. We saw signs on room doors to alert staff and visitors that this was in place.
- Audits relating to staff hand hygiene were in evidence on the wards. One senior nurse informed us that they would speak with individual staff members if they were observed contravening trust policies.
- All staff observed were seen to be adhering to the trust's 'bare below the elbow' policy.

- Data from the trust showed that from April to September, Broomfield Hospital had one or two cases of Methicillin Sensitive Staphylococcus Aureus (MSSA) each month, peaking at three cases in October 2014. It is unknown where these patients were accommodated in the hospital.

Environment and equipment

- The environment clinical areas were maintained.
- Systems were in place to maintain and service pieces of equipment, such as hoists. Fire-fighting equipment was available and had been checked on a regular basis. Electrical appliances had been tested to ensure that they were safe for use.
- Work had already commenced on the design of the two elderly care wards to provide an appropriate environment for those living with a dementia.
- Resuscitation equipment was checked on a daily basis.
- Some bed rails we saw in use during our unannounced visit put patients at risk of harm, because the rails were too far apart to prevent their limbs or heads from slipping through, causing possible entrapment.
- Falls mats were available for patients who were at risk of falls and who were inclined to get out of bed unaided. These alerted staff that patients were moving. However, the stroke unit had ordered more falls mats because of demand, but were unaware of when they would arrive.

Medicines

- The hospital used a comprehensive prescription and medicines administration record for patients, which facilitated the safe administration of medicines.
- Medicines interventions by a pharmacist were recorded on the medicines administration charts to help ensure the safe administration of medicines.
- We looked at the prescription and medicine administration records for 21 out of 118 patients on four wards. We saw that appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed.
- The records generally showed that people were getting their medicines when they needed them, there were few gaps in the administration records, and any reasons for not giving people their medicines were mostly recorded.
- On Danbury Ward we found that during the course of one night, three people had not received their intravenous antibiotics on time, as the ward had run out of stock overnight. This meant that patients were at risk.
- No attempt had been made to contact the on-call pharmacist to obtain further supplies, and this was not reported on the trust's incident reporting system. This could have prevented further doses being missed if staff had handled this situation in accordance with trust policy.
- On the same ward, one patient, who required administration of time-critical medicines for a chronic illness, was not always receiving them in a timely manner. This put the patient at risk of experiencing unpleasant symptoms of their disease. The hospital had received a complaint concerning administration of time-critical medicines in October 2013. The actions taken did not denote whether this had been upheld or not, or what actions had been put in place to prevent reoccurrence.
- An audit of the accuracy of prescription charts dated 1 October 2014 showed that across the hospital, wards were still not achieving the trust's targets for compliance; individual wards were not identified. However, the report concluded that standards had improved.
- If patients were allergic to any medicines this was recorded in their medicines administration record.
- Medicines, including those requiring cool storage, were stored appropriately, and records showed that they were kept at the correct temperature.
- Controlled drugs were stored and managed appropriately. Emergency medicines were available for use, and there was evidence that these were regularly checked, and intravenous fluids were stored separately in locked cupboards.
- A pharmacist or pharmacy technician visited all wards each weekday. We saw that pharmacy staff checked that the medicines which patients were taking when they were admitted, were correct, and that records were up to date.
- Pharmacy staff were also available on the wards to provide medicines to patients on discharge. This meant that patients were not kept waiting unduly for their medicines.

Records

- Patient's records were kept in a paper-based format. We were not informed of any timescales to move to electronic record keeping systems.

Medical care (including older people's care)

- Patient's records were kept in mobile lockable trolleys on each ward. We found that the trolleys were frequently unlocked and placed in corridors on the wards. This meant that they could be accessed by anyone visiting the ward areas.
- Two new documents for use by nursing staff had been introduced a few weeks prior to our inspection. One covered patient assessment and care plans, the other a care record. The care record documented observations on the two hourly care ward roundings for patients, and related to individual's care planning documents.
- The care planning in use was essentially a system of 'core' care planning. Core care planning is a way of having a consistent approach to care planning and delivery, whilst recognising the needs and standards of particular services and the people they serve. We found completion of documentation varied between wards and patients. Assessments were available for issues such as pain, nutrition, falls, pressure ulcers, skin condition and mobility, and personal care.
- Nursing staff on all wards told us that they were still getting used to the documentation, and had not always received appropriate training in its use. Up until the time of our inspection, there had been no documented audit of the system.
- On our unannounced visit to Danbury Ward, we saw that the completion of documentation was poor. There were numerous gaps in care rounding, care plans and risk assessments. For example, some patients had bed rails in place, but no risk assessments to support their use.
- We looked at documentation kept to record patient's vital signs, such as temperature, pulse and blood pressure, and fluid balance charts.
- Completion of fluid charts, designed to record patient's hydration, was not always in place. For example, on one ward we found input and output for the day for one patient had been entered, but not balanced. We brought this to the attention of a member of the nursing staff who rectified it.
- A discharge check list was available at the rear of all care plan documents. It covered essentials such as medication, next of kin being informed, and completion of the discharge summary. One member of staff we spoke with told us that it was a very useful tool to ensure they remembered to do everything for the patient before they left their care.
- In one ward area we saw a doctors notebook left on the nurses station desk.

Safeguarding

- Staff we spoke with were aware of the trust's safeguarding procedures for adults and children, what constituted abuse, and how to report it.
- Training was undertaken by all staff as part of their mandatory training units.
- Adult safeguarding training had been completed by 60% of medical staff and 89% of nursing staff.
- Safeguarding children training at level 2 had been completed by 45% of medical staff and 77% of nursing staff.

Mandatory training

- Mandatory training was encouraged in all the wards we visited. It comprised of units such as moving and handling, waste management, health and safety, hand hygiene, and basic life support.
- The training was mainly provided via e-learning, although some elements, such as blood transfusion, were undertaken on a face-to-face basis.
- Staff were individually responsible for completing their own mandatory training, but ward managers prompted their staff to complete this. However, staff informed us that this could be hindered by having available time to complete it during their shifts. Staff were reminded of its importance and the implications of non-compliance.
- Information received from the trust prior to our inspection showed that compliance levels varied between staff groups. For example, 64% of medical staff and 100% of nursing staff completed equality and diversity training, and 84% of medical staff and 91% of nursing staff completed hand hygiene training.

Assessing and responding to patient risk

- The trust used the national early warning score (NEWS) for managing deteriorating patients. The national early warning score is a simple, physiological score with a primary purpose to prevent delay in intervention or transfer of critically ill patients. Medical or nursing staff record measurements such as temperature, pulse and blood pressure. If scores were elevated, senior support was immediately sought and acted upon.

Medical care (including older people's care)

- During the hours of 8am and 8pm, a member of the trigger and response team (TART) was alerted to go to the ward, as well as members of the medical team for the patient concerned. Staff who were members of the TART team were trained in resuscitation.
- During the night hours, the TART team were unavailable, and a senior member of nursing staff was summoned, as well as members of the medical staff who were on duty.
- The trust had introduced the use of a sepsis early recognition tool for patients identified as having an acute infection. Although the use of the Sepsis Six care bundle had been introduced into the emergency department in November 2013, it was not introduced onto the wards at Broomfield Hospital until the Summer of 2014. A care bundle is a selected set of elements of care that when put together as a group, improve the outcomes for patients, in this case for those with acute infections.
- Nursing staff we spoke with were aware of the sepsis bundle and the importance of recognising patients with acute infections.
- Training for medical and nursing staff had been on-going in the use of the tool, with the tool being incorporated into the new care plan documentation.
- **At the time of our inspection, Broomfield Hospital did not operate a 'Hospital at Night' system. Hospital at Night is a system that** uses both a multi-professional and multi-speciality approach to delivering **care at night** to meet the immediate needs of patients.
- Although cardiac monitoring equipment was in place for patients requiring it on the stroke unit, we found that the audible alarms had been switched off. We were informed the alarms were 'annoying'. This meant patients were at risk of staff being unaware if they became unwell.
- Although it had been described as unacceptable practice by senior staff, some cardiology patients on cardiac monitors on Terling Ward were being nursed in side rooms. This was because the two bays behind the nurses station, which were easily visible by staff, were full. Ward staff informed us that this was because they had a high number of patients at risk of falls and they had been placed there so that they could be monitored more easily.

Nursing staffing

- All the medical wards had undergone a recent review of their nurse staffing levels, using a verified nurse staffing tool which took the acuity and dependency of patients into account.
- We were informed by some staff that nursing levels were much higher than normal during the week of our inspection. Some staff were concerned that it was not representative of normal staffing levels. However the rosters very clearly demonstrated that no additional shifts were requested during this week.
- Recruitment for nurses had been a problem in the hospital. Before our inspection, we saw clinical risk assessments for four medical wards undertaken in September 2014 to ensure control measures had been put in place to reduce the risks. Mitigating the risks had been made a priority, and the four wards were to receive a number of overseas nurses from December 2014.
- A phased uplift of £2.3 million for nursing had been agreed by the trust board in March 2014.
- Agency and bank staff were used when nursing numbers were below the accepted level to deliver safe care to patients.
- We saw the rotas for nursing staff on different wards. Both agency and bank staff were used on a daily basis. Where possible, the same agency staff were used on wards to give continuity of care to patients.
- We looked at actual v rostered staffing levels on three wards; we found them to be identical on the day of our visit for all three shifts, and saw them displayed on white boards near the entrance to the wards for visitors to see.
- Whilst it is acknowledged that the demand for medical beds was always high, some nursing staff informed us that they had been told they could not say 'No' if asked to accept a patient onto their ward, even when they felt the safety of the patient was at risk.

Medical staffing

- We received data from the trust prior to our inspection showing Broomfield Hospital's medical staffing skill mix. This showed that there were 2% more consultants than the England average, and 1% less middle career and junior doctors in post. Data also showed that the trust used 12.5 % bank and agency (locum) doctors, compared to 6.1% as an average in English trusts.
- All junior doctors we spoke with were very positive about their experience in the hospital. They had

received a 'good induction' at the commencement of their employment, and felt they had been given all the information they required. They had met with senior medical leaders and managers.

- Medical staff told us that it was busy within the medical areas in the hospital and getting busier. Some doctors felt there was a lack of continuity of care for patients; for example, a different registrar undertook the urology ward round every morning.
- The hospital had three renal and four cardiology consultants in post.
- There was a 'buddying system' in place for medical patients placed on other speciality wards (such patients are called outliers), such as gynaecology, surgery or burns. This meant that patients were reviewed by doctors from the medical directorate in a timely manner.
- On Baddow Ward we found that there was no registrar cover, and staff were unaware of when the post would be filled. Night time doctor cover for the medical wards amounted to one junior and one middle grade doctor. A doctor informed us that the workload was acceptable in the evenings, but not at weekends. They told us, "It's too much. It's a huge burden." At the time of our evening visit we found that there was no medical registrar cover for the medical wards.
- Junior and middle grade doctors informed us that consultants could always be contacted for help and advice when necessary, and would come into the hospital when required.
- We were present at a medical handover and found it to be of an acceptable standard. Staff highlighted those patients they were concerned about.
- Relationships between medical, orthopaedic and geriatric consultants were described as 'good' and they worked well together.

Major incident awareness and training

- On speaking with senior staff within the medical directorate, we found that the trust were giving high profile consideration to increasing the number of medical beds within the hospital.
- The problem had been recognised, and it was acknowledged that a further two wards for medicine were required. The trust were arranging a consultation and implementation plan. The timetable for securing the beds was unknown.
- Staff were aware of emergency policies, procedures and protocols. We saw that fire safety was undertaken as part of mandatory training.
- The trust emergency plan states the directorate is represented by the lead nurse for the medical wards and contributed to the corporate emergency plan from the medical directorate and ward perspective.

Nurse handovers

- We observed a handover from the day shift to the night shift on Danbury Ward. When we spoke to the incoming night shift staff following their handover, they were not aware of patients at potential risk. For example, they did not know that one patient was an insulin diabetic and that another patient was being treated for sepsis. This meant that patients were at risk of unsafe care.

Are medical care services effective?

Requires improvement

We found the medical services required improvement with regard to effectiveness. Care was generally provided in line with national best practice guidelines. Cardiac monitoring equipment was not being used appropriately on one ward, which put patients at potential risk. Some audits in which the hospital participated showed that improvements could be made to improve the effectiveness of services.

There was evidence of progress to providing seven day a week therapy services for the care of the elderly, although this was not yet in place. Nurses did not always have the skills to care for patients with particular needs. More emphasis had been placed on training nursing staff; barriers to this were the high nurse vacancy rates, and the availability of training courses in general.

Evidence-based care and treatment

- The trust's intranet system contained policies and procedures for any member of staff to access whenever required.
- National Institute for Health and Care Excellence (NICE) guidance was being followed by doctors across the medical directorate and specialties in the trust, such as for those patients suffering with heart disease, stroke or chronic obstructive pulmonary disease (COPD).
- Information from the national diabetes inpatient audit in 2013 showed that there were areas for improvement

by the trust, including improving pathways for both admission and discharges from hospital, and the care of diabetic patient's feet. A nominated lead and an implementation date had been identified for each of the areas. This was to be reviewed in June 2015.

- Improvement was required for pathways for patients with prostate cancer. Instead of the national target of 62 days for treatment, the trust was only achieving 80 days.
- The cancer patient experience survey from 2013/14 shows the trust in the bottom quartile of trusts in England for 5 of the 70 statements, including pain control and information being available. They were in the top quartile for 4 of the questions including staff giving information and advice to patients.
- Broomfield Hospital had no equipment to deliver radiotherapy on site. A senior clinician informed us that this had the effect of the hospital not being able to recruit oncologists. However, joint appointments with Southend Hospital had been made in the previous four weeks.
- It was senior clinicians opinion that the culture in Mid Essex was changing and local providers were now working together.
- From data the trust gave us, we saw the trust's outcomes relating to various treatment elements for patients admitted with a stroke. In November 2014, 81.8 % of patients had been sent directly to the stroke unit within four hours, and 100% had been scanned within 60 minutes. 97% of patients had spent 90% of their time on the stroke unit.
- The trust's heart failure audit for 2012/13 showed that 72% of inpatients received input from consultant cardiologists, compared to 57% of patients across other England trusts, with 100% of trust patients receiving an echocardiogram, compared to 91% across other England trusts. An echocardiogram gives information about the structure and function of the heart. Results for patients on discharge showed that the trust performed above the average for trusts across England, such as for referral to a cardiology outpatient appointment and discharge planning.

Pain relief

- Patients we spoke with informed us that they had received pain relieving medication (analgesia) in a timely way if and when it had been required. The medical wards accessed the trust wide pain relief service.
- Prescription charts showed analgesia had been prescribed when it was required.
- There were clinical guidelines and patient pathways for staff to follow when patients were in pain.
- Nurses we spoke with informed us that they would always ensure patients were prescribed analgesia if it was required.
- The pain service provided education, training and support for ward staff.
- The trust wide pain service was involved in care and discharge planning and were involved in the MDT meetings within the wards. The trust wide pain service attended ward rounds.

Nutrition and hydration

- The patient-led assessments of the care environment (PLACE) for 2014 showed that the trust were only just below the England trust average for quality of food, at 89%, compared to 90%.
- Patient opinions varied when we asked them about the quality of food they received. The majority of people told us that they thought it was good and they had sufficient choices.
- All patients on wards we visited had access to drinking water. A red tray system was in place to indicate patients who required assistance to eat their meals.
- We saw patients supported to take fluids and food appropriately, and at the correct pace for patients when this was necessary.
- Prior to lunch on one ward we saw the ward hostess ring a bell 15 minutes before lunch was served. This gave staff time to undertake blood glucose monitoring of patients where necessary, and prepare all the patients for lunch.
- On Terling Ward a designated renal dietician visited patients to advise with regard to their dietary and fluid input.
- On care of the elderly wards patients were able to make their choices for meals at the time of eating them. This helped those patients living with a dementia and who had difficulty in remembering. Portions were adjusted to support patients' wishes.
- On care of the elderly wards we found that full fat milk was used for patients; some organisations think this is beneficial for older people.
- Snacks were offered in between meals, such as cakes, biscuits and yoghurts.

- Specially-adapted cutlery was available for those patients requiring it.

Patient outcomes

- The Myocardial Ischaemia National Audit Project (MINAP) looks at how patients are treated when presenting with a myocardial infarction (heart attack). Broomfield Hospital did not treat patients suffering a more severe type of heart attack (STEMI). These were treated at Basildon Hospital. Of the 408 patients treated at Broomfield Hospital for the less severe type of heart attack, 95% were seen by a cardiologist, and 68% were referred for an angiography. Angiography is a type of X-ray to examine blood vessels.
- The Sentinel Stroke National Audit Programme (SSNAP) for 2014 showed Broomfield Hospital varied in its scores for aspects of care and treatment for patients with strokes. With scores awarded A to E, where A is highest, the overall SSNAP level was level D, which has reduced from a C in 2013. However, occupational and physiotherapy input scored A. It is acknowledged nationally that the criteria for the grading are very stringent. At present there are very few trusts that have achieved a 'B' grade.
- Bed occupancy within the trust for the first quarter of the year 2014/15 showed the trust was higher than the England average at 96% compared to 88%.
- There has been a 47% reduction in cardiac arrests for the year ending 2013-14, compared to 2012-13% of patients who had in-hospital cardiac arrests survived the initial arrest.
- The trust had an admissions policy in place. This covered elements such as emergency and elective admissions, and a requirement for equitable treatment for all patients ensuring safe and effective patient care.
- There were less observed readmission rates for general medicine, geriatric medicine and nephrology (renal) than expected.
- Our Intelligent Monitoring report for December 2014 displayed the trusts 'risk' status. Those totalled nine and included elevated in-hospital mortality rates for dermatological and cerebrovascular conditions.
- We saw evidence of medical engagement and participation in research activity.

Competent staff

- Patients we spoke with felt confident in the staff's ability to care for them appropriately.
- On Terling Ward, renal and cardiology patients were nursed together. We found that there were only five nurses who had either received or were undertaking specialist training in cardiology. This meant that not all shifts could be staffed by suitably qualified and experienced staff for those patients requiring specialist care. Doctors told us of their concerns about this.
- Danbury Ward was designated for both gastroenterology and oncology patients. Gastroenterology is a branch of medicine dealing with diseases of the digestive tract; oncology is a branch of medicine dealing with tumours. On our evening visit, we found of the three qualified nurses on night duty on Danbury, only one was a regular member of trust staff. They had been working on the ward for three months and their specialism was respiratory nursing. The other two nurses were agency staff, one of whom had not worked on the ward before. An additional three healthcare support workers (HCSW) were on duty, as well as a bank HCSW.
- We were informed by two nurses that even if they or their staff did not have the competency or expertise to care for a patient, they had been told they could not refuse to admit them if they had an empty bed on the ward. We were told that this left them feeling de-skilled, and put the patient at risk of ineffective care.
- Nursing staff were trained in basic life support and received regular updates.
- Pressure ulcer competency training had been launched in September 2014 for staff. A senior member of staff on one ward informed us that they had not yet completed it, so had been unable to roll it out to other staff.
- Appraisal rates across the disciplines showed 96% of medical staff and 63% of qualified nursing staff had received an appraisal. On individual wards, we found appraisal rates for nursing staff varied widely, with one ward we inspected achieving 100%.
- Nursing staff told us that there were no formal systems in place for regular supervision sessions with their line managers, but they could address any concerns with informal support from their managers, who were generally accessible.
- Plans had commenced to ensure that band 6 and 7 nurses could access leadership courses to develop their management skills. It was envisaged by senior nurses that eventually band 5 nurses would be able to gain access to the course in order to prepare them for management roles.

- We were informed by senior staff that staff development was poor. However, various grades of nursing staff stated that that more emphasis had been put on training, and that it was becoming easier to access both internally and externally. Barriers to training were seen as the high nurse vacancy rates, and availability of training courses in general.
- Junior and training middle grade doctors told us that they had opportunities for attendance at regular training sessions.
- Junior and middle grade doctors had access to supervisors and mentors, and felt well supported.
- The organisation and individual doctors have a responsibility to ensure their revalidation is up to date.
- We discussed revalidation of doctors in the directorate with a medical director. We were informed that the process was working well and that all medical staff were up to date.
- Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise. The process commenced on 3 December 2012, and combines training and appraisals. Doctors are only granted a GMC licence to practice for five years, consequently every five years each licence must be revalidated.
- The trust had produced a comprehensive document outlining the revalidation process and how it works. The responsible officer for the process was the medical director for the trust.

Multidisciplinary working

- There was a multidisciplinary co-ordinated approach to care and treatment that involved a range of professionals, both internally and externally. However we observed that nurses did not routinely accompany doctors on their routine rounds on the wards. As a result, nursing staff were not present to hear what the doctors said to patients, and were expected to read the medical notes to determine any follow-up plans and changes to patient care.
- The trust wide pain service was involved in discharge planning and admission avoidance in the accident and emergency department.
- Older people who required rehabilitation had access to three community hospital beds, although numbers were limited, and patients often had to wait up to a week for a bed at the place of their choice.
- Meetings on bed availability across the hospital were held three times a day, to determine priorities, capacity and demand for all specialities. Numbers of planned discharges from each ward were also discussed.
- A daily ward round was held to review care, treatment and discharge planning. Staff informed us that there were good relationships between nursing and medical staff.
- Patients living in the county of Essex, who experienced acute episodes of disease involving the heart or lungs, were referred to the Essex Cardiothoracic Centre in Basildon, which provided specialist treatment and care for such patients. It is run by Basildon and Thurrock University Hospitals NHS Foundation Trust.
- The trust wide pain service was involved in discharge planning and admission avoidance in medical care.

Seven-day services

- Staff told us that the process for having X-rays taken, and getting the results for people, could be slow at times, particularly in the evenings and at weekends, due to the out-of-hours cover rota.
- Staff told us that the level of cover by doctors for the medical wards at weekends was unacceptable. This view was supported by the junior medical staff.
- Unless a patient required medical review or intervention at weekends or on Bank Holidays, doctors did not routinely visit patients during those times.
- Staff reported good relations with their social work colleagues, but in care of the elderly wards, placements in care homes and care packages for patients returning home could take a long time, which delayed discharges.
- Occupational therapy and physiotherapy were not available seven days a week on the care of the elderly wards, at the time of our inspection,. Plans were in place to introduce this in January 2015.
- An out-of-hours consultant on-call rota was operated by the trust.

Access to information

- Patients reported to us during the inspection that they had no concerns regarding access to information relating to their care or treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had its own policies and procedures relating to consent. Patients informed us that they were asked for

their verbal consent before staff helped patients and before any procedures were undertaken. If any intervention was required, written consent was obtained.
- We found that there were also documents related to the Mental Capacity Act: Deprivation of Liberty Safeguards (DoLS). There were clear actions that should be taken if the trust needed to make an application to deprive a patient of their liberty, and specific professionals were mentioned to obtain clinical advice. Documents covered such issues as the duties of the trust, and how to ensure patients have access to an independent mental capacity advocate (IMCA)
- A list of factors that may require an application for Deprivation of Liberty had been attached to the document.

Are medical care services caring?

Good

Overall we rated the medical services as 'good' for caring. This was because the staff included patients in conversations, responded to patient's needs, and displayed a caring culture across the directorate. Despite being busy, staff found time to talk with patients, sharing a joke when appropriate. Patients and relatives were treated with respect by staff who provided emotional support when necessary. Patient confidentiality was not always adhered to.

Compassionate care

- Throughout our inspection we generally saw staff behaving in a caring manner towards their patients.
- Although staff were busy, we saw examples of quality conversations between patients and staff. This included enjoying the sharing of a joke when appropriate, which patients responded to well.
- Privacy curtains were drawn around patients when appropriate, such as when delivering personal care.
- We saw one patient on a care of the elderly ward walking with a hospital gown wide open at the back. We were informed that the hospital did not provide dressing gowns for patients, and that the relatives of the patient had been asked to bring one.
- During our unannounced inspection we were present on a ward when a patient's continence pad was being changed. We overheard a member of nursing staff telling the patient to "go in the pad" when they asked the nurse what they should do if they needed the toilet again. There was no comfort or reassurance around the message given.
- On one ward we saw personal patient information, including their date of birth, on a large monitor at the nurses' desk. It included which bed they were in. The monitor was easily visible for visitors, and the desk was not always manned; this meant that patient's confidentiality was breached.
- Patient's call bells appeared to be answered promptly.
- Recent Friends and Family Test results for the wards we visited were varied. The hospital average for the medical wards in November across 11 wards is 95% recommend. The average for not recommend is 2% for November.

Understanding and involvement of patients and those close to them

- Patients we spoke with told us that they had felt involved in their care and had been part of conversations with doctors and nursing staff. Staff had been approachable when they wanted reassurance or a question answered.
- Relatives told us that they had been kept informed of their loved one's condition, which had been appreciated.
- One patient told us that they had really wanted to go home; however, after a discussion with doctors and nurses they realised they were not ready for that yet.

Emotional support

- Patients and relatives we spoke with told us that the care in the hospital had been very good. One person told us, "They couldn't have done more for my mother. They've been wonderful. They go above and beyond what they need to do."
- On the care of the elderly wards we saw a number of patients who were living with dementia. Staff displayed quiet behaviour, and showed understanding and support to those patients. When necessary, they used diversional therapy to reduce anxiety levels, such as when patients wanted to leave the ward.

Are medical care services responsive?

Medical care (including older people's care)

Requires improvement

Overall we rated the medical services as 'requires improvement' for responsiveness. The number of medical outliers was regularly high, and the use of additional wards for medical patients had yet to be implemented. Day rooms on care of the elderly wards were not available. Specific care pathways for patients with dementia had not been introduced.

Service planning and delivery to meet the needs of local people

- Chelmsford was the third largest district in Essex in terms of population, with 168,310 people in the 2011 census. Approximately 51% were females and 49% males. The average age of people in Chelmsford was 40, and 97% spoke English.
- Broomfield Hospital experienced similar pressures on its medical services as other acute trusts in England. This resulted in a continuous struggle to balance the increasing attendance in its accident and emergency department, and subsequent demand for medical bed availability in the hospital. Work was being undertaken to reduce the number of admissions and improve discharge processes.
- Medical outliers were a continuous problem, and one senior manager informed us, "patients are going to the wrong ward at the wrong time". The average number of medical outliers on any day was between 30 and 50.
- The two care of older people's wards had day rooms for patients to sit in. Work had begun on improving the design and layout of the elderly wards for those patients living with a dementia; for example, the toilet doors were in a different colour to enable them to be seen more clearly.
- The local community was involved in creating a dementia-friendly garden in the grounds of the hospital, but this was not readily accessible to patients without help from staff.
- Physiotherapy and occupational therapy was generally delivered on Lister Ward, where a therapy room was available, including a kitchen for patient ability assessments. Patients on the older people's wards were required to go to Lister Ward, as no therapy room was available for them on their own wards.
- Therapy staff undertook home visits with patients to determine whether or not it was safe for them to return home.

Access and flow

- Bed occupancy was above the England average, with a trust-wide occupancy in Q3 2013/14 of 98% and 96% in Q1 2014/15.
- Patients were not discharged until a discharge form had been completed by a doctor. This sometimes led to delays and frustration for patients.
- The trust's escalation procedure for cancer patients set out the prospective monitoring required to track patients, providing guidance on the appropriate escalation procedure to follow should a patient be at risk of breaching the cancer target standards. The procedure had been developed in line with NHS guidance. The document was not dated or signed, and the policy for escalation was in draft.
- We were informed that medical patients were only moved to other wards in the hospital when they were fit to do so.
- We found on Writtle (gynaecology) Ward that staff had raised issues with regard to outliers who did not meet the ward's own protocol for acceptance. Junior staff on the ward had not felt able to refuse to admit such patients when pressurised by managers. Following our inspection, the ward was closed to medical outliers.
- Two months prior to our inspection, Goldhanger Ward had 15 medical outlier patients on a 23 bedded ear, nose and throat (ENT) ward. This had resulted in the ward being unable to admit emergency ENT patients who had needed to be transferred to another hospital for treatment.
- The trust had a system in place to ensure that medical outliers were reviewed by a doctor every week day.

Meeting people's individual needs

- We did not see any printed information for patients in any language other than English. A language line telephone service was available when required, for patients requiring interpretation.
- Twelve patients with a learning disability (LD) had been treated as inpatients at Broomfield Hospital since April 2014. A LD nurse was available to assist such admissions when this was necessary.

Medical care (including older people's care)

- We saw on one ward that the LD link nurse on the ward had developed pictorial menus for patients with a learning disability, which was positive and responsive to patient needs.
- A dementia nurse specialist had been appointed in the trust. Staff had found them to be approachable and knowledgeable when advice had been sought.
- The trust had promoted training for all staff to aid patients living with a dementia. We spoke with members of staff about their ability to help patients with a dementia, who told us that they felt confident.
- Dementia champions had been appointed on each ward to promote good quality care in the area for those patients with a dementia.
- A booklet called 'This is me' was available for relatives of people with a dementia to complete. The document helped staff care for those patients in a meaningful way.
- We saw the trust's gap analysis and action plan for dementia dated September 2014. The original plan had been agreed in August 2013, and was to be reviewed again in December 2014. A number of the items had either been achieved or were on-going. However, some items identified in 2013 had still not been completed, such as a care pathway for patients with dementia, which was still to be developed and implemented, and those patients who had a dementia had yet to be identified on trust systems. The latter had no date for completion on the plan.
- Specialist doctors, such as cardiology and respiratory, were only available Monday to Friday. Overnight, and at weekends or Bank Holidays, general medical doctors reviewed and treated those patients.
- Bariatric equipment was available for patients requiring this. There were also dedicated rooms with double tracked gantries in selected side rooms, which offered safety and comfort to bariatric patients.
- Results of some of the audits were displayed on wards, but they were not in a format that could be readily understood by patients or relatives.

Learning from complaints and concerns

- Between 1 September 2013 and 31 August 2014, 83 complaints were received in the medical directorate.
- Of the five latest complaints received by the trust, only one related to care in the medical directorate. The incident concerned staff attitude, and the patient received a written apology.
- Complaints/compliments leaflets were widely available for patients and relatives. They explained how people could make a complaint, and how they could access the Patient Advice and Liaison Service (PALS), with contact telephone numbers and addresses.
- The Patient Advice and Liaison Service office was situated in the hospital's main atrium, and open 9am to 5pm, Monday to Friday.
- During ward meetings, complaints and compliments were an agenda item. Senior sisters informed us that they always spoke about the issues raised with their staff, to ensure lessons were learned. We looked at ward meeting minutes from two wards and found complaints had been discussed. When we spoke to staff, they confirmed this.
- We saw evidence that complainants were invited to a meeting to discuss their concerns.

Are medical care services well-led?

Requires improvement

Overall we rated the medical services as 'requires improvement' for well-led. Local and trust leadership had changed in recent months, leading to more engagement from both sides. Whilst we found that locally teams felt supported by their local leaders, more senior leaders failed to address the issues that were well known in the service and made the service requiring improvements in the domains of safe, effective and responsive. The NHS staff survey 2013 showed staff were unable to contribute towards improvement, and communication between senior management and staff was poor. No formalised mortality and morbidity meetings were in place at medical directorate level. In the majority of cases, local ward leadership was good and staff felt supported. Training for nursing staff was receiving a much higher priority, although it was often difficult to access because of nurse shortages. Middle grade nursing staff were working towards achieving a leadership qualification although this had not yet been completed.

Vision and strategy for this service

- Senior sisters spoke positively about the way in which the trust had changed in recent months. Some were aware of the possible increase in additional medical beds and welcomed this.

Medical care (including older people's care)

- The senior leadership team in the medical directorate had a clear vision of the future of the service, but were aware that having sufficient beds, increasing nursing recruitment, and ensuring staff were delivering safe and quality care to all patients, was imperative.
- Some of the staff we spoke with were not aware of the trust's objectives, although this was visible as a screen saver on the trust's intranet.
- Staff stated that they felt supported in the work they did, and felt the previous bullying culture had disappeared with the appointment of the chief nurse and head of nursing for the medical directorate.
- All the staff we spoke with were proud of the work they did, and the care they provided for patients. They had a good sense of team work and stated that they all worked together for the patients.

Governance, risk management and quality measurement

- We asked staff if or how they would raise issues about safety concerns or poor practice in their department. All of those spoken to told us that they felt confident taking any concerns to their line manager and felt they would be dealt with promptly.
- Ward meetings were held monthly, although we were informed that information was not being captured in each area with regard to the staff who had read the meetings of those minutes.
- There were structured departmental meetings in place, such as monthly sister's meetings. Discussion at this meeting included performance and financial issues.
- Lead nurses within the directorate met weekly each Monday with the head of nursing as a senior team, these had an agenda and were minuted.
- Issues that were well known within the service had not been sufficiently addressed these included care pathways for patients living with dementia, management of outlier medical patients and training in pressure ulcer care.
- It was acknowledged that no formalised mortality and morbidity meetings were in place at medical directorate level.
- Planned and actual staffing levels were displayed on white boards for all shifts. During the week of our inspection shifts were generally well staffed.

Leadership of service

- A good rapport existed between all levels of staff. We were able to see this during our visit.
- The lead nurse informed us that they had developed a good relationship with the lead for the directorate. They worked together and met/spoke with them on a regular basis.
- A layer of management had been taken out of the trust's structure. This meant that the head of nursing was required to undertake business management for their directorate, which meant less time was available to undertake clinical support for their staff team. However, they felt this was a positive step, with clinicians having a much greater voice.
- Whilst staff told us that leadership on individual wards was generally good, we found that such local leadership required improvement owing to concerns we identified in the Safe, Effective and Responsive domains of this report.
- Staff we spoke with stated that the chief executive officer (CEO) and chief nurse were visible throughout the hospital on a regular basis; they felt they were both approachable. The CEO was reported as attending ward meetings when possible.
- The executive team had a monthly 'open' meeting, when any member of staff could attend and ask questions.

Culture within the service

- Generally staff on all wards were willing to speak with the inspectors in an open way.
- They were aware of the importance of quality and safety.
- Staff we spoke with told us that they felt supported by their managers, who had an open door policy and who were always approachable.
- Staff informed us that there was an open culture with the sharing of complaints and incidents.
- Discussions were held on lessons learned from them, and practices changed where appropriate.
- A senior sister on a care of the elderly ward explained how, when a patient had fallen, they had telephoned the relative and apologised to them.

Public and staff engagement

- Staff did not feel engaged in the organisation of the service. They felt that they could not contribute to the improvement of the service. This was evidence through speaking to staff and through review of the national staff survey results.
- We did not find any engagement of patients in the improvements to the service. Their only contribution was through the NHS Friends and Family Test or the Patient Opinions website. The trust answered posts on the Patient Opinions website but there was not evidence that these had been taken into account to improve the service.

Innovation, improvement and sustainability

- From discussion with staff, it was clear training for nursing staff was receiving a much higher priority, which meant staff felt more valued, although training was difficult to access because of nurse shortages.

Surgery

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

Information about the service

Broomfield Hospital has 272 surgical beds, caring for patients undergoing both elective and emergency surgery. There are also a number of chairs in the theatre day unit, for patients recovering from minor operations. Surgery admissions include general surgery, urology, gynaecology, trauma and orthopaedic. The surgical department last year operated on 34,000 patients, of which 41% were day cases, 24% were elective and 35% were emergencies, in eighteen operating theatres. The trust is a regional centre for gastric cancers, and for head and neck surgery, and has in excess of 4,000 staff employed over its four sites.

We visited seven wards, including specialist surgical wards, trauma and orthopaedics, ENT, the day unit, main theatres, anaesthetics and recovery areas, to observe care provided both pre-operatively and post-operatively. There was no dedicated day theatre. Staff told us that this was due to open shortly.

We talked with 25 patients, four relatives and 42 staff, including nurses, healthcare assistants, operating department practitioners, doctors, consultants, support staff and senior managers. We observed care and treatment, and looked at 18 care records. We received comments from people at our listening events, and from people who contacted us to tell us about their experiences. Before our inspection, we reviewed performance information from, and about, the trust.

Summary of findings

Services in the surgical department were not always safe for patients. 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. There was no system in place to facilitate learning from incidents or complaints. service had one Never Eventsince April 2014. However, almost all the staff we spoke with, some of them senior, were unaware of these events.

We saw staff who were caring; the patients we spoke with complimented staff on their caring approach and professionalism.

Shortages of beds resulted in patients often being admitted to an inappropriate environment, particularly in Goldhanger Ward, the ENT ward, and the theatre admissions unit. Patients' operations were often cancelled or delayed. This was mainly due to a lack of surgical capacity, because surgical beds were blocked by medical patients outlying on surgical wards.

Gaps in staffing were met using bank (overtime) and agency staff, but such staff were not always available. This puts at risk the nursing roles and duties, and the specific nursing requirements of each specialty ward. Staff have been recruited from overseas to meet current vacancies. However, the time from recruitment to active duty is several months and without appointments based on expected needs there is always an avoidable staff vacancy gap.

Surgery

We saw that appropriate equipment checks and maintenance were carried out.

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. A clinical governance framework was also in place; however, generally this was not embedded in the staff culture, and staff were unaware of how clinical governance improved care. We found that staff were responsive to people's individual needs; however, staff told us that there were often delays in patients' discharge from the hospital. We saw a lack of discharge planning for emergency admissions, with discharge significantly delayed by a step-by-step approach, rather than an early integrated discharge plan.

Are surgery services safe?

Requires improvement

Surgery services require improvement to ensure that patients are protected from potential harm through ensuring that there are sufficient and suitably skilled staff available, that incidents are learnt from and measures taken to ensure that systems are safe, and the confidentiality of records is maintained. Medicines management systems were found to be safe. Although the wards and the operating department were all very clean, we observed some lack of compliance with hand hygiene on some wards.

There was a reliance on temporary and agency staffing on all surgical wards, particularly at night. There were no systems in place to induct temporary staff. Often even temporary staff were not available. There was a very high vacancy rate, both for nursing and medical staff. Patients were often accommodated in unsuitable environments, such as patients who had had a stroke being accommodated on the ENT ward. This could result in delay in specialist therapy, and delayed recovery.

Nursing staff reported working a 13.5 hour day, which they found exhausting, whereas in other areas, nursing staff worked an 11 hour day.

The on-call consultants worked seven days in a row. This is not seen as best practice in a modern surgery department, and is considered potentially unsafe in two aspects: firstly, the potential continuous hours on duty are not compatible with safe practice, and may inhibit appropriate consultant involvement in the emergency activity of the unit. Also, the results of one surgical firm being on-call for seven days means that they build up an excessive number of emergency patients in one week, whilst other teams have few patients. To facilitate this, the emergency team borrowed junior doctors from other teams, reducing their continuity of training and practice. The trust stated that there was little evidence to demonstrate this that the number of patients are unmanageable. However, action had been taken to resolve this issue.

Surgery

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 in the hospital, even if they were within their department, or related to their practice, such as wrong site surgery.

Incidents

- The trust had reported five 'never events' within the hospital between April and October 2014. Although most nursing staff were aware of what a 'never event' was, no staff, even senior nursing staff, up to band 7, were aware of incidents within their department or the surgical directorate, which directly affected their ability to keep patients safe. We looked at minutes of ward meetings on three wards; which included feedback from incidents and action plans.
- Staff were open and honest about incidents they reported, and were all aware of how to use the trust's electronic recording system. We reviewed the incident reports from April 2014 to October 2014. There was a mixed category of incidents reported, with no particular identifiable trend. We saw staff reported when they made an error, such as needle stick and splash injuries. When we reviewed incidents for the past six months we found that many incidents were awaiting investigation, particularly those from August onwards. This meant that incidents were not investigated promptly, with lessons learnt and the incidents finally closed in a timely manner.
- Mortality and morbidity was reviewed within generic directorate clinical governance meetings, and in line with best practice. Any deaths were reviewed and discussed within the MDT.

Safety thermometer

- Each ward displayed their Safety Thermometer. These showed low risks and no specific concerns. However, Heybridge, Rayne and Notley Wards reported some grade 2 and above pressure ulcers, 6, 3 and 8 respectively, during 2014. In addition, Heybridge and Notley reported a number of grade 3 and above pressure ulcers. The numbers had fallen since August 2014. We discussed with a senior nurse on each ward what action was taken to prevent any further pressure ulcers. We saw recent action plans in place to prevent further occurrences. When we spoke with more junior nurses, they were aware of actions taken to prevent pressure ulcers. On all surgical wards there had been very few falls with harm.

Cleanliness, infection control and hygiene

- The hospital was visibly clean. Patients remarked on how clean the hospital was. One said, "I have been here quite a bit recently and it's always spotless." We saw that the operating theatre was extremely clean. We saw cleaning schedules and audits of cleanliness for all surgical areas.
- Infection rates were similar to those of other trusts for MRSA and C. difficile. The trust reported one incidence of MRSA bacteraemia this year.
- We observed that staff were using protective equipment and clothing, such as aprons and gloves. Hand hygiene gel dispensers were available at the entrances to surgical wards and units, and within each ward. Staff were observed using these. 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.
- There were regular hand hygiene and infection control audits across the surgical areas. The hand-washing audits for most wards showed 100% compliance. Staff were able to describe to us the 'five moments of hand hygiene'. However, we did observe some practice on Rayne and Heybridge Wards, where good hand hygiene was not practised consistently. For example, we saw a nurse assist one patient, not wash their hands, and then go to another patient and attend to their needs.
- A number of other audits took place, such as surgical site infection, and peripheral and central line infection, all which showed results in line with, or better than, national data.
- Audits completed by the infection control team showed positive results in all areas, with regards to, for example, infection rates and hand hygiene compliance. Each ward had an infection prevention and control link nurse. However, we noted that the monthly infection control meetings were poorly attended by ward staff. One told us that they often could not get to link meetings or educate their peers because shortages of staff meant that they could not be released.

Environment and equipment

- All surgical wards had a buzzer entry system. Visitors were required to use the intercom, and identify

themselves upon arrival before they were given access. Staff entered the unit by means of a swipe card that was unique to them. When we undertook our unannounced visit on a Saturday night, we noticed that all wards and parts of corridors were locked and inaccessible to anyone who was not a member of staff.

- The wards in the older parts of the hospital were clean and had made the most of the space available. There were sufficient side rooms in all wards, except in the Theatre Admissions Unit, which accommodated patients overnight, or longer, when the hospital was full. The unit had no side rooms. Bathroom facilities were sufficient, even in the older wards. All had separate bathing/toilet facilities for males and females.
- Most storage areas we saw, both on the wards and in the operating theatres, were clean and well organised. There was minimal equipment stored in corridors.
- Equipment was clean and most had 'I am clean' stickers attached.
- We checked resuscitation equipment in most wards and in the operating department. We found that equipment was checked daily, and the trolleys sealed once the equipment had been checked. Medicines used for resuscitation, and consumable items, such as syringes and needles, were all in date.

Medicines

- We found that the hospital used a comprehensive prescription and medication administration record chart for patients, which facilitated the safe administration of medicines. Medicines interventions by a pharmacist were recorded on the prescription charts to help guide staff in the safe administration of medicines.
- Fridges were locked and daily temperature recordings were within the normal range. Controlled drugs were locked away appropriately, registers had required entries, and staff checked stock balances at least daily.
- Medicines were available to meet the needs of patients, and this was corroborated through staff comments, and evidenced from charts. 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 when they were at home before they left the hospital. This was done by nurses and or a pharmacist.

Records

- We reviewed 18 patient records across eight wards and in the operating theatre. We noted that appropriate assessments had been completed accurately, such as venous thromboembolism (VTE) risk assessments, pressure ulcer risk assessments, and nutrition and fluid assessments. One nurse told us that they were developing a shorter assessment tool for patients who are expected to stay for less than 48 hours. We saw that mostly the assessment tools had been completed correctly; for example, the Malnutrition Universal Scoring Tool (MUST) and Waterlow scores were calculated correctly and evaluated, and the right action taken should a patient require further treatment.
- The medical notes we saw were completed thoroughly and were mostly legible. However, we did find one set of patient's medical notes that did not indicate that they had a penicillin allergy.
- There were no electronic records; both nursing and medical notes were in a paper format. On most wards, patients' nursing records were kept at the bedside. Medical notes were stored securely in lockable trolleys. However, all the trolleys we saw were not locked, but all were closed.

Safeguarding

- Safeguarding training for adults, levels 1 and 2, had been undertaken by most staff working within surgical wards and departments. For new staff this 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. Patients and relatives told us that they felt safe. A patient's relative told us, "We are very happy with the cleanliness and safety here." Staff on the surgical wards and in operating theatres told us that they understood the requirements of the Mental Capacity Act 2005, to ensure that treatment was provided in the patient's best interests.
- 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 decisions. We also found Mental Capacity Act checklists in patients' records that had been completed appropriately, and action taken to ensure decisions were made in the patients' best interests.

Surgery

Mandatory training

- The trust's target was that 75% of staff should have completed all their mandatory training. We saw from trust records that the majority of training for staff in mandatory subjects was up to date. All wards had exceeded the trust's target. Some wards, such as John Ray and Rayne Ward, over 90% of staff had completed their mandatory training. Staff told us that they were responsible for ensuring that they completed their training, and this was checked and reviewed by the ward leaders. Much of the mandatory training was via e-learning, In some subjects, such as infection control, all staff were up to date with their annual training.

Assessing and responding to patient risk

- We reviewed the case notes of 18 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, with the national early warning score (NEWS). It was well embedded and used effectively to identify and assess deteriorating patients. A high score triggered further intervention from a senior nurse or doctor to ensure that any changes in a patient's status were managed immediately.
- There was a trigger and response team (TART) that provided support for the management of deteriorating patients on the wards. This service was available seven days a week from 08.00hrs to 20.00hrs. Staff we spoke with were complimentary about the service that was offered by the team, particularly as they visited most wards every day to assess and offer advice to the staff on any patient that may be causing concern. During the night, any patients who were causing concern were seen by the clinical site manager, who if appropriate, would contact the on-call doctor.
- We found that World Health Organization (WHO) safety checklists were completed properly in the operating theatre. We saw that during one operating list, there was a delay whilst the consent was thoroughly rechecked to ensure that the right procedure had been consented for. This makes the operating theatre a safer place for the patient.
- In the operating theatre, we observed a senior team meeting, which took place three times a day and was chaired by the head of theatres. Updates and any escalation issues were shared, such as any problems in any theatre area, overrunning lists, or patients requiring surgery direct from A&E. This ensured that any problems that could affect the smooth running of the operating theatres and risk to patients, were discussed and planned, including patients with allergies to latex.
- The trust had recently implemented a procedure to ensure that patients who were dependant or unwell, had a nurse to accompany them to other hospital departments for tests, although one member of staff told us that it was not always implemented fully.

Nursing staffing

- Wards and departments had expected and actual staff numbers on display. We noted on most wards that the number of staff meant to be on duty was not always achieved.
- Nursing staff on most wards and departments worked from eight to 13.5 hour shifts. Most nursing staff worked long days, that is, 10-13.5 hours. It was unclear why the shift patterns were different for different wards. Although we did not investigate the shift patterns on every ward, it seemed that on the general wards the nurses worked longer shifts, whereas specialist areas, such as the intensive care unit, worked shorter shifts. One nurse told us, "Someone told me it was to ease congestion in the car park." The nurses who worked 13.5 hour shifts reported that their wards were very busy and they often did not leave work until 10pm, and then started their next shift the next morning at 7am. During our unannounced visit, on a Saturday night, we met one nurse leaving their ward at 10pm as the shift had been so busy. One told us, "By the time I get home, it's really late; I don't get time to wind down and end up having about four hours sleep. By the end of three days doing that, I'm exhausted." The Health and Safety Executive identified that long shift patterns could increase workers fatigue levels and could be a contributory factor in safety related incidents.
- Ward and department managers told us that they tried hard to ensure that the skill mix was suitable to support the patients in their care safely. However, all wards had a number of vacancies and reported that with people leaving, it was taking some time to replace them. This was coupled with maternity leave and long-term sick leave; therefore, they were never fully staffed. A patient told us, "Not enough staff. They all switch over in the middle of the week. At night there is barely enough."

- Shortfalls were filled by staff doing extra shifts, or bank/ agency workers. We saw that there was high use of agency nurses, particularly at night. Agency staff were booked from named agencies as part of the trust's commitment to safety. However, the expectations held by the trust were not those experienced by the staff requesting agency staff. We were told by staff on several wards and departments that the booking system was cumbersome, took an overly long time, and was sometimes not actioned in a timely way, which resulted in the shift not being covered. Furthermore, we found that when an agency nurse arrived on a ward, there was no consistent or robust system to induct them. Most wards reported that agency staff could administer intravenous (IV) medicines, but they had no proof whether those nurses had the skills and competency to do this. One nurse told us, "I found an agency nurse giving [name of medicine] IV as a bolus dose, when it should be diluted further in a bag of fluid." We looked at reported medication errors to ascertain if agency staff were making more medication errors than employed nurses. We found that there were no more reported errors by agency nurses than by the employed ones.
- Although the operating department had 26 vacancies, agency staff were rarely used. The staff there tended to cover the extra shifts as bank.
- A theatre co-ordinator was responsible for the daily management of all theatres. In addition, there was a specialist bed manager ('Theatre Flow/Bed Lead') in post. Part of their role was to find beds for patients who were listed for emergency surgery direct from the emergency department or the surgical admissions unit. They also found beds for patients who had been scheduled for day surgery, and were required to stay overnight because of clinical need.

Surgical staffing

- There were always junior and middle grade doctors on duty for the surgical service. Out of hours there was a consultant on-call. There was always 3 doctors on duty for surgery plus the on call consultant.
- The trust had a higher number of registrars (middle grade doctors) to consultants compared to the England average. This made the on-call arrangements for general consultants more challenging. This current on-call pattern expected consultants to do more on-call than at trusts of a similar size.
- The on-call surgical consultant generally covers a seven day period, handing over at 5pm on a Friday, usually to another consultant surgeon. This is considered potentially unsafe. The trust are aware of this issue and since our inspection have taken action to address rotas in some specialties.
- The potential continuous hours on duty are not compatible with safe practice, and may inhibit appropriate consultant involvement in the emergency activity of the unit.
- The results of one surgical firm being on-call for seven days means that they build up an excessive number of emergency patients in one week, whilst other teams have few patients. To facilitate this, the emergency team borrow junior doctors from other teams, reducing their continuity of training and practice.
- This is a long period of continuous on-call, and the patient numbers to hand over each day over this period was high. With such a large number of patients to review each day, attention to patients admitted as an emergency could have been diverted.
- General surgical consultants conducted ward rounds for all patients (that is both planned and emergency admissions) on both Saturday and Sunday. In addition, there was a consultant-led trauma theatre (orthopaedics) list seven days a week.
- The daily morning surgical handover was well organised, with a printed list of patients, working diagnosis and tests undertaken so far. The appropriate doctors were present.
- At the end of the day, doctors conducted a 'board round' with an anaesthetist, followed by a full handover for junior doctors at 8pm.
- There was a 25% vacancy/sickness rate. Much of the shortfall was filled with locum doctors. Locums were in post at all grades. Some were long term.
- A week after our inspection, we carried out an unannounced visit commencing at 9pm on a Saturday night. There were three doctors on duty for the general surgical wards. On-call consultants were available, should they be required.

Major incident awareness and training

- We saw a business continuity plan, dated May 2014, which outlined the trust's actions and response should there be a loss of essential services, such as utilities.

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

Are surgery services effective?

Good

National clinical audits were completed, such as the fractured neck of femur audit (latest data was from October 2013) and the national bowel cancer audit. Information on patient-reported outcome measures (PROMs) was gathered from patients who had had groin hernia surgery, vascular surgery, or a hip or knee replacement. All audits demonstrated that there was no evidence of increased risk, compared with national data, for patients treated within the hospital.

We saw that the trust had implemented a clear pathway for all patients admitted with a fractured neck of femur. This service was led and delivered by consultants, which meant that an experienced surgeon was operating on all patients who had been admitted with this type of fracture.

Some patients told us that they received good pain relief and were comfortable; however, generally feedback from patients with regard to pain relief was mixed. Staff demonstrated a broad understanding of the Mental Health Act and best interest decisions when patients lacked capacity to consent.

Evidence-based care and treatment

- The trust participated in a number of national audits, including the national neck of femur audit and the national bowel cancer audit. Outcomes from these audits demonstrated that there was no evidence of increased risk, compared with national data, for patients treated within the hospital.
- We saw that guidance was produced for pre-operative assessments in line with best practice, including the National Institute for Health and Care Excellence (NICE) and the Association of Anaesthetists of Great Britain and Ireland guidelines.
- Most elective patients attended the anaesthetic pre-assessment department a few days prior to their expected surgery. However, patients undergoing the orthopaedic, plastic, ophthalmic or gynaecological surgery, attended pre-assessment within those particular departments. This meant that patients received a more tailored pre-admission by staff who knew the speciality well. Patients who had co-existing medical conditions, such as long-term chest conditions, or co-morbidities, such as obesity, underwent a cardio pulmonary exercise test (CPET), to assess their fitness for surgery. If the patient was at risk, they were seen by the pre assessment unit's consultant anaesthetist, who assessed them further.

Pain relief

- There was a dedicated trust-wide pain team available Monday to Friday. An anaesthetist provided this cover out of hours. The pain team were involved in the care of patients who had chronic or acute pain. This team routinely visited all patients who had been prescribed epidurals or patient controlled analgesia (PCA). Nursing staff we spoke with told us that the pain management team was available to review any patients with analgesia (pain medicine) problems, when requested. This meant that patients who required pain relief, or who had complex requirements to control their pain, were seen and reviewed by a specialist team.
- Patients, who were receiving end of life care, were cared for, with regards to their pain control, by the palliative care team, who used a holistic approach to patients at the end of their lives. This included pain management.
- The pre-operative assessment for post-operative pain relief prepared patients to use patient-controlled analgesia. One patient told us that they were offered pain relief regularly. Some patients told us that they were comfortable. However, there were mixed views with regards to whether pain relief was given regularly enough or was effective. One told us, "I was three hours when I was in A&E, I had no pain relief. I kept asking for it." Another said, "I've got a lot of pain, I want them to put me out of it. The nurses say, 'we can only do what we can do'." We immediately escalated this to a clinical nurse specialist (CNS) for pain, who ensured that the patient was reviewed and given appropriate analgesia.
- The pain CNS told us that when they reviewed a patient's pain relief, they did not simply prescribe the appropriate analgesia, but discussed it with the junior doctor, who would prescribe the agreed medication. This was so that the junior doctors became familiar with up-to-date prescribing with regard to effective pain control.

- Patient records showed that pain scores were calculated and pain relief provided appropriately to patients; this included the use of patient controlled analgesia (PCA). Staff we spoke with confirmed that they had received training in PCA.
- The Abbey Pain Assessment Scale was not in place for patients with dementia; however, the Dementia CNS recognised that this was something that needed to be improved.
- The surgical service had access to a ward based epidural service from the trust wide pain relief service.
- There were clinical guidelines and patient pathways for staff to follow when patients were in pain.
- The pain service provided education, training and support for ward staff.
- The trust wide pain service was involved in care and discharge planning and were involved in the MDT meetings within the wards. The trust wide pain service attended ward rounds.

Nutrition and hydration

- The Malnutrition Universal Scoring Tool (MUST) assessments we saw were completed and scored accurately. We saw on Rayne Ward that one patient had been admitted with a low body mass index. They had been referred appropriately to a dietician.
- Dieticians were available Monday to Friday.
- During our inspection we reviewed 12 sets of nursing notes on the surgical wards. Fluid balance charts within most of the wards we visited were mostly complete. We saw that during the night, fluids were not recorded as accurately, which affected overall precision of fluid balance. We asked a band 6 nurse how they ensured that the fluid balance charts were complete, and they told us that they did spot checks. However, the hospital did not audit this formally in order to ensure improvements.
- A 'red tray' system was in place; this flagged to staff those patients who required support and monitoring with eating and drinking. We were told that patients could request drinks throughout the day. Patients told us that they made choices from a menu, and we saw staff asking patients to choose from a menu.
- We found that patients had food and drink within their reach at meal times.
- On Notley Ward, ward areas were split between a trained nurse, a healthcare assistant and a hostess, to ensure nutrition requirements were met.

Patient outcomes

- The trust took part in a number of national audits, including the national fractured neck of femur audit; results were broadly in line with those nationally, and access to surgery was better than that nationally. However, the average length of stay was significantly longer at 8.36 days, against a national average of 3.6 days.
- Results from the National Bowel Cancer Audit, National Emergency Laparotomy, and Lung Cancer audits were broadly in line with those nationally. However, the Bowel Cancer Audit showed that Broomfield Hospital was above the national average with regards to CNS input and reporting of CT scans.
- For patient-reported outcome measures (PROMs) for both hips and knee replacements, Broomfield Hospital was largely in line with England averages.
- The Standardised Relative Risk Readmission data indicated that Broomfield Hospital was significantly worse than expected in elective urology and general surgery. However, on investigation this was found not to be the case. The clinical director for surgery was going to investigate whether this was a data entry or a coding error.
- The National Confidential Enquiry into Patient Outcome and Death (NCEPOD guidance 2003 for non elective surgery in the NHS) standards for unscheduled care require a staffed emergency theatre to be ready on a site where non elective surgery could be required. Broomfield Hospital had an operating theatre fully staffed at night for emergency surgery. Furthermore, another team was available on an on-call basis should this be required. There was a separate on-call team for obstetrics.

Competent staff

- There was a comprehensive induction for new staff. This included both a trust-wide induction and local indication. We spoke with several new members of staff, including a band 5 nurse, a porter and a receptionist, who all said that their induction had been beneficial.
- Staff we spoke with reported that they had regular appraisals where they could discuss their work. All the

staff we spoke with confirmed that they had received an appraisal. We received information from the trust that demonstrated that all surgical wards, apart from Goldhanger Ward, reached the trust target of 80%, and their staff had been appraised. Staff confirmed that they had the opportunity to discuss performance and career aspirations with their line manager. All the staff said that they found the appraisal process useful. However, most told us that once the appraisal was completed, nothing else happened with it, and it was rarely referred to for training purposes.

- Staff were given the opportunity for specialist training. Many of the more senior staff told us that the trust was sponsoring them to do higher degrees.
- Nursing staff, health care support workers, and ward clerks on surgical wards and departments, all received annual appraisals. The document which the trust provided us with recorded 100% of surgical staff as having completed an annual appraisal for the last financial year.
- Some of the junior medical staff were undertaking a rotation programme, and as part of this they had protected study days.
- Senior doctors were appraised as part of General Medical Council Guidelines.

Multidisciplinary working

- During our observations on the ward, we noted that there was an effective system in place to discuss a patient's care and treatment, and that this included consultants, doctors, therapists and nurses, and integrated multidisciplinary ward rounds.
- Each ward had a large wipe clean board, with the patients' names and the team who was caring for them. Some wards added an admission date, expected discharge date, when risk assessments were due, and if tests had been ordered.
- We also saw handovers, many of which involved the multidisciplinary team. Some involved discussion at the patient's bedside, which ensured that patients were involved when their care and treatment were being discussed and handed over to the next shift. On some wards, we saw that additional handovers were carried out at the ward board.
- For those patients who were admitted to the trust for elective surgery, we saw documented evidence of pre-operative information to ensure that patient care and treatment were consistent.
- We found evidence of multidisciplinary working in all areas we inspected. We saw records of patients admitted for surgery that demonstrated multidisciplinary team input.
- There were a large number of CNS's in post, in a range of specialities, who had a positive impact on patient care. Both nursing staff, and patients that we spoke with, appreciated the support and expertise that the CNS's offered.
- We saw that the colorectal team had a positive multidisciplinary approach to patient care. Records demonstrated that the team communicated effectively, and followed up patients in a timely manner. For example, patients who required follow up after bowel cancer were followed up using a remote follow-up process not requiring hospital attendance. Investigations are arranged according to protocol by a clerical worker and the results scrutinised by CNSs, only those with abnormalities referred back for MDT discussion and on-going intervention if necessary. This system frees up 850 outpatient appointments per year for other patients.
- There were physiotherapists and occupational therapists attached to the orthopaedic wards, John Ray and Notley, who joined the ward rounds to discuss issues such as mobilisation and rehabilitation for patients.
- On Goldhanger Ward (ENT) there was a speech and language therapist based there permanently.
- The trust wide pain service was involved in discharge planning and admission avoidance in surgical services.

Seven-day services

- The consultants did not conduct daily rounds for elective patients. These were seen daily, by the junior doctors. Emergency patients were seen daily, including Saturdays and Sundays, by a consultant surgeon.
- Consultants were on-call for all out-of-hours periods.
- Most facilities were available out of hours, this included physiotherapists, radiographers, radiologists and the pharmacy service, who were all available at night and weekends.
- Broomfield Hospital had an operating theatre fully staffed at night for emergency surgery. Furthermore, there was another team available on an on-call basis should this be required. There was a separate on-call team for obstetrics.

Surgery

Access to information

- There were a large number of information leaflets about a number of procedures and what to expect, which was an important part of preparation for surgery. These included risk and benefits of certain procedures, wound care, and types of anaesthetic. Some were obviously professionally printed, whilst others were badly photocopied.
- Most wards had developed leaflets regarding their own specialities. 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.
- We saw that all wards had information boards for patients, with both specific information pertaining to their speciality, and more general information, such as how to avoid a thrombosis.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were able to give their consent when they were mentally and physically able. Consent for elective surgery was taken by senior staff as a single stage on the operative day. Staff acted in accordance with the law when treating an unconscious patient, or in an emergency. Staff we spoke with said they understood and acted in accordance with the Mental Capacity Act 2005. Staff had received training in aspects of the Mental Capacity Act 2005, including provisions for depriving someone of their liberty in their best interests.
- Care and treatment was given to patients who could not give valid informed consent in their best interests. General day-to-day care and treatment decisions, such as giving medications, giving personal care, nutrition and hydration, and performing tests, were made by the clinical teams.
- Medical notes included suitable information about how decisions were reached if a patient did not have the capacity to consent.
- There were dementia and learning disability CNS's in post and champions for these specialities on each ward; however, enthusiasm amongst some of the nursing staff regarding being a champion varied. They told us that they often could not get to link meetings or educate their peers because shortages of staff meant that they could not be released.
- 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 a decision for themselves.

Are surgery services caring?

Requires improvement

The surgery service requires improvements to ensure that all patients receive a service that is caring and compassionate. During our time spent on the surgical wards, we observed both negative and positive interactions and caring behaviours between staff members and patients. Patients had mixed views about the level of care they had received. Each ward had a system of 'intentional rounding', where patients' requirements were checked and care needs delivered. However, these were mostly seen as a 'tick box exercise'. Patients observed that staff were always too busy to stop and chat to them. We saw and overheard sensitive and considerate interactions between staff and their patients. However we also heard from patients that staff could be insensitive at times and that they overheard or witnessed times when other peoples dignity and privacy were not respected. Not all patients were treated with privacy and dignity.

Compassionate care

- Staff practiced and understood the principles of delivering compassionate care to patients. This included supporting patients who were confused or anxious. Staff said that they would talk to a patient and tell them their name, smile, be relaxed, and try and help the patient to relax.
- The Friends and Family Test dated September 2014 showed that 543 patients and relatives responded to the survey, a response rate of 32%. Out of these, an overwhelming majority said they would either recommend or highly recommend the services at Broomfield Hospital.
- The patients had mixed views about their care. They told us, "The best treatment I have ever had. Really lovely people." "The nurses are really busy, but they still manage the care." "[Name of nurse] and [Name of nurse] are lovely, but some of them just give tough love."

"Brilliant care." "Hell of a racket going on at the nurses' station. It's like a night club, lots of dragging chairs." "I asked a nurse if I could see a dentist as I had toothache. She said no."

- All visitors we met said that they had been given time with the nurses and doctors to ask questions, and this had been done in a private room if appropriate.
- We observed care being delivered where patients' privacy and dignity was preserved. Nurses and healthcare assistants were talking to patients and their relatives with kindness and compassion. We observed the curtains being drawn when any patient received personal care. We did observe one interaction on Rayne Ward where a patient with dementia, who was obviously confused, was walking around in a hospital gown that was open at the back. We indicated this to a healthcare assistant, who immediately rectified the situation.
- A patient on Heybridge Ward told us that he had seen a nurse change another patient's colostomy bag. They told us that the curtains were not drawn to maintain the patient's dignity, and the procedure was carried out whilst other patients were eating their lunch.

Understanding and involvement of patients and those close to them

- Most of the patients and relatives that we spoke with told us that they had received suitable explanations, and understood what was happening with their care. One told us, "The doctor told us what was going to happen and the nurse explained again to my wife." Patients told us that they had some information about what was expected to happen next, but others were unsure. Another patient told us, "No one seems to know how to treat these ulcers. I don't know what's happening next."
- Relatives told us that staff had given them the advantages and disadvantages of any proposed treatment options, including the risks and benefits.

Emotional support

- Clinical nurse specialists were available for specialties including breast surgery, colo-rectal surgery, stoma care, orthopaedics and pain. This was to support patients including their emotional needs.
- There was a chaplaincy service, and patients could request to see their own minister, which the nurses or ward clerk would arrange. One told us, "The chaplain comes here. I've been here a fortnight. I would like them to come more often."
- Although there were counselling services available, when we asked several senior nursing staff they were unsure how to access these services.

Are surgery services responsive?

Requires improvement

Surgical services require improvement to ensure a responsive service. The hospital did not meet the national 18-week maximum referral to treatment (RTT) waiting standards for general surgery and trauma and orthopaedics. However, it did meet this target for other types of surgery. The Department of Health monitors the number of elective surgery cancellations; this is an indication of the management, efficiency and quality of care. The trust had a higher than the national average number of patients whose operation was cancelled and not treated within 28 days.

We discussed cancellations with clinical, medical and surgical staff, and were informed that elective surgery was often cancelled on the day due to pressure of beds and staffing.

All patients who were to undergo planned surgery were seen by the nurse-led pre-operative assessment department.

Service planning and delivery to meet the needs of local people

- The breakdown of cancelled operations indicated that the reasons for cancellations included: lack of theatre time; overrun of waiting lists; lack of high dependency unit bed availability; and ward bed spaces unavailable. The highest percentage of cancellations was due to bed availability on wards, and theatre overrunning was next highest.
- We discussed cancellations with clinical, medical and surgical staff, and were informed that elective surgery was often cancelled on the day due to pressure of beds and staffing. We were told that this was a regular occurrence. In the quarter between October and

December 2014 we noted that the hospital had cancelled 180 operations. This caused some breaches in referral to treatment guidelines. We were also informed by a number of ward and theatre staff that cancellation of elective surgery was determined by the increases in emergency surgery, and bed space availability.

- 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 this was 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, in an effort to mitigate cancellations, the operating department employed a senior nurse whose role it was to manage the operating lists, to maximise bed usage and to prevent unnecessary admissions. For example, they would negotiate with the surgeon to alter the order of the list, so that a patient, who was more likely to go home, could be operated on earlier in the list. This prevented unnecessary overnight stays and blocking beds for the next day's admissions. One member of staff said, "They have a feel for the patient's needs. They ask the right questions and find beds."

Access and flow

- We found that theatre sessions mainly started and ended on time.
- Patients requiring treatment for fractured neck of femur were seen by a consultant within 48 hours of admission, as required by best practice pathways and guidance.
- There were plans to move the theatre admissions unit to another newly refurbished area to make a '23 hour' ward.
- The clinical director told us that there were further plans to build a surgical admissions unit, which would relieve pressure on the surgical wards, as patients could be admitted, assessed, and only admitted to the main hospital if they needed an inpatient stay of 72 hours or more.
- We saw an operational policy, dated November 2014, which had been devised to assist managing patient access to correct inpatient services, and ensure that patients were kept safe. To facilitate this, operational meetings were held three times a day, in order to enable both emergency and elective admissions. All wards were 'buddied,' so patients would be admitted to an appropriate environment. For example, some surgical wards, although able to accept medical patients, would not accept those that were medically unstable, as their staff did not have the skills to care for them properly.
- The trust's record for rebooking and treating patients within 28 days, whose operations had been cancelled, was broadly in line with the England average. Between January and March 2014 this applied to seven patients, and between April and June 2014, 14 patients were cancelled and did not undergo surgery within 28 days. The England average for all trusts with regards to referral to treatment times (RTT), seen within 18 weeks, is around 90%. Since November 2013, the trust were performing better than this standard at 92%. All other types of surgery were below the England average.
- Staff told us that there were often delays in patients' being discharged from the hospital. Whilst there were dedicated discharge co-ordinators employed to improve the discharge process, staff told us that delays occurred because patients had to wait for take home medicines, and because there were often disruptions in organising care packages for patients who were being sent home that required assistance from social services.

Meeting people's individual needs

- The trust had specialist nurses for both dementia and learning disabilities, who were able to provide advice and support to ward and department staff, and patients when required. They were supported by champions on each ward. However, staff told us that often the champions were not engaged, or did not have time to support other staff with regard to caring for people with particular needs.
- The areas that the trust served had a very low population that 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 relatives to provide translation for their loved ones, but acknowledged that this was not ideal due to safeguarding concerns.
- We did not see any adjustments to make the surgical wards a dementia-friendly environment. It was not clear that any intentions to improve the environment for these patients had been achieved at ward level.
- We spoke with one patient who had a sensory disability and required someone to sign for them. Due to previous

experiences in the hospital, where a booked interpreter had not turned up, they had asked their own interpreter to come in to provide this service. This had been agreed with the hospital in advance. The patient understood that the interpreter would be permitted to be in recovery, immediately post operatively. However, the interpreter had waited for three hours and was then refused entry. They were eventually allowed in after a complaint was made via another staff member. The patient was told that they could not have the interpreter present in the recovery area as they were of the opposite sex. This meant that a patient with a sensory disability may not have been able to make their needs understood when they were vulnerable.

- The hospital is made up of a variety of buildings, some of them dating back to the 1930s; the most modern building was opened in 2010 and housed almost all the surgical wards. They were bright and spacious. However, because of the buildings were all on different levels, it was confusing that the ground floor in some buildings was on a different level to that in others. Each area was designated by a building number, such as A or B, all having different colour codes, and a floor level. The wards and departments all had names, and numbered location levels. However, the signs were often insignificant and difficult to see clearly. There were no signs in other languages, or for example, to assist those with a sensory disability.

Learning from complaints and concerns

- Informal concerns or complaints were dealt with by staff on duty, and the ward leaders either took responsibility to address these, or were informed about how they had been managed. However, one patient told us, "Staff can't stay long enough to hear a complaint."
- Formal complaints were redirected to the hospital's Patient Advice and Liaison Service who initiated an acknowledgment. The complaint was then passed to the relevant person in the hospital to respond fully.
- On one ward, the consultant and lead nurse dealt with their own complaints, although they were logged by the trust. They told us that it was often more beneficial to phone the patient, have a discussion, and then follow it up with a letter. They told us that by using this method, their department had no unresolved complaints.
- 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. However, they were not disseminated by any other means or by staff meetings, which were too infrequent for information to be given in a timely manner.

Are surgery services well-led?

Requires improvement

We found that the leadership of the surgery service required improvement as whilst most staff said that they felt supported at local level there was little action taken at a more senior level to address the issues of safety, caring or responsiveness that we identified. Some staff felt unable to challenge decisions made by senior staff such as the consultants who were not using the five steps to safer surgery checklists and the admission of medical patients onto surgical wards. The local nursing leadership were well respected because of their clinical skills and knowledge. Most nurses at all levels spoke highly of the chief nurse and the CEO, who had both responded to staff concerns. Furthermore, 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 at ward level and above.

There were good outcomes from national clinical audits; however, most of the junior doctors were not involved in audit.

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.'
- Senior nursing staff could not see beyond recruiting into their vacancies, and the problems this caused with providing good care for the patients. They reported that this was an on-going problem, but were all aware of the trust's recruitment campaign in an effort to mitigate staffing shortfalls.
- One of the surgical clinical leads explained to us that the consultant body was too large to all meet. There were

differing arrangements for separate directorates; therefore there was no, one vision, again, beyond providing the best care and treatment for patients. There was an idea that elective and emergency surgery should be linked. There was a concern that patients who were of high acuity on Heybridge Ward required high dependency facilities, within that specialist area, rather than in the critical care area. However, the clinical director was conscious of the fact that the nursing team needed to be increased and built up before this could happen.

Governance, risk management and quality measurement

- There was limited feedback to nursing and medical staff following incidents reported on the internal IT systems.
- We found limited action on the issues such as cancelled patients, delays in discharge and negative feedback received from patients.
- Some surgeons were not completing the five steps to safer surgery checklists
- Each directorate had its own governance meetings, which were mostly held monthly. Some of these meetings were multidisciplinary, with both clinical and nursing staff. There were separate meetings held with the chief nurse and senior nurses, which included some aspects of clinical governance, such as incident reviews and audit results. We saw the minutes to some of these meetings. However, essential information from these meetings was inconsistently and mostly poorly disseminated downwards to more junior staff.
- The clinical director told us what they were proud of, which included the endoscopy service which was in the final stages of reaching the Joint Advisory Group on Gastrointestinal Endoscopy (JAG).
- There was a very low level of quality improvement review on the wards; no junior doctor or nurse suggested that they had completed an audit of any aspect of medical care, and specifically, there was no audit data from the junior doctors. There was also no audit awareness from the nursing staff, except the Safety Thermometer data.

Leadership of service

- Most staff spoke very highly of both the CEO and the chief nurse.
- Some staff told us about the CEO's 'open door' policy, where staff had free access to speak with him if his door was open. Some had taken advantage of this, and felt that they had been listened to.
- All wards and departments had clear leadership, with substantive leaders in post.
- Nursing staff reported that all the senior nurses, including the chief nurse, did 'Clinical Tuesdays', where they worked on the wards on a Tuesday. The chief nurse would carry out basic nursing tasks, such as washing patients. This hands-on approach was much appreciated by the nursing staff. The more junior staff reported that they rarely saw any of the senior managers.
- The theatre manager responsible for theatres had identified areas for safety improvement, and had a training and development lead, who assisted with making quality and safety improvements, such as implementation and audit of the five steps to safer surgery checklist.
- There was a dedicated template for root cause analysis, which was used when there was a serious incident. However, there was a lack of learning throughout the surgical directorate and the trust with regards to incidents.
- Senior theatre staff told us that they felt supported by the senior theatre team, and were confident that changes would be made to further improve safety within theatres. One of the clinical directors told us that on Mondays and Tuesdays the junior staff operated with the senior staff supervising. This was in an effort to ensure that the junior staff received operating experience.

Culture within the service

- The trust had many members of staff who had worked for the trust for many years. Most said that they were proud to work there, and wanted to do their very best to ensure patients got the best care. Many told us how much they loved their jobs and the people they worked with.
- Some staff told us that they had challenged some surgical consultants regarding the use of the five steps to safer surgery checklist in theatre. However, they expressed concern that consultants would sometimes behave inappropriately when a challenge was made. Staff told us that they felt uncomfortable in being able to pursue their concerns when challenge was

unwelcome and not responded to in a collaborative manner. This was concerning in light of the trust's number of 'never events' with regards to wrong site surgery.

- Prior to our inspection, we had received some concerns raised anonymously by members of staff, some of which were general, others quite specific. We did explore these concerns in some detail during our inspection, using a variety of methods; but found that we could not substantiate them. However, it is unusual to have several such contacts relating to undermining behaviour within a single unit. We noticed when we spoke with some staff that they said to us, "I hope I haven't given the wrong answer."

Public and staff engagement

- There had been some recent trust-wide recreational/ social events, which some staff told us they had enjoyed, particularly meeting people whom they would not usually talk to in their day-to-day work.
- The hospital had a very active and involved patient council. There are twelve members on the council who meet regularly and assist the hospital in improving the experience for patients. For example, they are involved in several committees, including infection control, and they assist in devising and collating patient surveys. One said to us that they each adopted several wards or departments and visited them regularly. They told us, "I bring things to their attention and the hospital makes sure they get done. Sometimes it's a little thing, but little things do make a difference to patients. I know because both I and family members have been patients here."
- The hospital had over 400 volunteer workers. They provided services such as driving people to hospital, and delivering newspapers and other items from the trolley, which was taken to the wards daily. Some also worked at the reception desk, and at strategic points around the hospital, directing patients and visitors. We spoke with one who told us, "Since I retired this has given me a sense of purpose. I know this place like the back of my hand. I like helping people and chatting to them. I hope I can continue for many years."

Innovation, improvement and sustainability

- We saw good evidence of team and multidisciplinary team working in most areas that we inspected. Staff told us that they learned from their colleagues in other disciplines. For example, a porter told us that he was a dementia champion, and although they had received specific training, they had learnt from the nursing staff how to approach people with dementia and how to recognise if they were distressed.
- Quality improvement activity at ward level was low and in many areas, the nursing staff felt too busy to innovate.
- The senior clinical staff contributed to national outcome audits with good contribution rates and outcomes.
- Many of the senior staff we spoke with were being sponsored to do higher degrees. Their dissertations surrounded projects to improve the patient experience or their departments.
- The operating department had seconded a member of staff for three years to consider the patient's pathway through the department, risk assess each step, and develop policies and procedures surrounding this.
- There were a large number of CNS's who worked with both the nursing and medical staff, and were valued by the patients for delivering personalised individual care.

Specialist burns and plastic services

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

Information about the service

The St Andrew's Centre is based within Broomfield Hospital and is home to the trust's specialist burns and plastic surgery service. The Burns and plastic service comprises of one directorate, led by the same senior management team.

The Burns service is a supra-regional burns centre for major paediatric and adult burns in the South East of England. The centre serves a population of approximately 9.8 million, and is part of the London and South East of England Burn Network (LSEBN), an operation delivery network for specialised burns treatment. Burns service provision includes emergency treatment, reconstructive treatment, revision treatment, multidisciplinary pre-surgery assessment, post-operative assessment, hospital and community care, therapy and psychosocial specialist burns care. The burns unit consists of a Burns intensive care unit (ITU), which provides care for adults and children, from six months of age, who require high dependency unit (HDU) care or organ support. Burns ITU includes an admission room, six ITU/HDU beds used flexibly according to patient dependency, and an operating theatre used for both emergencies and semi-elective burns surgery. There are two low-dependency wards, Adult Burns Rehab and the Children's Burns Ward, both with eight beds for patients requiring lower intensity care, including those who have 'stepped down' from Burns ITU. There is also a dedicated burns outpatient department, which has an additional outreach team who provide outpatient clinics to service users throughout the region at multi-locations.

The plastic surgery service serves a population of 3.2 million and provides comprehensive head and neck, hand, burns, skin, abdominal wall, lymphedema, vascular, and cleft lip and palate plastic surgery. This service provision includes emergency treatment, reconstructive and revision treatment, multidisciplinary pre-surgery assessment, post-operative assessment, hospital and outpatient care, therapy and psychosocial care. Within Broomfield Hospital there are three plastic surgery wards: Stock Ward, a 24-bedded ward specialising in breast reconstruction, head and neck, and free-flap surgery; Billericay Ward, a 24-bedded ward specialising in hand and trauma plastics, and Mayflower Ward, which is a day case ward open Monday-Saturday for trauma assessments and pre-surgical elective admissions. The St Andrew's Centre also houses a plastics outpatient department in the hospital, which includes a minor operation service, at times providing skin graft services; and there is another day case location at Braintree Community Hospital, which provides day surgery and outpatient clinics. Outpatient services are also delivered regularly at other NHS trusts in Colchester, Southend, Harlow, Basildon, Romford and East London.

During our inspection we visited the three plastic surgery wards, the plastics outpatient department and all the burns service areas within Broomfield Hospital. We spoke with 20 people who used the service, and 56 members of staff, including service leads, managers, nurses, anaesthetists, doctors, domestics, support workers, physiotherapists and occupational therapists, domestics, healthcare assistants and play specialists. We also reviewed people's care records.

Specialist burns and plastic services

Summary of findings

We found that there was a very different service provided to the plastic surgery patients and the burns patients. The burns patients received an exceptionally good service whilst the plastic surgery patients received a service which was concerning in terms of safety and responsiveness. We have reported them as a single service as this is how the trust identifies them however where necessary we have separated our findings for the individual services. The burns service was safe. There were a sufficient amount of qualified nurses and doctors on duty at all times. Whilst we found that the service was not compliant with national staffing standards for paediatric services, in terms of not employing a burns paediatric consultant or burns paediatric anaesthetist, and not having paediatric-trained nurses on duty at all times in Burns ITU, we observed that the trust was actively implementing suitable practices and strategies to mitigate these risks, and we were assured that the service provision provided to children was therefore safe. Bank and agency use was high across all areas within the burns unit, although figures did demonstrate a declining trend.

However in the plastic surgery service whilst there were systems in place to assess and monitor safety in real-time, we found that the service did not respond appropriately to risk levels in the service or for individuals. There was an unacceptable level of thematic serious incidents and 'never events', whereby the service was slow to react and failed to implement necessary changes in a timely way. Staff across all disciplines in plastic surgery told us that the trauma service provision was unsafe. One doctor told us that the service was, "Medically potentially dangerous" and a nurse said that the trauma service was, "Dreadful and unsafe". Action plans were in place to improve this service; however, action required had not taken place as planned. We were concerned that senior hospital managers had not acted appropriately or in a timely way to address these serious on-going issues.

There were also significant gaps in the checking history of emergency equipment within the plastic surgery service. We observed non-compliance with national standards in terms of infection control, and some environments were not fit-for purpose, as they did not contain sufficient room for dealing with emergencies. Compliance with mandatory training required improvement. There were also substantial nurse and junior doctor shortages in some areas, with high use of agency and bank nursing staff. Staff sickness was also higher than expected. Significant changes had been made to the plastic surgery service provision without due regard to the impact on people's safety and staff's wellbeing. We found that nursing staff on the ward did not always have the time to complete patient's risk assessments and care plans accurately or fully. This meant that vital risk assessments, including pre-operative assessments in some areas, were not being undertaken safely, nor in line with evidence-based care and treatment. We observed instances where this put patients at risk of harm. We did however, see examples of outstanding practice with regard to patient pathways for breast reconstruction and hand therapy.

In the burns service there was a truly holistic and patient-centred approach to assessing, planning and delivering care and treatment to people who used the service. There was evidence of innovative and pioneering approaches to care delivery, and outcomes for people using the service were outstanding, and had been reflected in national research papers. Staff were encouraged to develop their competencies and knowledge within the field, and this was recognised as being integral to ensuring high quality care. Care and treatment was delivered in line with current legislation, standards, and national or internationally recognised evidence-based guidance, and the service had developed numerous local guidelines and protocols which supported staff to deliver first-class treatment.

The plastic surgery service was not so effective. We found that the monitoring of some patient's outcomes of care and treatment required improvement; we found that mortality and morbidity meetings were not occurring, and return to theatre and length of stay rates were not monitored. There was, however, evidence of robust local auditing, which monitored success rates of breast reconstruction and free-flap surgery. Development and training opportunities for all permanent staff across disciplines were impressive, with the exception of nurses in the plastics outpatient department, who supported minor operations without

Specialist burns and plastic services

having undertaken scrub nurse training or competency-based assessments. Also, due to the high use of agency and bank nursing staff, we were concerned that not all staff were competent to deliver plastic surgery care. Pain management and fluid hydration was also not adequate in some areas, particularly for patients waiting for long periods of time on the trauma theatre list.

Feedback from people who used the burns service, and those close to them, was consistently positive about the way staff treated people. People told us that staff, "Go above and beyond their duty". We observed that people were treated with dignity, respect and kindness during all interactions with staff. The trust involved people who used the service and those close to them as 'partners' in care and treatment. The emotional support available to people using the service and their loved ones was truly outstanding. In the plastic surgery service the recent Friends and Family Test (FFT) results from Billericay and Stock Ward were in line with the trusts average score.

In the plastics outpatient department staff did not always see people's dignity as a priority; we saw that staff were frequently knocking and immediately entering consultation rooms before receiving a reply, interrupting consultations which were sometimes regarding sensitive matters. In some clinics, patients had their consultations in the same room as other patients; whilst there was a subtle notice on the door notifying patients that they could request to be seen alone, we were not assured that patients would always feel comfortable to make this request.

People could access the burns service in a seamless and timely way. People's individual needs and preferences were central to the planning and delivery of tailored services. There were innovative approaches to provide integrated person-centred pathways of care, which involved other service providers. Bed occupancy figures were good, and there was a proactive approach to understanding the needs of different groups of people, and to deliver care in a way that meets these needs and promotes equality.

However in the plastic surgery service there was minimal effort made to plan and deliver services based upon needs analysis. People were frequently and consistently not able to access the emergency plastics service in a timely way for an initial assessment, diagnosis or treatment, and people experienced unacceptable waits for this service. Bed occupancy rates were consistently high across all wards. However, formal complaints were minimal, and where complaints were received, they were handled appropriately and led to some improvements in care.

The burns service had a clear vision and credible strategy to deliver high-quality care which promoted good outcomes for burns patients. The governance arrangements ensured that staff were clear about their responsibilities, and quality and performance were regularly considered. This ensured that staff identified, understood and managed risk effectively. Staff were inspiring and strived to deliver and motivate each other to ensure that clinical excellence flourished. The service frequently took the lead nationally, to learn continually and improve, to support safe innovation, and to ensure the future sustainability and quality of burns care across the world.

In the plastic surgery service, whilst we found outstanding examples of leadership across all ward levels, we found other areas, particularly at senior manager level, that required improvement. This was because the plastics service strategy was not underpinned by detailed, realistic objectives and plans, and because care was not always safe, effective and responsive. Also, the arrangements for governance and performance management at senior management level did not always operate effectively, and risks and issues raised by ward staff were not always dealt with appropriately, or in a timely way. Leaders at local level did have the necessary experience, knowledge and capability to lead effectively; however, they were not supported to do so due to financial and service restraints. Staff satisfaction was mixed; in some areas staff, "Loved their job", but in other areas staff felt, "Demoralised" and, "Exhausted". We saw numerous examples of outstanding practice throughout the service which demonstrated innovation and development in plastic surgery nationally.

Specialist burns and plastic services

Are specialist burns and plastic services safe?

Inadequate

The plastics and burns service was inadequate in terms of ensuring the safety of all patients using the service. In the plastic surgery service there was an unacceptable level of thematic serious incidents and 'never events', whereby the service was slow to react and implement necessary changes and in a timely way. There was little evidence of learning from incidents, because appropriate action had not been taken following multiple incidences of patient falls and pressure ulcers. We found evidence that incidents were not always being reported by the plastic surgery service.

A suitable amount of equipment was readily available which was well maintained. In the past twelve months the burns service had reported two MRSA colonisation incidents, two E. coli bacteraemia and three MSSA bacteraemia incidents. We observed that all areas within the burns unit were visibly clean and well organised, there were robust cleaning schedules in place and all staff practiced good infection control principles. The burns service learned when things went wrong and improved safety standards as a result. There were reliable systems, processes and practices in place to keep people who used the service safe.

Staff across all disciplines told us that the plastics trauma service was unsafe. One doctor told us that the service was, "Medically potentially dangerous" and a nurse said that the trauma service was, "Dreadful and unsafe". Whilst we found that there was an action plan in place to improve the flow of the trauma service, staff told us that this had, "Been talked about for ages but no changes ever happened". We were concerned that senior hospital managers allowed such operating procedures to be unchanged for such a long period.

There were significant gaps in the checking history of emergency equipment within the plastic surgery service. We observed consistent non-compliance with national standards in terms of infection control, and some environments were not fit-for purpose, and posed risk to service users because they did not contain sufficient room for dealing with emergencies.

There were a sufficient amount of qualified nurses and doctors on duty at all times within the burns service. However, the service did not employ a paediatric consultant or paediatric anaesthetist, which meant that the service was not compliant with relevant national paediatric staffing standards. Also, whilst Burns ITU employed two registered nurses who had obtained paediatric intensive care qualifications, staff told us that on occasions there was not always a paediatric nurse on duty when a child was admitted to Burns ITU. This was also not in line with national standards for paediatric services. However, we found that the trust was actively implementing practice and strategies to mitigate these risks in relation to staffing. We were therefore assured that the service provision provided to children was safe. Bank and agency use was high across all areas within the burns unit, although figures did demonstrate a declining trend. However within the plastic surgery service there were substantial nurse and junior doctor shortages in some areas, with high use of agency and bank nursing staff, and staff sickness was higher than expected. Significant changes had been made to the plastic surgery service provision without due regard to the impact of this on people's safety and staff's wellbeing.

Records confirmed that mandatory training was generally good throughout the service, with the exception of only 71% of doctors having completed children's safeguarding training. However, this issue had been highlighted at the recent Burns and Plastics governance meeting, and action was being taken to improve compliance. The service had a 'Burns Unit Major Incident Plan' in place; however, this policy was last reviewed in April 2013, and did not have a review date on. This meant that we were not assured that it had recently been tested.

Incidents

The burns service:

- The burns service had not reported any 'never events' in the past 18 months. 'Never events' are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- The trust had an electronic incident reporting system in place. Staff said that they could access the hospital's

incident reporting system, and understood their responsibilities in regard to this. Staff were able to describe to us what constituted an incident and when they would raise one.

- In the past 18 months the burns service had reported three serious incidents, two relating to pressure ulcers acquired, and one due to a child-related safeguarding incident. We found that thorough investigations had been undertaken following reported incidents, including a root cause analysis, and lessons learnt had been recognised and implemented where applicable. For example, subsequent to a patient developing a pressure ulcer within the service, we found that a tissue viability study session and pressure ulcer competencies had been introduced for all nursing and support staff, aiming to prevent a similar occurrence.
- Mortality and Morbidity meetings were held monthly in the burns department and were minuted.

The plastic surgery service:

- The plastics service had reported four 'never events' in the past 18 months. 'Never events' are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. The four 'never events' were all regarding wrong site of surgery, in particular regarding skin surgery and lesions. Since the fourth incident, the service had introduced new measures to reduce the chance of this incident being repeated. This included mirror checks, whereby the patient and the consultant used a mirror and the patient pointed to the particular lesion or area for surgery and consented; skin marking with a medical pen; medical photography where appropriate; and a strict rule whereby if there are 'no notes' then 'no surgery'. We found that this practice had been implemented alongside the WHO Surgical Checklist in the minor operations department. However, after the first and second 'never event', recommendations from the root cause analysis, such as these, were not implemented. This meant that the service did not take appropriate action which may have prevented reoccurrence. Some registered nurses we spoke with across the service did not know what a 'never event' was.
- The trust had an electronic incident reporting system in place. Staff said that they could access the hospital's incident reporting system and understood their responsibilities in regard to this; however, agency staff could not. We were concerned that some staff were not able to tell us in detail what constituted an incident and when they would raise one. We observed two people's care records on Billericay Ward, and found that one patient had a grade two pressure ulcer, and another record confirmed that a medication record error had occurred; in neither case had an incident form been raised. We bought this to the sister's attention and they took appropriate action immediately.
- In the past 18 months the service had reported 12 serious incidents. We found that multiple thematic incidents were occurring within the plastics service, such as falls and pressure ulcers. For example, there had been five serious incidents raised regarding patient falls between July 2014 and November 2014. Staff told us that they had not received tissue viability training, not undertaken pressure area competencies, or had falls prevention training. We were therefore not assured that staff were supported to learn from serious incidents. We did, however, note that on Billericay Ward there were regular falls assessment audits and that these had been implemented as a result of the serious incidents raised.
- We asked to see mortality and morbidity meetings for the plastics service; however, the trust did not provide us with these. Whilst staff confirmed that these meetings occurred for the burns part of the directorate, and that they were minuted, we found that there were no mortality and morbidity meetings within the plastics service. We were therefore not assured that the plastics service was reviewing its mortality and morbidity rates appropriately. Our concern about this was heightened given that there had been two recent unexpected deaths on the plastics wards.

Safety thermometer

- The trust used the NHS Safety Thermometer to determine safe care within each ward area.
- NHS Safety Thermometer results were not visible to patients and visitors

The burns service:

- Results we examined demonstrated safe practice and continual improvement. For example, on the Children's Burns Ward, the Safety Thermometer results demonstrated that 'harm free' care was 100% since March 2014, and on the Adult Burns Ward results had improved dramatically, when January 2014 (33%), and

June and August 2014 (100%) data was compared. However, we found that there were two months of Safety Thermometer data missing from the Burns ITU annual results.

The plastic surgery service:

- We examined the results for each ward for the past 12 months. Generally, the results were very good, although some month's data was missing. During September 2014, Mayflower Ward and Stock Ward demonstrated 100% harm free care, and Billericay Ward 86.21%, due to pressure ulcers acquired.

Cleanliness, infection control and hygiene

The burns service:

- We examined hospital-acquired infection data from October 2013 and November 2014 across the burns service. There had been two incidences of MRSA colonisation reported, which occurred within the Adult Burns Rehab Unit. However, there were no incidences of MRSA bacteraemia.
- There had been three incidences of MSSA bacteraemia reported, one within Burns ITU, and two on the Children's Burns Ward, and two cases of E. coli bacteraemia also on Burns ITU.
- Each area conducted hand hygiene audits regularly, and demonstrated good hand hygiene practice. On Burns ITU, compliance with hand hygiene had been 100% for the past three months.
- We saw that cleaning schedules were robust, and cleaning staff told us that they underwent additional training to enable them to clean in various burns areas due to those areas posing a high risk of infection. Staff were compliant with the trust's infection control polices and protocols. Staff practiced good hand hygiene, used personal protective equipment appropriately, and wore their uniforms above their elbows.
- Whilst we observed the national 'I am Clean' green stickers on some equipment, which alerted staff as to what equipment was clean and what was not, this was not practiced consistently throughout the service.

The plastic surgery service:

- During October 2013 and November 2014, the plastics service had reported no incidents of MRSA or MSSA bacteraemia; there was one reported case of C.difficile on Stock Ward; with three cases of MRSA colonisation on Billericay Ward and one on Stock Ward.
- MRSA screening for both elective and emergency patients was low across all wards. On Billericay Ward compliance with screening for elective surgery patients was significantly low for the past three months: August 2014 (66%); September 2014 (53%) and October 2014 (67%). On Mayflower Ward results were equally poor for emergency patients: August 2014 (74%); September 2014 (63%) and October 2014 (60%). This meant that the service was not following the trust's infection prevention policies and procedures, and at times it was not screening almost half of the patients admitted for surgery.
- We were concerned that staff were not following trust policy and national standards in relation to infection control. On Mayflower Ward we observed dirty linen on the top of bins on three occasions, a nurse pushing a dirty dressing trolley around the ward and into the clean medicines room wearing dirty gloves and an apron, and a patient's dirty blood-stained wound dressings left on their bedside table.
- On the plastics outpatient department, in the dressing's clinic, we found that patients were encouraged to wash their open wounds in hand-washing basins in the bay. There were no dedicated and separate sinks for wound and hand washing. This increased the risk of cross-contamination in a high risk of infection area, due to multiple open wounds and dressing changes.
- Throughout the service we observed that staff were not decontaminating their hands prior to care delivery, and we saw several staff walking around wards with dirty aprons and gloves on.
- We did not see the 'I am Clean' green stickers used consistently for equipment. These stickers were used elsewhere in the trust, and alerted staff as to what equipment was clean and what was not. This meant that staff could not clearly identify what equipment was ready for use.
- We asked to see surgical site infection rates for the plastics service; however, we were not provided with these.

Environment and equipment

- Each area we visited was bright, clear of clutter and well organised. There were adequate storage facilities and suitable levels of equipment for safe monitoring and effective treatment.

The burns service:

- Resuscitation equipment was in line with national guidance and had been checked regularly.
- Records confirmed that equipment had been serviced recently, and equipment checked appeared visibly clean.

The plastic surgery service:

- On every ward we identified gaps in the checking history of resuscitation equipment. For example, on Stock Ward we found significant gaps during the month of November 2014, and according to ward records for the past two weeks alone, the equipment had not been checked on 17, 18, 22, 23, 24, 25 and 26 November 2014. We bought this to the attention of the nurse in charge, who confirmed our findings.
- Throughout the service we found that substances that were considered 'Control of substances hazardous to health' (COSHH) substances were not stored in a safe place, and therefore not in line with legal requirements. We bought this to the attention of the matron for the area.
- There was not a dedicated plastics outpatient department for children. This meant that children waited and were seen in the same place as adults, and that the service was not meeting national standards for children and young people. This was however highlighted on the service's risk register.
- On Mayflower Ward we were concerned to see that assessment rooms with desks and minimal space were being used to nurse patients before and after surgery. In the event of an emergency, in those environments, staff would struggle to manoeuvre and get equipment into the room. Therefore the environment was not fit for purpose or safe. Staff told us that this practice was due to bed capacity issues within the ward, and several staff members confirmed that this was common practice.
- In the plastics outpatient department staff told us that the environment was, "Not fit for purpose", and that there was a, "Considerable lack of space". Staff also told us that the environment, in terms of space, had not changed since 1998, and that it was not sufficient given the significant increase in service demand since then. There were up to 56 clinics held in the department each day. We observed that the waiting room was crowded, and that the environment was immensely busy. Whilst staff told us that there were, "Talks about changing and improving the department", they also told us that this had, "Been on the cards for years and nothing had happened".
- We also observed that the minor operations theatre in the plastics outpatient department was dated, cramped and untidy.

Medicines

- Records confirmed that controlled drugs, such as Morphine, were checked daily. Medications for resuscitation were also checked daily with the emergency equipment.
- Medicines were stored securely throughout the directorate. For example, on the Children's Burns Ward medicines were stored in a locked cupboard behind a secure door whereby only staff had access via an electronic card system. We checked fridge temperatures and were assured that they were being monitored appropriately, and that medicine was being stored safely.
- We observed that medicines were prescribed and administered safely. On one occasion in the plastic surgery service, we found that where medicine had been omitted, the reason for this was not always recorded in the patient's care records. In the minor operations area of the plastics outpatient department, we were concerned that people undergoing surgery did not have a name or allergy band in place. This meant that medicines were not given in line with the trust's medicines management policy, and this was unsafe practice.

Records

The burns service:

- On the ward areas, paper patient records were in use and we found that these were stored securely. Staff on Burns ITU used an electronic patient record system called 'MetaVision', which was password protected.
- Risk assessments were completed in care records. We saw that assessment records were completed appropriately and provided prompts for staff to follow local protocols and evidence-based care. On the Adult Burns Rehab Ward an 'Adult Ward In-Patient Care Record' was used for each patient. This was a thorough

booklet consisting of numerous holistic patient assessments and applicable care plans, as required. Staff told us that they liked these booklets, and always had time to complete them appropriately.

The plastic surgery service:

- Patient records on ward areas were not stored securely, because they were in and around trolleys with open lids and next to patient bays. In the plastics outpatient department we observed patient notes and clinical lists with personal data on, left in corridors which were easily assessable to visitors. On Mayflower Ward we saw three computers in the assessment rooms which were not locked, and we were able to access multi-patient confidential data, which included medical history and contact details. At the time of our inspection, these rooms were also being used for patients. We bought this to the ward manager's attention.

Safeguarding

- There were up-to-date safeguarding policies and procedures in place which incorporated relevant guidance and legislation. Staff told us that they could access these via the intranet, and they were knowledgeable as to what constituted a safeguarding concern and how to raise matters appropriately.
- The burns service had a dedicated safeguarding nurse, who worked three days a week, and out of these hours staff had access to the trust safeguarding team. One staff member told us that the safeguarding support was, "Excellent here".
- Care records had sections for safeguarding assessments, which were supposed to be completed during admission. However, in the plastic surgery service we found that these were not used consistently, and at times, were not completed accurately.
- Safeguarding assessments were undertaken on every admission throughout the burns service. Staff were knowledgeable about their role in safeguarding, and nursing staff confirmed that they had received safeguarding training in the past year. Training records showed that 95.7% of nursing and support staff had completed both adults and children's safeguarding training recently. However, only 71% of doctors had completed children's safeguarding. This issue had been highlighted at the recent Burns and Plastics governance meeting, and was being addressed.
- There was regular safeguarding supervision for registered nurses in the burns unit.

Mandatory training

- Staff told us that they were compliant with mandatory training across the service. Records confirmed that 92 % of nursing and support staff were compliant across the burns service. In the plastic surgery service on Billericay Ward compliance was good (90.7%); however on Stock Ward (81.7%) and Mayflower Ward (86.1%) compliance required improvement.

Assessing and responding to patient risk

- Throughout the service a national early warning tool called NEWS (national early warning score) was in place for patients. For areas that provided paediatric care, 'children's early warning tools' (CEWT) had been implemented. When completed, early warning tools generate a score through the combination of a selection of routine patient observations, such as heart rate. These tools were developed and introduced nationally to standardise the assessment of illness severity and determine the need for escalation.
- We observed care across the service and reviewed documentation. We found that patients' health needs were well managed, and documentation was designed to guide staff in the assessment of patients' needs and the planning of discharge.
- We looked at completed charts. There were clear directions for escalation printed on the reverse of these observation charts, and staff spoken with were aware of the appropriate action to be taken if patients scored higher than expected.
- On the Adult Burns Rehab Ward we observed that patients' NEWS (scores) were recorded on the patient boards behind the nursing desk; this was so that the nurse in charge was constantly aware and had an overview of patients' wellbeing. This practice had been implemented subsequent to a serious incident in a different directorate relating to the recognition of deteriorating patients. This meant that the service had learnt and changed practice in response to trust-wide incidents, and was proactively working to improve recognition of the deteriorating patient.
- There was a trust-wide trigger and response team (TART), who attended the ward when alerted by staff about high NEWS (scores). Staff told us that they knew how to contact the team when required.

- The 'WHO Surgical Checklist, Five Steps to Safer Surgery' was in place and used in the plastics outpatient department for minor operations. We checked and found that this tool was being used.

Nursing staffing

- The 'Safer Nursing Care Tool' had recently been used to determine safe staffing levels in each area. In some areas we found that the actual amount of nurses correlated with the establishment needed, and in other areas nursing positions were not filled. Staffing numbers, both actual and established, were written on boards in every area, and were in public view.

The burns service:

- During our visit we observed that there were a sufficient number of trained nursing and support staff on duty to ensure safe and effective care across the service. Staff told us that they had enough staff to provide excellent care.
- Two adult nurses on Burns ITU were trained in paediatric intensive care; all nursing staff had undertaken paediatric basic and advanced life support, and most had experience in caring for children on the unit. Staff we spoke with told us that when a child is admitted to Burns ITU, the service tries their utmost to provide a paediatric nurse to care for that child; however, they also acknowledged that this is not always possible. This meant that the service was not always meeting national paediatric ITU standards, which stipulate that "nurses working with children and young people should be trained in children's nursing with additional training for specialist services or roles" (The Royal College of Nursing; Defining staffing levels for children and young people's services, 2013). However, the trust was aiming to mitigate this risk through the recent introduction of a paediatric nurse rotation programme, whereby paediatric nurses from the Children's Burn Ward took turns to work on Burns ITU.
- Staffing records we examined demonstrated that there was a good skill mix of staff on duty at all times. There was always a senior staff nurse on duty.
- Different areas had varying methods of handover; for example, on the Adult Burns Rehab Ward a handover tool and shift checklist had been implemented to support effective communication between staff. Staff here told us that their handover process was robust and effective.
- The Children's Burns Ward was staffed by paediatric nurses, who were given opportunities to gain further training, such as in 'Emergency Management of Severe Burns', and these staff rotated and worked in Burns ITU frequently. During our inspection we were told that two paediatric nurses from the Children's Burns Ward were on maternity leave and that two Burns ITU nurses, who wanted to gain further paediatric experience, were covering their leave. However, at all times there was a paediatric nurse present.
- Nursing staff sickness was low throughout the service. In September 2014 staff sickness was below the England average (4.26%) on the Adult Burns Ward (1.1%), the Children's Burns Ward (1.3%) and Burns ITU (3.3%).
- Bank and agency use was high across all areas within the burns service, although figures did demonstrate a declining trend. For example, on the Adult Burns Rehab Ward, in August 2014, bank and agency use was 15.5%, and by October 2014 this had reduced to 12.8%. The high rate of bank and agency use was on the directorates risk register, which stated that the service was awaiting approval to recruit more staff. Senior nursing staff told us that where possible, they used internal bank agency, or their own staff did overtime. They also confirmed that when new bank and agency staff came to the service they had a brief induction when they commenced their shift, which covered the ward layout, emergency procedures, and information to assist them with patients' care. Staff told us that this was an effective system for the short term until recruitment plans were implemented. We saw records to confirm this.

The plastic surgery service:

- On Billericay Ward, we found that the Safer Nursing Care Tool had been conducted in the past four months and that the established figures determined by the process were now being recruited to. The senior nurse on Billericay Ward told us that the acuity measurement was due to be conducted again shortly.
- However, staff on Mayflower Ward and in the plastics outpatients department told us that they did not have enough staff. On Mayflower Ward we observed that staff were frantically busy; staff told us, "We are run off our feet" and, "At times it is hard to cope, and some staff are demoralised". The Safer Nursing Care Tool had recently demonstrated that nursing levels (Whole Time Equivalent) needed to increase from 13.94 to 16.28 on

Mayflower Ward. However, staff told us that nursing numbers had not improved to reflect the establishment needed; furthermore we were told that, "Things are busier now than ever before and we are due for another audit [Safer Nursing Tool audit]". We were therefore not assured that current acuity measurements reflected ward activity.

- Mayflower Ward struggled to meet its current establishment of nursing numbers without taking new acuity into account. Records confirmed that on Mayflower Ward, between 8 September and 5 October 2014, there were three registered nurse shifts and 16 healthcare assistant shifts unfilled.
- We observed that low staffing levels on Mayflower Ward had had a direct impact on patient safety. For example, staff told us that they could not complete patient assessments in a timely way. One nurse said, "I have two patients in theatre and I still have not completed their admission paperwork or nursing assessments because I do not have time". We also observed that a member of theatre staff came to the ward to complain, as pre-operative assessments had not been completed accurately by ward staff for a patient who had just been taken to theatre. This included a lack of allergies written down and wrong information regarding loose dentures recorded. That morning we also noted that there were a few occasions where theatre staff had come to the ward to collect a patient for theatre, yet the patient had not had their admission or pre-surgery ward checks completed.
- In the plastics outpatient department we were also concerned about nurse staffing levels. Staff told us that the nurse-led dressing clinic was, "Heaving" and, "Ridiculously busy". Nurses often had to complete up to 60 dressing changes per day, and several members of staff told us that this led to a frequent, "Two hour delay" for patients to be seen. Staff confirmed that at times, this meant that care was disjointed because the service usually booked dressing clinic appointments with the nurses, and hand therapy appointments with the therapists, back to back. However, because of the frequent and long delays to be seen in the dressing clinic, therapists told us that they often have to do patient's dressing changes in the hand therapy clinic. This was not safe because the therapists are not trained to complete dressing changes, and this practice was also not being completed in a suitable area in terms of infection control.
- Handover of patients between nursing staff was well-structured, and staff communicated effectively with one another. On the wards, the nurse in charge of each area demonstrated that they knew why all the patients on the ward were admitted and what their individual needs were.
- On some wards, we found that staff skill mix was good during day shifts. For example, on Billericay Ward, between 3 November and 30 November 2014, there was always a senior or very experienced nurse on duty and in charge. However, at night here, and on other wards during the day, records demonstrated that junior nurses and sometimes bank and agency staff were left in charge of entire wards. Staff we spoke with confirmed that this occurred at times. This was not safe practice.
- On Stock Ward, gaps in senior nursing posts had been recently recruited to. Stock Ward had recently employed four new senior nurses (sisters), who were current employees who had been promoted. This meant that some areas had acted to improve skill mix.
- Agency and bank use was exceptionally high across all ward areas. Billericay Ward used the highest amount of agency and bank staff, followed by Mayflower Ward and then Stock Ward. On Mayflower Ward there were approximately 10.5 Whole Time Equivalent agency/bank staff used during August, September and October 2014. Every month this equated to approximately half of the wards monthly expenditure. Staff told us that the high rate of bank and agency staff usage was a concern. One member of staff told us that this concern was due to the lack of agency/bank familiarity to the plastics speciality. Another member of staff told us that high and unfamiliar use of agency and bank staff has, "A negative effect on teamwork and morale".
- Ward managers did, however, tell us that they made every effort to block-book bank and agency staff to ensure continuity where possible, and that bank staff were often nurses who had worked for the St Andrew's centre before.

Medical staffing

The burns service:

- Specialist burns consultants were available 24 hours a day, seven days a week.
- Anaesthetists employed had a special interest in paediatrics, although they were not paediatric anaesthetists.

- There was not a dedicated paediatrician for burns, however the team of paediatricians at the hospital support the burns team. This was not compliant with relevant national standards. However, this risk was on the directorates risk register and plans had already been implemented to mitigate such risk. Contracts had been formalised between the trust and two paediatric intensivists (paediatric intensive care unit, or PICU, staff) from Great Ormond Street Hospital, whereby the PICU staff attended the St Andrew's service twice a week, and supported paediatric ward rounds. Staff told us that these PICUs also provided daily support via video link with the St Andrew's multidisciplinary burns team, whereby all paediatric cases were discussed. This service was available 24 hours a day, seven days a week as required. There was also a provisional pathway in place for severely burned children to be transferred to compliant paediatric burns centres in England, such as in Birmingham, Manchester, Liverpool and Bristol. There was an on-going audit occurring between St Andrew's and LSEBN to thoroughly define the threshold for transfer. There was a close working partnership with the paediatric burns centre at the Children's Hospital in Birmingham, whereby the Birmingham trust shared their paediatric pathways and protocols with St Andrew's, which supported the development of the St Andrew's paediatric burns service provision.
- We observed handover of patients between doctors. Handover between burns medical staff was well-structured and well-attended. Staff told us that handover times provided an opportunity for staff to discuss clinical decision-making and this was a "great form of support".
- Locum doctors had not been used within the burns service provision for the past three months and staff told us that prior to this it was very rare for locums to be used.
- Records confirmed that a burns anaesthetist was available 24 hours a day, seven days per week.

The plastics service:

- Doctors told us that junior doctor cover was adequate during the week. However, they raised concerns that there was only one junior doctor on duty at night for the burns and plastics directorate. One doctor told us that, "Out of hours cover by the SHO is limited as there is only one SHO looking after emergency admissions and the wards". Several staff confirmed that one SHO (senior house officer) out of hours was not sufficient given the ever increasing volume of activity within the plastics service. We noted that this concern was on the directorate risk register, which also confirmed that there was a, "Further risk identified due to future reduction of trainees".
- Records confirmed that there was always a registrar on duty 24 hours a day, seven days a week, and several staff confirmed that middle-grade cover was good.
- We observed the handover of trauma patients between plastic's doctors. Handover was well-structured and well-attended.
- Within the burns and plastics directorate 22 consultants were employed. There was a consultant on-call 24 hours a day, seven days a week.

Major incident awareness and training

- The service had a 'Burns Unit Major Incident Plan; in place, which staff were aware of. This detailed a clear operational protocol in the event of a major incident. The provider may like to note that this policy was last reviewed in April 2013 and did not carry a review date. This meant that we were not assured that it had recently been tested.
- This major incident plan was used in conjunction with the trust's 'Major Incident Plan' and 'Critical Care Surge Plan', all of which were available for all staff to access via the trust's intranet.
- The service also fed into the London and South East of England Burn Network (LSEBN), whose purpose it is "to provide a framework to ensure there is a co-ordinated approach to burn care in London and the South East, and that patients have access to the best possible services". St Andrew's had regular contact with LSEBN, and were alerted promptly if there was a major burns incident requiring an admission.
- The plastics service followed the trusts 'Major Incident Plan' and this was available through the trust's intranet. Senior staff told us that they were aware of this document and could access it if required.

Specialist burns and plastic services

Are specialist burns and plastic services effective?

Requires improvement

There was a truly holistic and patient-centred approach to assessing, planning and delivering care and treatment to people who used the burns service. There was evidence of innovative and pioneering approaches to care delivery and outcomes for people using the service, which had been reflected in national research papers. Staff were incredibly proud of these outcomes. Staff were actively engaged in activities to monitor and improve quality of care and outcomes. The service participated in local and national audit, including peer review, and research was proactively pursued. Staff were encouraged to develop their competencies and knowledge within the field, and this was recognised as being integral to ensuring high quality care.

The burns service staff were committed to working collaboratively, and demonstrated innovative and efficient ways to deliver seamless and continuous care to people who used the service. We observed exceptional multidisciplinary team working within and throughout the service provision, as well as with external organisations. There were systems in place to ensure that care and treatment were delivered in line with current legislation, standards, and national or internationally recognised evidence-based guidance. The service had developed numerous local guidelines and protocols which supported staff to deliver first-class treatment.

However the plastics service was inadequate in terms of effectiveness. Whilst there were policies and care records in place, containing holistic risk assessments and care plans for each patient, which reflected current evidence-based guidance, standards and practice, we found that nursing staff on the ward did not always have the time to complete these accurately or fully. This meant that vital risk assessments, including pre-operative assessments in some areas, were not being undertaken safely, nor in line with evidence-based care and treatment. We observed incidences where this put patients at risk of harm. We did, however, see examples of outstanding practice with regard to patient pathways for breast reconstruction and hand therapy.

Within the plastic surgery service the monitoring of some patient's outcomes of care and treatment required improvement, as we found that plastics mortality and morbidity meetings were not occurring, and return to theatre and length of stay rates were not monitored. There was, however, evidence of robust local auditing, which monitored success rates of breast reconstruction and free-flap surgery. Development and training opportunities for all permanent staff across disciplines was generally impressive, with the exception of nurses in the plastics outpatient department, who support minor operations without having undertaken scrub nurse training or competency-based assessments. Also, due to the high use of agency and bank nursing staff, we were concerned that not all staff were competent to deliver plastic surgery care.

At times, pain management, within the plastic surgery service, was not acceptable, particularly for patients waiting for long periods of time on the trauma theatre list. These patients were also often left as 'nil by mouth' for prolonged periods of time, without consideration given to fluid replacement. Whilst in some areas staff appraisal rates were good, in other areas this required improvement and meant that staff were not supervised or managed appropriately. All staff we spoke with, including leads, recognised that trauma care performance, in view of waiting times for assessment, diagnosis and treatment, was often poor, due to a lack of facilities and limited staff.

Evidence-based care and treatment

- Relevant trust policies and care records showed that patient assessments and treatment were provided in line with recognised guidance, legislation and best practice standards. For example, the trust followed venous thromboembolism (VTE) prevention measures as set out by the National Institute for Health and Care Excellence (NICE) 2010. We observed adherence to this national guideline. Staff told us that they could access trust-wide policies via the intranet.
- There was a range of trust-wide evidence-based policies, such as a Blood Transfusion Policy, that staff could access via the intranet.
- Other local audits that were practiced included hand hygiene, moving and handling, blood transfusion and, most recently, the introduction of falls assessment audit.

- There were bi-monthly directorate governance meetings. We reviewed the minutes of these meetings and found that they were well attended, and that they included discussions about relevant national guidance and updates where necessary.

The burns service:

- There were also numerous burns-specific policies that had been developed within the department and as part of a multidisciplinary team effort. This represented outstanding practice. These were based on evidence-based practice that was issued by relevant organisations such as the British Burn Association (BBA) and the National Network for Burn Care (NNBC). However, we found that these policies were not ratified by the trust board as per trust-wide policies, nor did they have a review date or signature of agreement on them. Staff had quick access to these policies via the electronic patient record system. One member of staff told us that these policies were, "Excellent and were always followed" and another said, "We are really proud of our [burns] policies we have here".
- We observed extensive infection control audit data for the past three months for all areas. This demonstrated good infection control practice and compliance with national guidance such as Surgical site infection: Prevention and treatment of surgical site infection issued by the National Institute for Health and Care Excellence (NICE) 2008. For example, on Burns ITU and the Children's Burns Ward there was 100% compliance with this guidance. Other recent and local audits included moving and handling audits, and a blood transfusion audit. The burns service regularly underwent peer review processes.

The plastics services:

- Staff told us that whilst the assessment records encouraged thorough assessment and good plans of care, they described them as extensive and unrealistic, because staff on the plastics wards and in the plastics outpatient department did not have the time to complete these fully. Several staff across different wards reiterated this.
- On several occasions we observed that people's needs assessments were not being completed fully or accurately. This meant that vital risk assessments, including pre-operative assessments, were not being undertaken safely by nurses, or in line with evidence-based care and treatment.
- There were also specific plastic surgery policies and guidance in place that had been developed by the St Andrew's Centre. For example, the hand therapy team had developed extensive guidance for hand care that reflected each consultant's choice in treatment and preferred regime. This included 'Extensor tendon repairs mallet injury' and 'Radial nerve injury' guidance. This guidance was dated and agreed by the relevant consultant. The breast team had also developed numerous policies and guidance on breast care, such as 'Deep Inferior Epigastric Perforator Flap (DIEP Flap)' guidelines, and patient information leaflets which reflected up-to-date evidence-based practice.
- We were, however, concerned about the lack of policies and procedures for the minor operations service in the plastics outpatient department. For example, there were no policies in place for tourniquet application, diathermy use, and swab and needle counts.
- Staff in the plastics outpatient department used the World Health Organization (WHO) safety checklist in the operating theatre to confirm patient identity and the correct operation. They had worked to modify and adapt it to local circumstances as proposed by WHO.
- The directorate also held regular audit meetings whereby local audit results were discussed, such as free-flap audit results. This was also an opportunity for teaching sessions; for example, recently there had been a teaching session on 'New British Manufactured Scar Treatments' by an external speaker, and a training session on tracheostomy care. These meetings were available to all staff; however, the service did not minute the meetings, or maintain a record of attendance.

Pain and itch management

- Medication charts confirmed that staff administered pain relief to patients as prescribed. Records confirmed that patient's pain scores and sedation scores were assessed regularly.
- There was a dedicated pain team within the trust, and staff knew how to contact them for advice and support when required.
- We observed that the burns service benefited from twice daily multidisciplinary rounds in Burns ITU and on the

burns wards. During this time the anaesthetist took the lead in reviewing the current medication the patient was on, their pain and itch scores, and prescribed analgesia and anti-itch medication as required.

- There was a dedicated burns anaesthetist available 24 hours a day, seven days per week, who took the lead in pain management. There was a trust-wide pain team available. Staff told us that the team were very useful and accessible when required.
- On the Children's Burns Ward there was a child-friendly pain scoring system which supported staff to determine pain experienced.
- On Billericay Ward and Stock Ward, the plastics surgery service wards, people told us that they received pain relief in a timely way, and the medication records we examined confirmed that medicine was administered by nurses as prescribed. However, we were concerned because patients on the trauma list, who were waiting for theatre on Mayflower Ward, did not always receive analgesia as required. One patient had injured their finger and had been asked to return to the ward the next day for their operation as the department was too busy at the time. This patient told us that their pain was, "Excruciating" and when we asked what their pain score was out of three they told us, "Five" and it had been that for over 12 hours meaning they couldn't sleep. We bought this to the attention of staff, and this person received appropriate care and pain relief subsequently.

Nutrition and hydration

- Staff used the malnutrition universal screening tool to identify patients at risk of malnutrition. Inpatient records we reviewed showed that staff had completed these tools accurately and fully where required.
- During our visit we observed that those patients who were admitted had water jugs within reach and that there were regular hot drinks rounds on the wards. In the plastics outpatient department there were water facilities for people waiting, and a café bar where people could purchase food and drink.
- There was a designated dietician for the burns service, who was available during week days, and attended daily multidisciplinary ward rounds.
- There were regular meal times on the ward areas, with a variety of food choices. Patients told us that the food was, "Good" and that they, "Had choice in meals".
- We observed that food and fluid charts were updated regularly where required. In relation to fluid balance on Burns ITU, we found that the electronic patient records system was strictly monitored and updated, as expected, by nursing staff, to reflect fluid intake and output.
- In the plastic surgery service we were concerned that people waiting to attend the trauma theatre on Mayflower Ward were being kept as 'nil by mouth' for extensive periods of time, and that no fluid replacement therapy was provided. One patient told us that they had been kept as 'nil by mouth' for 12 hours the day before, only to be told at the end this time that their operation had been cancelled. Another patient told us that they had been kept as 'nil by mouth' every day for five days because their operation had been cancelled daily due to other emergencies taking priority. A third patient who had their operation on one of the mornings of our inspection was still waiting to be discharged at 10pm. This was because their discharge letter needed completing and the doctors were too busy in theatre with another patient. This person told us that they were, "Hungry and thirsty" as they had not been provided with food and drink during their wait as they didn't have a bed anymore.

Patient outcomes

- We did not identify any outliers relating to burns care. An outlier is an indication of care or outcomes that are statistically higher or lower than would be expected. They can provide a useful indicator of concerns regarding the care that people receive.

The burns service:

- The St Andrew's unit had demonstrated that it has, "Clinical outcomes comparable to the major burns centres around the world" following a retrospective cohort study undertaken by service leads in 2012. According to trust figures, the mortality rate for those operated upon within 24 hours had been reduced by 20% for 2003-07 from 1998-2002. We judged this as outstanding. Staff told us that they were in proud of their accomplishments within St Andrew's.
- The service is part of the London and South East of England Burn Network (LSEBN), which is an operational delivery network for specialised burns. The LSEBN was established in 2008 in response to the National Burn Care Review, published in 2001. The review identified clinical networks as the organisational model, or way of working, to drive change and improve burn care services

for the population in specific areas. LSEBN is one of four networks across the country. In 2010, the national Specialised Service Commissioning Groups (SCG) jointly agreed to undertake a major review of burns services in the LSEBN, with the intention of determining the long-term configuration for burns services in the network. At the time of our inspection, the St Andrew's Centre was participating in this review.

- There was also a recent local audit which fed into the 'National Cardiac Arrest Audit' which identified numbers of cardiac and peri-arrest calls made by each area.
- Burns ITU did not have arrangements in place to submit Intensive Care National Audit and Research Centre (ICNARC) data. Senior managers told us that they had been in discussion with ICNARC, and that they had been advised that due to low capacity of Burns ITU patients, this would displace confidence intervals in terms of statistical analysis and therefore participation was not recommended. However, the service did analyse and use cumulative sum analysis (CUSUM) techniques, which is a tool to monitor the rates of adverse outcomes (mortality). We reviewed the CUSUM data since September 2012 which demonstrated that this service performed at a level comparable which was equal or better than most burns services in the world.
- The St Andrew's Centre was in fact part of the first study to develop and implement real-time outcome monitoring for mortality in burns using CUSUM techniques. This was following the service leading an eight year retrospective study of mortality, which was performed on all admissions to the St Andrew's Burns ITU service. The study described a successful design of an early warning system to monitor outcomes in burns intensive care settings. The study was undertaken in partnership with Great Ormond Street Hospital, London and the Anglian Ruskin University, Chelmsford, and was published in 2013.

The plastic surgery service:

- The standardised relative risk for elective readmission rates in plastics (111) was higher than expected – a figure greater than 100 represents that there were more than expected and it is above the England average (100).
- The standardised relative risk for non-elective readmission rates in plastics (71) was better than expected – a figure less than 100 is interpreted as a positive finding as it is below the England average (100).
- We asked the trust for records confirming return to theatre rates following spells of surgery, however; the service did not provide us with this information. We were therefore not assured that the plastic surgery service was monitoring this.

Competent staff

- There were burns and plastics competencies for newly qualified nurses and new starters. However, we were concerned that not all staff were competent to deliver plastic surgery due to the high number of bank and agency used on the ward areas, and because they had not undergone such competency-based learning.
- Across the plastics service 17 nurses had completed the accredited Burns and Plastics course, one was awaiting results, and four were part-way through the course. Staff were supported to develop their skills through other accredited specialist training too: three nurses had undertaken a hand course, four had completed training in head and neck plastic surgery, 12 had completed mentorship training, and 20 were deemed competent in airway management.

Competent staffing

The burns service:

- Records confirmed that appraisal rates were improving significantly throughout the burns service; for example, on the Children's Burns Ward in August 2014 staff appraisal rates were only 62.5%, but by October 2014 this had increased to 100%. Appraisal rates were good in all areas for nursing and support staff, the Adult Burns Ward (100%) and Burns ITU (90.5%).
- There was a burns competency pack in place for newly qualified staff and new starters, which comprised of three levels of competencies and assessments. Records confirmed that all new staff underwent this process.
- Each area maintained a record of training and development which demonstrated that a large proportion of staff had received appropriate specialist training. In Burns ITU 26 registered nurses had obtained post-registration ITU courses, and 17 had achieved HDU course accreditation. On the Adult Burns Ward two nurses had been funded and completed Burns Rehabilitation courses, six had undertaken the Burns and Plastics postgraduate courses, and three nurses had achieved accredited training in the Emergency

Management of Burns Patients. Staff told us that training and development opportunities within the burns service were "excellent" and that they "consider themselves very fortunate".
- Staff and records also confirmed that there was always a paediatric nurse on duty on the Children's Burns Unit.
- Junior anaesthetists and surgeons, who typically come from plastic surgery backgrounds, participated in the twice daily patient ward rounds. Junior doctors were responsible for presenting the progress of the low dependency patients at the ward rounds within the team, which in turn provided learning opportunities and the time to ask senior colleagues questions.
- There was also a three day burns course that was available to all staff, which was delivered in-house.

The plastic surgery service:

- Appraisal rates for staff were variable across the different departments. On Mayflower Ward 93.3% of staff had received an appraisal, however on Billericay Ward this figure was only 69.6%.
- Hand therapists and doctors further told us that the training opportunities within the directorate were "excellent" and that they were, "Incredibly supported to develop our expertise". Training records we looked at confirmed this.
- We were also concerned that nurses in the plastics outpatient department, who were supporting minor operations, had not received scrub nurse training or competency-based assessments. One nurse we spoke with, who worked in the minor operations theatre, could not tell us what the protocol was for scrubbing prior to an operation.
- The directorate had funded four healthcare support workers to develop their skills further. These members of staff had either recently or nearly gained degrees in Health Care, awarding them the title of Associate Practitioner (band 4 grade). We saw that two of these staff were relatively new in post, and that supportive competencies and job role specifications had been developed and were being implemented. These practitioners could admit, assess and analyse patient observations.

Multidisciplinary working

- There were multidisciplinary (MDT), consultant-led ward rounds which occurred daily on the plastic surgery wards and twice daily on Burns ITU and the ward areas, and which were attended by the burns anaesthetist and burns consultants, as well as anaesthetic and burns clinical fellows, senior nursing staff, junior medical staff, plus other key members of the burns team, including physiotherapists, dieticians and clinical psychologists. The entire multidisciplinary team also met to discuss the patients in more detail on a weekly basis.
- The hospital discharge team were also involved in ward rounds depending on patient need.
- There were arrangements in place for working with social care partners in safeguarding investigations; there were systems in place for district nurse referral arrangements, and discharge summaries were sent to patient's GPs routinely at discharge.
- There were arrangements in place whereby paediatric intensivists attended daily paediatric burn ward rounds. This occurred on site every Monday and Friday and remotely via telelink on every other day.
- Patients that were 'stepped-down' from Burns ITU benefited from follow-up and continuity of care from the same team because of the multidisciplinary model of care in place. Senior staff also told us that if a person is discharged from the burns service and moved to the plastics wards for burns reconstruction treatment, then one of the burns nurses will go and see the patient, and the same surgical and anaesthetic team will consistently be involved.
- On Billericay Ward, a plastic surgery ward, we observed a 'discharge board' which identified patients who had complex discharge needs. This had been implemented to improve MDT working, because it acted as a quick reference point for nursing staff during handover, and for all members of the MDT, to determine patient needs that were outstanding. Staff told us that this supported effective discharge planning.

Seven-day services

- Staffing we spoke with, and records reviewed confirmed, that there was always a burns consultant and burns anaesthetist available 24 hours a day, seven days a week.
- There was a plastic surgery consultant on-call 24 hours a day, seven days a week, and a middle-grade doctor was always on duty at all times. Nursing staff told us that plastic surgery doctors always answered their pagers promptly and attended the ward quickly when needed urgently.

Specialist burns and plastic services

- Imaging services, physiotherapy, dietetics and a pharmacy service were also available seven days a week.

Freedom of information

- Staff we spoke with were aware of the Freedom of Information Act (2000). If requests were made this was escalated to senior managers and the trust-wide governance team. Records also confirmed that any freedom of information requests within the directorate were also discussed at the Burns and Plastics bi-monthly clinical governance meeting.

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

- Training on consent, the Mental Capacity Act and Deprivation of Liberty Safeguards (DOLs) was part of mandatory training for staff. Records confirmed that 92% of nursing and support staff across the burns directorate were compliant with these subjects.
- The trust had policies in place regarding consent, the Mental Capacity Act and DOLs, which were accessible to staff via the intranet. Staff we spoke with told us that they could access the intranet, and demonstrated adequate knowledge about the subjects and applicable legislation.
- The burns service also had a dedicated mental health nurse who worked within the burns multidisciplinary team three days per week. Staff told us that this supported them with MCA and DOL applications as required. Outside of these working hours, there was a safeguarding team who could also provide specialist knowledge and support.
- Staff were also knowledgeable about Gillick competency and Fraser guidelines. These guidelines are tools used to assist professionals in determining whether a child is mature enough to make their own decisions about care and treatment.There were appropriate forms in place for obtaining written consent.

Are specialist burns and plastic services caring?

Good

Feedback from people who used the burns service and those close to them was consistently positive about the way staff treated people. People told us that staff on the burns unit go, "Above and beyond their duty". We observed that people were treated with dignity, respect and kindness during all interactions with staff, and people told us that they believed that staff truly cared about them. Feedback systems, such as the Friends and Family Test, were used on ward areas and demonstrated excellence in the burns service. The recent Friends and Family Test (FFT) results from Billericay Ward and Stock Ward were, however, relatively poor, although we saw marked improvement in results on Billericay Ward in the past three months. Mayflower Ward did not conduct the FFT nor provide a similar alternative method of obtaining patient feedback.

The burns service involved people who used the service and those close to them as ‘partners' in their care and treatment. Patients and their families told us that staff supported people to make informed decisions. The entire burns team, alongside the various support systems which were implemented, provided patients and those close to them with support to help them cope emotionally. People’s emotional needs were highly valued by staff and were embedded in people’s care and treatment. Staff recognised and respected the totality of people’s needs, and always took people’s cultural, social and religious needs into account.

We observed that in the plastics outpatient department staff did not always see people’s dignity as a priority. There were no vacant/engaged signs on the doors of consultation rooms, and we saw that staff were frequently knocking and immediately entering rooms without a reply, interrupting consultations. Some of these consultations were regarding sensitive matters, and this was therefore not appropriate. Patients were also seen in the same room as other patients for their consultations. Whilst there was a subtle notice on the door informing patients of this system and notifying them that they could request to be seen alone, we were not assured that patients would always feel comfortable to make this request.

Specialist burns and plastic services

Compassionate care

- We saw that staff treated people in a warm and caring way throughout the service.

The burns service:

- Patients we spoke with were consistently positive about staff within the burns service; one person commented, "They are amazing", and another said, "Staff go out of their way here [to help] and are extremely kind".
- The Friends and Family Test (FFT) was used on the Adult Burns Rehab Ward and the Children's Burns Ward, and reflected excellence. For example, on the Adult Burns Rehab Ward the results for the past year confirmed that 100% of people asked would either be likely or extremely likely to recommend the service to their friends or family. There were also comments cards available on the Children's Burns Ward. The FFT was not used on Burns ITU because staff said that is was not appropriate given the sensitivity of injuries experienced, although when patients were 'stepped down' from ITU to the wards, the FTT was then given. Staff on ITU told us that they sometimes asked patients about the care they received on ITU if they returned as an outpatient, months after their admission; however, we found no record of any conversations held.
- However, we did see a plentiful number of cards on Burns ITU and across all areas, from patients and those close to them who had recently used the service, which confirmed that staff delivered highly compassionate care.

The plastic surgery service:

- Patients we spoke with were consistently positive about staff within the plastics service; one person commented that, "Everyone is really lovely", and another said, "Staff are first-class here and just brilliant". Despite patients being unhappy with their care in relation to waiting times on the trauma theatre list, every patient we spoke with, who was waiting on the trauma list, told us how caring or kind the staff on Mayflower Ward were.
- The Friends and Family Test (FFT) was used on Stock Ward and Billericay Ward. This tool is recognised nationally and is given to patients or those close to them, to give feedback about service quality, and to determine whether that person is likely to recommend the service to their friends and family. We found that the average response rate during April 2013 to July 2014 was relatively poor both on Stock Ward (47%) and Billericay Ward (35%). There had been 877 responses on Stock Ward and 1,154 on Billericay Ward during this period. In October 2014, the FFT result on Billericay Ward was 70, which demonstrated a vast improvement from previous results. The FFT was not used on Mayflower Ward, nor was a similar alternative method of patient feedback used.
- In the plastics outpatient department there were no vacant/engaged signs on the doors of consultation rooms, and we observed that staff were frequently knocking and immediately entering rooms without a reply, interrupting consultations. Some of these consultations were regarding sensitive matters and this was therefore not appropriate.
- We were also concerned that in the plastics outpatient department there was a hand trauma room which was used by up to three consultants at a time to see numerous patients at the same time. Whilst there were subtle notices on the door informing patients of this system and notifying them that they could request to be seen alone, we were not assured that patients would always feel comfortable to make this request and therefore felt it did not ensure patient's privacy and dignity.

Understanding and involvement of patients and those close to them

- Patients said that staff always kept them well informed about their condition and treatment. One person said, "They explain everything to me all the time". Patients on the Adult Burns Rehab Ward told us that the nurses completed two hourly care rounds which provide them with updates. One patient was waiting to go to theatre, and confirmed that he knew when he was going because he had recently been updated regarding timings. One person said, "Staff are really good at explaining everything", and despite several people being unhappy about the long wait for trauma theatres, these patients could not speak more highly of staff on Mayflower Ward, and were pleased about the regular updates that staff gave them about waiting times.
- On the Adult Burns Rehab Ward 'adult ward in-patient care records' were used and had boxes which the registered nurses completed when they spoke with a

patient. These boxes were used to record a summary of conversation. It also prompted the nurse to ask 'is there anything the patient would like to discuss'. Records confirmed that this practice was occurring.

- Throughout the services there were information boards visible informing patients and those close to them about the service offered. For example, on the Adult Burns Rehab Ward we observed posters reiterating the importance of dignity in care and what patients should expect, and information about free legal advice in view of Power of Attorney support.
- Literature displayed on the wards and on the trust's website demonstrated that the service actively encouraged patients and those close to them to be involved in care and treatment.

Emotional support

- There was a dedicated burns and plastics psychology team who provided mental health support for plastics patients as required. This included a counselling service for patients following trauma and burns incidents.
- The trust had a chaplaincy which was multicultural, and this could be accessed to provide emotional and spiritual support for patient and families. We observed posters on ward display boards which promoted this service.

The burns service:

- There was a range of emotional support available for children and young people. There were four nursery nurses and four play specialists employed, who worked across the children's burns service, and endeavoured to ensure that children were supported with psychologically-grounded play, to prepare and distract them during care and treatment. Their aim was to alleviate children's anxieties.
- On the Children's Burns Ward environments were designed to purposefully distract and entertain children during their stay, through bright walls and colourful decoration. Children's movies were provided on bedside televisions. Children had access to play rooms which were filled with age-appropriate toys for all ages of children admitted.
- The children's burns service encouraged parents to stay the night with their child, and there were enough fold-up beds for each admission. There were two relatives' rooms on the Adult Burns Rehab Ward that could be used for relatives of adult patients, so they could stay over if their loved one was admitted to Burns ITU.
- The twice daily ward rounds included the presence of the burns clinical psychologist, and therefore mental health needs of patients were assessed at every round.
- Patients that were 'stepped-down' from Burns ITU benefited from follow-up and continuity of care from the same team because of the multidisciplinary model of care in place. This meant that if patients return for burns reconstruction care over several years they received care and treatment from the same team who knew them well.
- The St Andrew's Centre jointly worked with the London Burns Support Group. This group is for people over 16 years of age who have experienced a burn of any size that have been treated at St Andrew's. It offers meetings four times a year, which include social events and speakers. Family and friends were welcome. This group offered support, but also provided an opportunity for patients to support other burns victims.
- The service also provided the Children's Burn Club, which is a registered charity under the umbrella of the Mid Essex Health Trust, which was funded by the London and South East of England Burn Network. The club was open to any child or young person under the age of 18 years old that had a burn injury. It offered support to young burn survivors and their families to help them come to terms with burn trauma and altered body image, and included fun activities like residential camps, days out, workshops and parties, and peer support amongst members was encouraged. This support helped people rebuild self-esteem, confidence and expectations after a burn injury.
- Young adults aged between 18-24 years had the additional option to join the Young Adult Children's Burns Club.
- Burns ITU provided patient diaries, which are used when a patient has been sedated for some time whilst they are mechanically ventilated. After discharge from ITU, patients often report having gaps in their memory from their condition or they may remember nightmares and hallucinations. A patient diary is written by healthcare staff and those close to the patient, and includes daily entries on the patient's condition in everyday language.

The plastic surgery service

Specialist burns and plastic services

- The plastics service employed a number of clinical nurse specialists. This included breast reconstruction and skin cancer nurse specialists, who provided their own nurse-led clinics in the plastics outpatient department. One breast reconstruction nurse was also based on Stock Ward and provided specialist care during admission for patients undergoing elective breast reconstruction surgery.

Are specialist burns and plastic services responsive?

Requires improvement

People could access the burns service in a seamless and timely way. People's individual needs and preferences were central to the planning and delivery of tailored services. The service was flexible and ensured continuity of care for patients. St Andrew's worked with other organisations, such as the London and South East of England Burns Network (LSEBN) and local authorities throughout the boroughs where people lived, to ensure that service provision met people's needs holistically.

There were innovative approaches to providing integrated person-centre pathways of care, which involved other service providers, such as the developing Burns Outreach service, which aimed to deliver outpatient care nearer to home for patients who did not live in close proximity to the centre. Bed occupancy figures were low, although at times due to ensuring same sex bays, patients who were deemed suitable were transferred to the plastics wards. Staff assured us that patients were only moved if they were admitted for dressings care, and then staff from Burns Rehab would attend the plastic ward to do all dressing changes and the patient would be seen by the burns multidisciplinary team twice daily.

There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that meets these needs and promotes equality. Services had been designed and planned with thought to the needs of children of all ages, and those living with dementia and learning disabilities. Complaints received were minimal and when a complaint was received, records confirmed that it was managed and responded to in a timely way, and improvements were made across the service where possible.

The plastic surgery service was concerning in terms of responsiveness. This was because there was minimal effort made to plan and deliver services based upon needs analysis within the regional boundaries. Some of the service facilities and premises were not appropriate and did not meet the needs of people using the service. People were frequently and consistently not able to access the emergency plastics service in a timely way for an initial assessment, diagnosis or treatment, and people experienced unacceptable waits for this service. Bed occupancy rates were consistently high across all wards. However, formal complaints were minimal, and where complaints were received, they were handled appropriately and led to some improvements in care.

Service planning and delivery to meet the needs of local people

- The burns service has clear plans in place which set out how it planned to meet the needs of the people within its service provision boundaries. There was involvement with other organisations such as the London and South East of England Burns Network (LSEBN), whose purpose it is to 'provide a framework to ensure there is a co-ordinated approach to burn care in London and the South East, and that patients have access to the best possible services'. St Andrew's had regular contact with LSEBN and followed the guidelines and protocols issued by this organisation.
- We asked to see the plastic directorate's service plan and relevant objectives. We found evidence that there was minimal effort made to plan and deliver services based upon conducted needs analysis. We were therefore not assured that the service had been designed to meet the needs of local people, and our observations confirmed these concerns.

Meeting people's individual needs

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

pre-assessment stage with the patient and relatives where appropriate. During our visit we observed that one patient who was living with dementia had relevant assessments undertaken, and subsequent to this, the trust had provided one-to-one support for this person.

- There was a learning disability nurse specialist for the trust. Staff we spoke with were aware of the support this nurse specialist offered, and knew how to access their contact details. Staff were also knowledgeable about the trust's safeguarding team and the dementia nurse specialist.
- There was a school teacher who was part of the children's burns service, who provided educational support to children and liaised with the child's school as required.
- On every shift there was a play specialist and nursery nurse/health care assistant on duty who were based on the Children's Burns Ward, but also offered support in Burns ITU as required. There were also entertainers that visited the ward regularly, such as a magician, who had all undergone routine Disclosure and Barring Service (DBS) checks.
- The Adult Burns Rehab Ward contained a gym with extensive modern rehabilitation equipment. There was a dedicated burns physiotherapist team and an occupational therapist to support rehabilitation.
- The trust offered special diets which met people's individual needs, such as vegetarian, vegan, gluten-free and halal meals.

Access and flow

The burns service:

- Patient flow into the burns service was seamless. Admissions were accepted through burns consultants, and following discussion with the senior nurse lead. There were also admission guidelines in place which were followed by the service and used by the LSEBN to direct care to the centre. There was a Burns ITU admission room which had been situated purposefully and in close proximity to A&E and the Burns service entrance, which was used for transfers in.
- When adults or children were 'stepped down' from ITU, they were transferred to either the Children's Burns Ward or the Adult Burns Rehab Ward for further care and treatment.
- Following discharge from hospital there was a dedicated burns outpatient service which was situated within the hospital close to Burns ITU. The department offered a nurse-led clinic, led by a senior sister and six registered nurses, who ran daily clinics Monday to Saturday. A consultant clinic was also run once a week on a Tuesday morning, where patients attended to discuss future plans and where burns scars were reviewed.
- There was a paediatric consultant outpatient clinic that ran two Tuesdays each month. In order to ensure that children were treated separately from adults, as per national children's service standards, burns outpatient clinics for children were delivered from the Children's Burns Ward.
- The burns outpatient department further accepted new referrals of wound size 5% or less, and followed the St Andrew's 'taking of new referral' guidelines.
- Bed occupancy rates throughout the service were consistently good. We reviewed data for all areas between November 2013 and November 2014. As an example, on 28 October 2014 the occupancy for each area was below the England average: Burns ITU (50%); Children's Burns Ward (13%) and Adult Burns Ward (88%). On the occasion whereby the Adult Burns Rehab Ward reached full capacity, which according to data we reviewed, had been reported as twice in the last year, patients who were assessed as able to, for dressings etc., would be transferred to one of the directorate's plastic surgery wards.
- On the week of our inspection we noted that there were two burns patients admitted to Billericay Ward, which was one of the plastic surgery wards, due to there not being a bed available in a same sex bay, although there were beds available. Staff told us that it is not uncommon for this to happen. Staff did however assure us that such patients were only moved if they were admitted for dressings care, and staff from Burns Rehab would attend the plastic surgery ward to do all the dressing changes and the patient would also be seen by the burns team twice a day.
- The St Andrew's service recognised that travelling to Chelmsford from the outskirts of the London and South East area could be lengthy for some patients. Consequently, in November 2013 the service developed a Burns Outreach service, to enable outpatients who had used the service, to be treated closer to home.

Outreach guidance and criteria had been developed to support this system. Staff told us that this was a developing service and we saw plans for further development.

- There were six ITU/HDU beds used flexibly according to patient dependency in the Burns ITU department for a population of approximately 9.8 million. There were also a further two Burns HDU beds available, but staff told us that these were not commissioned.
- There were no out-of-hours discharge delays reported in the past year, and the numbers of elective surgery appointments cancelled due to lack of Burns ITU beds was not applicable because the burns service had their own theatre.

The plastic surgery service:

- People could assess the service through referral from A&E and other services. There were elective surgery and emergency admission pathways. Emergency trauma patients requiring the plastic team would be seen initially on Mayflower Ward during Monday to Saturday, between 7am and 9pm. Out of these hours patients would be seen on Billericay Ward. Following assessment, these patients were either admitted for treatment or discharged home as required. Patients were also referred to the plastics outpatient department, whereby decisions in care and treatment occurred. At times access and flow into the plastic's trauma service was poor.
- Mayflower Ward was commissioned as a day case elective admissions and trauma ward, where all elective admissions were seen, with the exception of free-flaps which went to Stock Ward. Mayflower Ward consisted of two bays of four beds, four side rooms and a bay with four theatre trolleys. Staff told us that despite Mayflower Ward originally being a day case ward, since April 2014, the service now used 12 of its beds as a contingency ward for plastic patients and medical outliers, and it was now open 24 hours a day, seven days a week for contingency patients.
- Staff on Mayflower Ward also told us that, on average, and in addition to the contingency patient care, ""We see 30-35 trauma admissions and roughly 20-28 elective admissions on Mayflower per day". During our inspection we noted that all 12 contingency beds were full, and staff told us that it was, "Very normal to have two or three medical and surgical outliers in these beds". Staff also confirmed that, at times, these contingency beds were used for patients who had stepped-down from intensive care.
- Every member of staff we spoke with, across all disciplines, raised concerns about the high level of attendances and workload on Mayflower Ward. Staff told us that Mayflower Ward, in terms of access and flow was, "A nightmare", "Dangerous", that, "It can't go on", that it was, "Medically potentially dangerous", and "Horrendous on here". One senior doctor told us that there was, "A severe lack of physical capacity here". Our observations confirmed staff concerns, and we saw that at times, this ward set up put patients at risk of harm. This is because people's trauma operations were regularly cancelled, some up to five days in row, where patients were starved for 12 hours a day unnecessarily and in pain; that due to capacity, people were being nursed pre-operatively in communal waiting rooms that were incredibly busy, with insufficient seating at times; post-operatively patients were frequently being nurse in inappropriate rooms; and that staff did not have time to complete patient assessments accurately or fully.
- We noted that there was an action plan in place to improve the trauma service; however, staff told us that this, "Had been talked about forever but nothing ever improved". Even the directorate risk register confirmed that there had been, "Minimal progress to date" with the action plan and this comment was dated November 2014.
- We were also concerned that for some patients there was an increased risk of long waits (currently one year) in plastic surgery for delayed DIEP (deep inferior epigastric perforator flap) surgery, due to increased demand for immediate DIEPS for breast cancer. The directorate risk register confirmed that this issue was not improving as it indicated that, "Due to pressures of no beds and urgent cancer cases waiting [times] have increased"; this comment was dated November 2014.
- Bed occupancy rate within the plastics service was consistently high, and at times figures demonstrated that occupancy went beyond capacity. For example, on 30 October 2014 bed occupancy rates were high across all plastics wards: Billericay (96%); Mayflower (100%) and Stock (100%). On 29 October 2014, bed occupancy on Billericay Ward was 108%.

- Staff told us that the admission processes for electives and emergencies were often unrealistic due to volume of work, and new and extensive paperwork. One member of staff told us that they were responsible for admitting up to 20 patients a day, and that paperwork, if done thoroughly, could take "20 to 30 minutes to do properly". This was therefore an impossible task at times. Whilst there was an outpatient clinic for elective admissions in the plastics outpatient department, ward staff on Mayflower Ward told us that pre-assessment paperwork is, "Not done properly there as they are too busy as well".
- With the exception of the extensive waiting times for delayed DIEP surgery, on Stock Ward we saw outstanding examples of admission processes, and good access and flow for breast patients. Patients were pre-assessed and provided with pre-operative and post-operative care, in a dedicated breast bay on Stock Ward by the same nurse specialist.
- We were concerned that discharge arrangements were poor for trauma patients. Staff told us that doctors were often too busy to complete discharge summaries following surgery, particularly out of hours, and this meant that there were delays in discharging patients. On one evening during our inspection, we noted that there were patients waiting at 11pm to be discharged. One nurse told us that, "This is very common" and that they frequently have to deal with angry patients as a result. One patient who was waiting for their discharge summary told us they were, "Furious, hungry and tired". These discharge delays were also not being monitored by the service.
- Discharge information on some areas was very good; however, on Mayflower Ward and Billericay Ward we were concerned regarding the lack of, and outdated, patient discharge literature.
- We asked to see the cancellation rates of surgery due to lack of bed capacity for the past 12 months. Records we were shown confirmed that during this time 1.4 operations were cancelled a week in plastics for bed related reasons. When we spoke with staff, they told us that emergency and elective operations were often cancelled daily. During our inspection, on one morning alone we found that one elective patient had been cancelled, and that there were four trauma roll overs from the previous evening. We were therefore not assured that the service was monitoring cancellation rates accurately.
- We reviewed records which indicated "the number of patients not treated within 28 days of a cancelled procedure" in the past 12 months in the plastics branch of the directorate. During October 2013 and September 2014 four patients breached this target.
- The trust was meeting the Referral to Treatment (RTT) targets for plastic surgery, for admitted patients, non-admitted patients and patients on incomplete pathways.
- We spoke to prisoners at the local prison about their experiences of Broomfield hospital. One prisoner told us and it was confirmed by staff that they had arrived late for this appointment in Mayflower ward due to the logistics of taking prisoners out of the prison. The prisoner and his guards had to wait for seven hours to receive treatment which lasted approximately 15 minutes. There were no special arrangements made to preserve this person's dignity as they waited in the general waiting area. This person was not offered food and drink whist they waited.

Learning from complaints and concerns

- Information for people about how to make a complaint, raise concerns or compliment the service, was displayed where visitors would see it. The information included details of the Patient Advice and Liaison Service (PALS).
- Staff described the value of dealing with people's concerns straight away before they developed into more significant complaints. Staff said that when a concern was raised with a member of staff this would be referred to the most senior nurse on duty who would then inform the matron for the service.
- The burns service had only received one complaint between November 2013 and November 2014, which related to a safeguarding incident. All staff we spoke with were aware of this complaint and we were assured that the action learnt from it was being practiced.
- In the past three months the plastics service had received four formal complaints and this was regarding the trauma service on Mayflower Ward. We found that

staff at local level had since introduced a system whereby staff on Mayflower Ward regularly called theatre for updates about patient waiting times, and relayed this to patients and kept records accordingly.

Are specialist burns and plastic services well-led?

Requires improvement

The burns service had a clear vision and credible strategy to deliver high-quality care and promote good outcomes for burns patients. The governance arrangements ensured that staff were clear about their responsibilities, staff regularly considered quality and performance, and staff identified, understood and managed risk effectively. There was a systematic approach taken whilst working with other organisations to improve care outcomes and tackle health inequalities. However the plastics service strategy was not underpinned by detailed, realistic objectives and plans. The arrangements for governance and performance management at senior management level did not always operate effectively, and risks and issues raised by ward staff were not always dealt with appropriately or in a timely way

The leadership and culture within the organisation reflected its vision and values, encouraged openness and transparency, and promoted the delivery of high-quality care across teams and pathways. Local leaders in the burns service were inspiring, and strived to deliver and motivate staff to ensure that clinical excellence flourished. The service engaged with other organisations, staff, patients and those close to them, seeking and acting on their feedback to improve the quality of the service.

Leaders at local level in the plastic surgery service had the necessary experience, knowledge and capability to lead effectively; however, they were not supported appropriately to manage their service effectively due to financial and service specification restraints. Staff satisfaction was mixed; in some areas staff, "Loved their job", but in other areas staff felt, "Demoralised" and, "Exhausted". In some areas there was a limited approach to obtaining the views of people who used the service. The approach to service delivery and improvement was reactive and focused on short-term issues. However, we saw numerous examples of outstanding practice throughout the service, which demonstrated innovation and improvement in plastic surgery.

The burns service took adequate steps to learn continually and improve, to support safe innovation, and to ensure the future sustainability and quality of care. The leadership in the service encouraged staff to be innovative, caring and co-operative. Staff were incredibly proud of their model of care and the first-class outcomes delivered. Innovation and success were celebrated.

Vision and strategy for this service

- The trust vision and strategy was visible throughout the wards and corridors. Staff knew and could quote this vision.
- There was also a directorate service strategy in place which gave: a brief description of service provision; a budgetary overview with planned figures and year to date variance figures; current service pressures; and current service activity. We saw that the strategy was used to determine activity volume and plan services accordingly. However, we were concerned about the reality of this strategy in plastic surgery services, as it was not underpinned by detailed realistic objectives and plans.
- On the Children's Burns Ward there was a specific philosophy that had been developed and recorded, with a clear vision and strategy for that specific area. This was an example of outstanding practice.

Governance, risk management and quality measurement

- The service had systems in place to identify, monitor and manage risk effectively. Incidents, serious untoward incidents, complaints and audits were analysed and reported to the governance team. This system was robust and effective. However we were concerned that learning from incidents did not always lead to necessary improvements, nor did they occur in a timely manner, and that important information regarding incidents was not fed back to the entire directorate. For example, nurses in the plastics outpatient department and on Mayflower Ward were not aware of the recent 'never events'.
- The service measured service quality through an indicator dashboard. There was one dashboard for each

inpatient area and these indicated elements of risk within the service. The dashboard was colour coded (green, amber and red). If an area was highlighted 'at risk' it was presented in red, which alerted those scanning the dashboard. The dashboard contained information such as patient falls, pressure ulcers acquired, MRSA incidences, staff sickness and agency usage rates. For October 2014, across all wards and ITU, all elements of the dashboards were green, indicating safe practice, with the exception of one MRSA case being reported on the Adult Burns Rehab Ward.

- CSUM data was used to measure service quality in terms of mortality rates (as previously described thoroughly under the 'Effective' section of this report).
- There was an up-to-date risk register for the burns and plastics directorate, which outlined current risk within the service. The lead nurse for the directorate was aware of all of the risks identified and we saw that there were action plans accordingly, with clear review dates. There was also evidence that action had been taken and risk resolved in some cases. For example, it had recently been recorded that ventilation in the burns outpatients department was insufficient, and this had since been improved.
- In the plastic surgery service we were concerned about the number of risks on the register that had not been addressed in a timely manner, nor had sustainable action plans in place. This related to the trauma service provision, the insufficient amount of junior doctors to maintain '48 working time directives' and to sustain service activity at 100%, and insufficient bed capacity to meet demand in elective and emergency plastic surgery on Mayflower Ward.
- The directorate held bi-monthly governance meetings. This was an opportunity to identify risk and drive improvement across the service. Staff within the burns service were able to tell us about the complaints raised, risk perceived, and success within the centre. Staff on some of the plastic surgery wards were able to tell us about the complaints raised, risk perceived and success within the centre; however, on other areas senior nursing staff were not aware of recent issues such as thematic 'never events'.
- There were also regular and minuted band 7 (sister level) nursing meetings across the burns and plastics service.
- Staff had access to a folder on each area, which included risk assessments undertaken of the local environments and copies of the trust's risk management policy.
- There were regular ward meetings on Stock Ward and Mayflower Ward, which were well attended. Senior nurses on Mayflower Ward told us that ward meetings had ceased on their ward since the contingency beds were opened, as staff did not have the capacity to attend. Instead, we observed that the ward manager completed a team brief regularly which was emailed to all staff. Staff told us that they could access their work emails.
- We were also concerned that the plastics service did not pursue mortality and morbidity meetings, and that staff from the minor operations service did not attend surgical directorate meetings, which again presented a missed opportunity to identify lessons learnt and improve practice accordingly.

Leadership of service

- There were display boards within each area which had photos of the staff employed, their names and job roles. This meant that leaders were easily identified by patients and visitors.
- The burns service was led by a head of nursing and a clinical director, who was the lead burns consultant. Staff told us that these leads and the matrons for the area were, "Approachable and accessible" and, "Get things done", and that they thought highly of them and respected their wealth of knowledge.
- The plastics service was led by the same head of nursing and a clinical director. Whilst staff told us that these leads and the matrons for the area were also approachable and accessible. However, staff were concerned that necessary improvements were not be implemented across the service provision. One member of staff told us "they [the service leads] try their best but they aren't given the support that is required".
- Senior ward managers were dedicated, enthusiastic and inspiring. The managers of each unit demonstrated clear leadership principles and the trust values. Staff spoke highly of their seniors. They said that they felt respected, valued and well-supported by managers.
- We were also told several times that staff felt very well supported because there was always a senior nurse and consultant on duty at all times.

- Each inpatient area had a regular team meeting, and we saw that minutes of these meetings were communicated to each member of staff. Staff we spoke with were able to give us examples of what they had learnt from attending or reading meeting minutes.
- Ward managers had achieved training in leadership and management.
- We were concerned that heads of department, within the plastic surgery service, told us that there was no trauma co-ordinator employed by the service; however, at local level, a senior nurse told us that there was an allocated trauma theatre co-ordinator and gave us their name. This meant there was a lack of clarity about authority and leadership roles.

Culture within the service

- Staff were very open and honest with inspectors. They said what worked well and what did not work as well. Staff said they would raise concerns with managers if necessary, in line with the trust's whistleblowing policy, and they felt that they would be listened to. Staff gave examples of when they had done this and how managers had taken appropriate action.
- Within the burns service there was a positive ethos, immense pride in service quality, and mutual respect between colleagues. Staff throughout the service said that they were passionate about their job, felt respected by peers, and enjoyed working within the burns service.
- Medical staff in the plastics service told us that they were well supported by their seniors, and told us that it was "the place to be" in view of plastic surgery placements for junior doctors.
- Nursing staff told us that they felt supported by their managers, but felt the staffing levels and workload meant they found it hard to undertake care to the standard that they wished.
- All staff told us that they felt able to speak openly if they had a concern, although with some aspects of the service provision they felt that senior managers within the hospital were not taking appropriate action to support them to deliver a better service.
- Nurses, particularly on Mayflower Ward, told us that staff were "demoralised"; "exhausted" and this reflected the "high turnover of staff and staff sickness".
- Despite this, staff across the service were proud to be a part of St Andrew's and of their expertise; it was very clear that staff worked beyond expectations in spite of immense service pressure. This was reflected in what people using the service told us.

Public and staff engagement

- Staff from the burns service told us that they were encouraged to be involved in service development and that the regular team meeting was an opportunity to raise ideas. Play specialists from St Andrew's frequently attended other burns services within the LSEBN to get ideas as to how they could improve their children's burns service. One play specialist showed us an example of a large laminated picture which covered the entire wall of one room, which they had implemented after seeing the idea elsewhere.
- The Children's Burns Ward was purpose built in 2010. Staff told us that they were involved in the design, and that they regularly attend other burns units to get new ideas for their area.
- Staff also confirmed that they are actively involved in the trust's Children's Burns Club.
- An inpatient survey, in the form of the Friends and Family Test, was conducted monthly in each ward area except mayflower ward. This was an opportunity for the public to engage with the service.
- Staff from the plastic surgery service, who had the opportunity to attend ward meetings, told us that these meetings provided an opportunity to discuss service provision and ideas for improvements.

Innovation, improvement and sustainability

The burns service:

- The children's burns team had recently developed a project where they were working with the local health visiting team to educate health visitors about burns prevention in children.
- Twice daily multidisciplinary (MDT) ward rounds had been developed by the service, which meant that patients across all areas were reviewed at least twice daily by the entire team, which in turn improved MDT working relationships and continuity of care.
- A Children's Burns Club had been developed for children who had sustained a burn and used the service.

On-going charity work, led by the service, occurred, which in turn was used to improve the club and the burns service provision. For example, charity funding was used to buy clothing for patients who lacked this.

- The service had developed an intense three day burns training programme, which was available in-house, but was also available for other organisations to attend via the British Burn Association (BBA) website.
- When there were times of low bed occupancy, the team practised role-plays, and staff told us that these efforts had, in their view, led to improvements in care. During our inspection we observed this role-play practice whereby a manikin was used.
- The St Andrew's burns service had demonstrated that it has "clinical outcomes comparable to the major burns centres around the world" following a retrospective cohort study undertaken by St Andrew's service leads in 2012. Staff told us that they were "proud of our accomplishments here". There were many examples whereby professionals employed by the centre had published burns specific research papers in national and international healthcare journals.
- There was a dedicated research team within the burns service, which worked to innovate and improve burns services locally and nationally.
- The emergency call bell system had been upgraded in 2013 so that in in the event of an emergency anywhere within the burns service the emergency call is heard in burns ITU, alerting the anaesthetists and burns surgeons who attend immediately, ahead of the trust crash team.
- The St Andrew's Centre was part of the first study to develop and implement real-time outcome monitoring for mortality in burns using CUSUM techniques. This was an eight year retrospective study of mortality which was performed on all admissions to the St Andrew's Burns ITU service. The study described a successful early-warning system to monitor outcomes in burns intensive care settings. The study was undertaken in partnership with Great Ormond Street Hospital, London and the Anglian Ruskin University, Chelmsford, and was published in 2013. CUSUM was consequently being used by the St Andrew's Centre.

The plastic surgery service:

- The trust told us that 60-70% of plastic surgeons across the UK had trained and worked at St Andrew's.
- The service employed over 20 consultants, specialising in various types of surgery, from burn reconstruction to cleft facial work, skin cancers and breast reconstruction.
- St Andrew's had recently commenced partnership working with the Anglian Ruskin University in Chelmsford. The partnership was entitled StAARS, and promoted training and research, and had three research fellows, as well as many overseas consultants.
- StAARS had recently been selected as one of 30 nationwide projects to participate in research to improve surgical outcomes, supported by £75,000 funding from Shine and the Health Foundation.
- There was a dedicated research team within the directorate, which worked to innovate and improve plastic services locally and nationally. We observed that a number of professionals from the plastics service had published research in national and well respected journals.
- The trust and breast reconstruction nurses had set up a 'Breast Reconstruction Awareness' (BRA) group, which was a registered charity. We found that the money raised through this scheme had been used to make various improvements within the breast service; for example, in the breast reconstruction bay on Stock Ward, every bed had a dual cardiac monitor and observation machine, which had been bought through charity funding.
- We observed outstanding breast reconstruction pathways, and numerous applicable patient information booklets, which had also been funded by the BRA charity.
- The hand therapy team, which consisted of physiotherapists and occupational therapists, had regular meetings, whereby if one of the team had recently attended training or read a new research article that was useful, they shared this information with their colleagues.
- The plastic surgery service employed a number of clinical nurse specialists. This included breast reconstruction and skin cancer nurse specialists, who provided their own nurse-led clinics in the plastics outpatient department. One breast reconstruction nurse was also based on Stock Ward, and provided specialist care during admission for patients undergoing elective breast reconstruction treatment.

Specialist burns and plastic services

- The trust also supported nurse-led treatment. The breast care nurses offered a nipple-tattooing service to patients who had undergone extensive breast surgery. This was a relatively new service.
- There was a dedicated burns and plastics psychology team, who provided mental health support for plastics patients as required. This included a counselling service for patients following trauma and burns incidents.
- Nurses, support staff, hand therapists and doctors told us that the training opportunities within the directorate were "excellent" and that they were "incredibly supported to develop [their] expertise".

Critical care

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

Information about the service

The critical care service at Broomfield Hospital provides specially-trained staff and equipment for the management and monitoring of patients with life threatening conditions. The service has a total of 32 beds across the general intensive care unit (ICU), medical high dependency unit (MHDU), the burns unit and the neonatal unit. This report focuses on the ICU and MHDU critical care provision.

The ICU and MHDU provide a mix of level 3 and level 2 beds. Level 3 are patients requiring advanced respiratory support alone, or basic respiratory support, together with support of at least two organ systems. This level includes complex patients requiring support for multi-organ failure. Level 2 patients require higher levels of care, and more detailed observation and intervention. They may have a single failing organ system, or require post-operative care.

The intensive care unit (ICU) has 16 beds, two are side rooms, and one bed is utilised for the peripherally inserted central catheters (PiCC) service. The medical high dependency unit (MHDU) has eight beds, two are side rooms. Both are closed units, and intensive care consultants provide medical cover 24 hours a day, seven days a week.

ICU and MHDU are in a period of transition, with planned integration of MHDU into the critical care directorate from March 2015. The ICU is located in close proximity to the burns unit and the pathology laboratories.

Summary of findings

During the inspection we visited the ICU and MHDU. We talked with 18 staff, which included senior and junior medical staff, nursing staff (registered and non-registered), managers and administration staff, three patients and two relatives.

We observed care and treatment during the inspection, and also reviewed patient documentation. The ICU had a computerised information system (CIS), known as MetaVision, which had been in place since 2008; the MHDU had paper records. We reviewed eight sets of notes from the CIS, and five sets of patient records from MHDU.

We found that the critical care service was safe, effective, caring and responsive to meet the needs of patients and relatives, and the service was well-led, with strong local leadership of the units. Accommodation facilities were available for relatives to use.

Medical staffing levels were in line with national guidance, Core Standards for Intensive Care Units 2013, with factors such as case mix, patient turnover, and ratios of trainees considered. Consultant staffing did not follow the generally preferred model (of blocks of consecutive days), but continuity seemed to be addressed with regular handover rounds.

Nursing staffing establishment levels and skill mix were adequate across both units. Of the band 6 and band 7 nurses, 100% had an intensive care qualification, with 50% of band 5 nurses having the same qualification.

Critical care

The management at service level were clear about their roles and vision for the service. The forthcoming merger with MHDU was a change which concerned some staff, but this was being managed in an open and transparent way, with full multidisciplinary team involvement, and regular forum information sessions.

We found that staff morale was high, and that a supportive environment was in place, with robust competency and training packages, small team allocations, and close working with the wider multidisciplinary team (MDT). Innovation and development were evident from the development of a trigger and response team (TART), which took on the role of an outreach team, and provided support for care of critically ill patients within the hospital, and a nurse-led peripherally inserted central catheters (PiCC) service.

Are critical care services safe?

Good

Services within critical care were safe for patients. Staff were aware of the systems and processes in place for reporting of patient and staff incidents. There had been 40 incidents reported in ICU, and 61 incidents in MHDU. Staff we spoke with said that they were encouraged to report incidents, although they did not always receive feedback about the incidents they had reported. Medical staff were aware of the processes for reporting incidents, although they felt that most issues were reported by the nursing team. Feedback was available via unit communication books, newsletters and email.

Medical and nursing staffing levels were adequate. We found a good level of consultant clinical involvement and support in place, including out of hours and at weekends, and similarly good support of senior nursing staff. One member of senior nursing staff was designated in charge on a daily basis. This person was supernumerary in ICU, but this was not always the case in MHDU. Nurse to patient ratio was 1:1 for level 3 patients, and 2:1 for level 2 patients. One non-registered member of staff was allocated on every shift. Turnover of staff was minimal, with one whole time band 6 vacancy on ITU. Agency staff levels were between 10 and 15% in October and November 2014. Competency packages were in place for agency staff.

There was good multidisciplinary working by critical care staff, and mutual respect for staff in the department. There were three ward rounds each day, with a larger ward round on a Monday and Friday to ensure consistency over the weekend.

We found support and response from pathology and radiology was good, with instant availability and viewing of films and results available via the computerised information system (CIS).

The environment was clean, and each bed space area was adequate for equipment access. The proportion of single/isolation rooms was low by modern design standards. Arrangements were in place for the effective control of infection and management of medicines.

Incidents

- There had been three serious incidents that required investigation within the ICU in the last 18 months, and two within the MHDU. These incidents related to grade three pressure ulcers, medication administration, and a maternal admission. Root cause analysis had been undertaken and actions implemented to reduce the risk of reoccurrence. There had been no 'never events' reported.
- Systems and processes for the reporting of incidents were in place. Junior and senior staff were aware of how to report incidents via the Datix system, which was accessible online.
- A total of 40 incident reports had been submitted in ICU and 61 in MHDU in the period April-November 2014. A log of incidents was in place, and learning was disseminated through communication books, and at team meetings. Time was allocated monthly for band 6 and band 7 meetings, and minutes were produced.
- We saw evidence learning in place following a serious incident on a general ward (patient death due to blocked tracheostomy). A multidisciplinary guideline had been devised and implemented. A weekly multidisciplinary team ward round was undertaken of all patients with tracheostomy, and enhanced teaching, training and support to the wards was in place. Patients were reviewed weekly by the trigger and response team (TART), and an e-learning package was developed and implemented for doctors.

Safety thermometer

- We saw that information about staffing levels, mandatory training, staff hygiene, pressure ulcers, complaints and compliments were displayed on noticeboards in both units. This dashboard of information contained monthly and year to date (YTD) data.
- Data showed that ICU had ten grade two and one grade three pressure ulcers YTD, and MHDU had five grade two and one grade three YTD. We reviewed three of the root cause analysis documents for pressure ulcers, which had been completed in a timely fashion, and had clear and reasonable action plans; one of the three had been classified as avoidable.
- Risk assessments for patient pressure ulcers and venous thromboembolisms (VTE) were completed on admission and updated regularly, and had been documented in the CIS and nursing notes.

Cleanliness, infection control and hygiene

- The equipment and environment within critical care was noted to be visibly clean. Hand gel was available at the entrance to the department and throughout the unit. We observed the use of 'I am clean' indicator stickers, which were in place on items of equipment.
- Staff hand washing / hand hygiene audits were completed monthly, and both units had scored 100% compliance. Staff followed the trust policy on infection control.
- The 'bare below the elbow' policy was adhered to, and hygienic hand-washing facilities and protective personal equipment, such as aprons and gloves, were readily available. We observed that aprons were colour-coded for each bed space to easily identify if staff did not change their aprons if they needed to assist other patients, which was good practice.
- We observed staff wearing the correct personal protective equipment (PPE) when undertaking clinical care with patients. Isolation protocols were seen on MHDU, with a patient in a side room.
- Each bed space was noted to be clean and have adequate space to allow for equipment and interventional care to be undertaken.
- Both ICU and MHDU had one housekeeper between the hours of 8am and 4pm, Monday to Friday, and staff spoke highly about the role of the housekeeper. Out of hours and at the weekend the non-registered member of staff assisted with the cleanliness of the unit.
- Intensive Care National Audit and Research Centre (ICNARC) data for infection rates (from October 2013 – June 2014) showed that there had been no incidence of unit acquired C. difficile infection or MRSA infection. Incidence of catheter-related blood stream infections (CRBSI) were low.
- MRSA screening was undertaken on admission and weekly thereafter, and documented on the CIS.
- We saw evidence of supervision and direction to new starters regarding infection control practices, and this was also included in medical staff induction.

Environment and equipment

- Electrical testing stickers were seen to be in date on items such as portable warming devices.

- We saw that the resuscitation equipment was checked daily and restocked; there was a record which stated the time of the inspection, and the individual who had undertaken this check.
- Use of dedicated technicians (critical care scientists) was in place to support equipment in the critical care service, to ensure safe and effective use was maintained. The team provided on-site support Monday to Friday, from 8am to 8pm.
- A member of the team gave an example of a recent issue where two pressure relieving mattresses had been reported with holes in similar locations. The team identified a potential user issue, and communicated to the ICU staff some improvements to prevent reoccurrence. This was documented in the communication book; however, staff stated that a more appropriate method of communication would be utilising the email option on the computer information system, but this was not in use.
- A robust, replacement indicator programme was in use, which had a risk framework attached. Biomedical engineering had a flag system when equipment was due to go out of service, and the item would be highlighted to senior staff via email. This system was seen by staff as an improvement, and staff felt that generally, equipment was replaced in a timely fashion due to the complexity of the equipment in use.

Medicines

- We examined the medicine storage area in ICU and MHDU. Medicines were stored correctly and securely. All medicines, including intravenous fluids, were stored in locked clean utility areas, and access was via a swipe card, which was closely monitored by the lead nurse. Two agency swipe cards were available, which were sanctioned on a daily basis when required.
- We observed adequate security measures in place for the storage of controlled drugs. The controlled drugs were checked and accounted for, with daily checks by two members of staff recorded. We saw that administration of controlled drugs was recorded. The stock balance of an individual preparation was confirmed, including recording of specific amounts administered and discarded.
- We found that fridge temperatures were being regularly recorded. Acceptable parameters in temperature were displayed, and staff were aware of actions required if temperature changes occurred.

Records

- ICU had a computer information system (CIS) called MetaVision, which provided full medical, allied healthcare professional and nursing notes, and included daily checks by the nursing staff. Staff had individual log-ins for the CIS, which identified the individual making entries. Support and response from pathology and radiology was good, with instant availability and viewing of films and results available on the CIS.
- In MHDU, paper records were still in use; entries in notes were dated, timed and signed with designation and contact details. We reviewed five sample sets of medical and nursing notes on MHDU. The majority of notes provided clear documentation, with good examples of multidisciplinary entries seen. However, some notes from A&E were less detailed, with some loose multiple sheets stuck into notes with Micropore tape.
- Robust physiotherapy and occupational therapy rehabilitation plans were seen. Plans exist to adopt the full MetaVision CIS across all areas once the MHDU becomes part of critical care in 2015.
- Clear detailed documentation of invasive lines, including date of insertion, duration and infection control practices, were recorded.
- Risk assessments for patients for pressure ulcers, falls and VTE were being completed appropriately, and reviewed at the required frequency. Risks assessments identified required actions to minimise risks to patients.

Safeguarding

- Staff confirmed that they had received safeguarding awareness training, and confirmed actions that would be undertaken to keep people safe. Staff were aware of their safeguarding responsibilities.
- We reviewed eight patient records on the computer information system. One patient had a safeguarding issue identified, which had been escalated and included in the discharge handover.

Mandatory training

- Mandatory training records showed 99% completion in ICU, and 95% completion in MHDU.
- There were 85 nursing staff in total across both areas. In each area, the nursing staff were allocated into teams with an individual band 7 as the responsible lead. Staff training and attendance was monitored both by the lead nurse and by the band 7.

- There was an education and audit room for the ITU / MHDU teams. This was utilised regularly, and had equipment and multiple screens to enable live streaming of teaching, and viewing of multiple sets of information.

Assessing and responding to patient risk

- Patients were monitored using recognised observational tools and monitors. Within the computerised information system (CIS) were certain (mandated) score observations that had to be completed in order for the record to progress and be saved. Embedded guidelines were included in the CIS to provide decision support, such as guidelines on sedation, cooling post cardiac arrest and tracheostomy care. This provided immediate information availability for staff. However, it was noted that the majority of guidelines seen did not have an identified author, or issue and review date.
- The hospital used a national early warning score tool (NEWS); the score alerted doctors, nurses and the trigger and response team to which patients were deteriorating and needed to be reviewed urgently. We saw that this ensured that staff provided early and appropriate treatment.
- A deteriorating patient group was in place, which was consultant-led. However, this had not been attended well by other groups (surgeons and physicians). The director of nursing had agreed to attend forthcoming meetings with a view to helping to improve attendance.
- Nursing handovers occurred twice a day. Staff told us that as they were a small unit, they were able to communicate any changes to patients or other risks to other staff easily.

Nursing staffing

- Staffing levels were 92% for ICU and 89% for MHDU, with a small turnover of staff. When staffing levels were not met from permanent staff, the unit used agency or bank staff to cover absences.
- We were informed that there was a small regular group of agency staff who were used for consistency, and saw paperwork evidence of agency induction and orientation to the unit, and a specific competency pack for agency staff. Bank shifts were covered by staff already working on the units.
- Nursing ratios to patients were in line with national guidance: 1:1 for level 3 patients, 2:1 for level 2 patients. We saw individual 1:1 care and this was corroborated with the rota. There was one non-registered member of staff allocated on each shift.
- New staff remained supernumerary for a period of two weeks. We spoke with a member of the team who had been in post for six weeks. She informed us that the supernumerary period had taken place, and a mentor was identified and worked with her. Team allocation and support was provided from the beginning, and she felt supported.
- A supernumerary senior nurse led each shift on ICU; however, the nominated lead for MHDU was not always supernumerary. Senior staff from ICU already worked across in MHDU in preparation for the amalgamation to ensure consistency and communication.
- Face-to-face handovers took place at every shift change, morning and evening. At each evening handover the multidisciplinary team would attend, including the trigger and response team member of staff.

Medical staffing

- Care in the ICU was led by a team of intensive care-qualified consultants. An intensive care consultant was available to the unit at all times, and would not be covering any other clinical responsibilities during this period. Medical cover out of hours was provided by one trainee and one consultant.
- The consultant rota followed a locally-agreed model of one day a week. This did not follow the pattern of multi-day blocks of consultant cover, which is generally accepted as best for continuity of care, and is recommended in the core standards for intensive care units. However, the medical staffing model used was confirmed by both senior and junior medical staff as locally effective and reliable, with high levels of involvement and overlap from the consultants.
- The surgical consultants review their patients daily on the ICU/HDU. They discuss management plans of these patients with the ICU consultants and alert them to deteriorating patients on their ward under their care. In complex cases a multi-disciplinary team meeting is convened. Specialist input from services such as cardiology occurs case by case.
- There was a robust induction in place for medical staff, which included familiarisation with the unit and

equipment, roles and responsibilities, mandatory training, tracheostomy, e-learning and CIS training. Doctors were also required to work a shift on the unit alongside the nursing staff.

Major incident awareness and training

- The trust had a major incident plan in place. Each designated area had a response card with the policy, highlighting actions; ICU was action card 37. Staff confirmed verbally that they were aware of the major incident plan and were able to find the information quickly. The policy was available on the intranet, and a hardcopy of the action card was laminated and displayed in each unit.

Are critical care services effective?

Good

Critical care services were effective. Good outcomes were achieved for the care, treatment and support of patients. Positive patient feedback was observed and received during the inspection, regarding both treatment and outcome of care.

Patients care and treatment was routinely documented and reviewed, supported by the computer information system (CIS). All staff within the multidisciplinary team were seen to work collaboratively, and were involved in assessing, planning and delivering patient care and treatment.

Staff were qualified, in line with best practice, and the continuing development of staff skills, knowledge and competency was seen to be ongoing and fully embedded. There was an appraisal system in place for permanent clinical and administration staff, and mandatory training provided.

The lack of bathroom facilities for patients on ICU was recognised by staff as a limiting factor in the patients' rehabilitation process. Staff had fundraised, and plans were in place for provision of a wet room in ICU to address this.

Evidence-based care and treatment

- Data from the national case mix programme, provided by the Intensive Care National Audit and Research Centre (ICNARC), was limited. This was apparently due to prior technical issues with the computer system submission (verified by ICNARC). The only data available was from October 2013-June 2014 and therefore, it was difficult to clearly benchmark performance. However, based on the nine months of available data, mortality outcomes were better than the England average and health care-acquired infection rates were low.
- The computer information system (CIS) supported good clinical audit. A programme of audit was embedded into the system, with set requirements for regular review, such as Waterlow score, sedation guidance, and nutrition and hydration. Care pathways within the CIS had clear and detailed documentation.
- There was an ongoing plan for audit submission at local, regional and national level, with planned involvement of medical trainees. A total of nine audits had been submitted between April 2013 and March 2014. The NICE 50 gap analysis and head injury audit had been completed and submitted ahead of schedule.
- The ICU had implemented and sustained quality improvement initiatives. One example of this was the ongoing data collection from the 'Matching Michigan' audit that identified improvements to reduce the rate of catheter-associated bloodstream infections. This audit ended in 2011; however, ICU had continued to monitor against this as an indication of best practice.
- We reviewed five sets of patient notes from MHDU, and routine clinical care and daily assessments of patient condition were recorded, such as observations, care rounding, positioning, falls assessment, Waterlow score and VTE assessment.
- We viewed the environment in accordance with the advisory standards of Health Building Note 57 (HBN 57) for critical care facilities, and although not all were met by the built environment, there was adequate provision for good infection control practice.

Pain relief

- Medication and sedation was continually monitored and documented within the CIS system. The patients who were able to speak with us confirmed that they were regularly asked about their levels of pain.
- The critical care service had access to a unit based epidural service from the trust wide pain relief service.
- There were clinical guidelines and patient pathways for staff to follow when patients were in pain.
- There was a pain team who supported the service Monday to Friday as well as providing education, training and support for ward staff.

Critical care

Nutrition and hydration

- Patients who were unable to eat or drink received nasogastric feeding within 24 hours of their admission to ICU and HDU.
- Daily assessment for nutrition and hydration was recorded for each patient. This assessment was part of the daily 'must do' nursing assessments in the CIS.
- There was no lead dietician for the critical care services. The assessment, implementation and management of appropriate nutritional support for patients was led by the consultant, in collaboration with the MDT. Dietetic advice was sought when required.
- One patient said that breakfast was delayed at times due to staff handover, and toast was cold. However, nursing staff would make fresh toast when this occurred, and patients confirmed that lunchtime and evening meals were given promptly. Another patient confirmed that he had received help at mealtimes when necessary.

Patient outcomes

- Early readmissions were low (1%) suggesting that discharge processes were effective.
- Time to admission data after referral was well documented, and prompt responses were evidenced and were within the four hour standard.
- All pressure ulcers above grade 2 were reported as an incident on the Datix system, and a duty of candour letter was sent from the tissue viability nurse. Pressure ulcer grading information and pictures were displayed in the staff room in ICU for training and information.
- Mortality and morbidity meetings were undertaken monthly and were well attended by all staff groups. Minutes were seen of meetings during 2013; however, a change of consultant had meant that no minutes from meetings had been regularly taken throughout 2014.

Competent staff

- Across the critical care service 100% of band 6 and band 7 nurses, and 50% of band 5 nurses had an intensive care qualification.
- ICU had a band 6 clinical nurse lead / educator who provided teaching, supervision and support to all unit staff to enhance clinical skills. This role was 50% supernumerary and was valued by the staff we spoke to. This role included organising student rotas and liaising with the education manager. A training spreadsheet was maintained, and team days were allocated to allow for learning and development and mandatory training to take place.
- Consultant support and provision, including weekends, was good. Two medical staff informed us that there were allocated clinical and educational supervisors, who provided ongoing support and feedback, providing a positive and supportive learning environment.
- All nursing staff we spoke with confirmed that they had received a local induction and annual appraisal. Data showed that 83% of ICU staff, 89% of MHDU staff and 100% of the trigger and response team staff had received their appraisal prior to the inspection.
- Nurse competencies packages were in place that advanced in complexity to enable ongoing development.
- Ongoing development was supported throughout the service. We spoke with one band 7 member of staff who, alongside four other colleagues across the trust, was currently undertaking a two year Masters qualification as part of the NHS Leadership Academy. This was supported from board level, and they had accompanied the director of performance to clinical commissioning group (CCG) meetings as part of this course.
- We spoke with junior doctors, who felt that they received good support from consultants and nurses, and who stated that they were introduced to the working of the unit in a way that was not replicated in some other trusts.
- We spoke with one newly-appointed consultant, who told us that they felt supported, and he was observed to have an excellent rapport with patients and other staff. He stated that the induction and essential skills training had been good, and that the unit was well known to be a good place for trainees due to the levels of mentoring and support.

Multidisciplinary working

- A strong multidisciplinary approach was evident throughout the critical care services. Daily multidisciplinary team ward rounds were well represented from all groups: medical, nursing, trigger and response team, physiotherapy and pharmacy.
- We observed multidisciplinary ward rounds taking place, and they appeared to function well, with the involvement of all staff.

- The service had a dedicated team of physiotherapists - six full time substantive physiotherapists supported by one band 3. Patients were seen within the first 24 hours of admission, and care plans and treatment were discussed collaboratively with nursing and medical staff.
- Patients confirmed that weekly targets were set by the occupational therapist and physiotherapist teams, which were achievable and motivating, and progression was clearly documented in patient notes.
- A member of the trigger and response team visited every patient following their discharge from the critical care unit, to ensure support was provided to the ward areas.
- All staff reported that the unit provided effective care because of strong 'team working'. Nursing staff confirmed that the response from the medical team was supportive, constant and consistent.

Seven-day services

- The trigger and response team were available seven days a week, as was the support from physiotherapy.
- Consultant cover was provided seven days a week, and ward rounds continued as per weekdays; that is to say, three times a day over the weekend. Custom and practice was that the consultant cover for the weekend attended the ward round and handover on Friday evening.

Consent and the Mental Capacity Act 2005, and Deprivation of Liberty Safeguards (DoLS)

- Patients were, whenever possible, asked for their consent to procedures appropriately and correctly. Patients who were able to speak to us were able to confirm that they were asked to give permission for treatment.
- Frequently, intensive care and high dependency patients may be unconscious or may be unable to provide their consent. Staff were able to provide examples of patients who did not have capacity to consent, how they acted in the patient's best interests, and whenever possible, consulted with their relatives. We found that the Mental Capacity Act 2005 was adhered to appropriately.
- Documentation of discussion and support provided was seen in both medical records in MHDU and ICS on ICU. We reviewed thirteen patient records (eight in ICU / five in MHDU), and found clear and well documented assessments of Mental Capacity Act assessments (MCA 1&2) and Deprivation of Liberty Safeguard assessments (DoLS) in both the computer system and paper notes.

Are critical care services caring?

Good

Critical care services were caring, and we observed patients and relatives being treated with compassion, kindness, dignity and respect. The 1:1 ratio of staff to patient enabled the staff to build up trusting relationships with patients and their relatives by working in an open, honest and supportive way. Patient and relative feedback was actively sought through a variety of methods.

We received feedback from patients confirming that they were involved with decisions about their care; they felt supported and cared for throughout and were very positive about the standard of care received.

We saw support and information being given to relatives in a respectful, dignified way. Counselling, spiritual care, and chaplaincy service information were on display outside the ICU.

Separate facilities were available for families should overnight accommodation be required. A relative's room was available on ICU, however not on MHDU. Staff had recognised this as a need and had plans to try and accommodate this.

Compassionate care

- Throughout our inspection, we saw patients being treated with compassion, dignity and respect. Patients and relatives we spoke to were highly complimentary about all the staff in the unit. Patients stated that staff were caring, friendly, approachable and responsive to their needs. Examples of comments from patients were, "nice nurses" and "feel safe" and "staff were excellent, polite and caring and asked regularly about pain''.
- Staff were observed to treat patients and their relatives with compassion and respect, and ensured that patient's privacy and dignity were maintained at all times. Due to the range of patient complexity, the patients were allocated to a bed space according to

acuity, which resulted in male and female patients being next to each other. One patient confirmed that at all times her dignity was maintained by the nursing staff, and curtains were used for privacy.
- Relatives were encouraged to visit. Visiting hours were allocated from 1.30 to 3pm and 4.30pm to 8pm to allow patients time to rest. Flexible visiting time was at the discretion of the nurse in charge, for new admissions and patients who were at the end of life. Open visiting time was available for relatives of patients with dementia.
- Accommodation was available for relatives to stay, which consisted of a separate living room area, and two bedrooms with en suite showers. Keys were held by the lead nurse who facilitated this when required.
- Satisfaction surveys were available for patients and relatives to evaluate their experience of the critical care department. There was also a comments box located outside the ICU, and business cards displayed on the noticeboard, with a dedicated email address to give consultant feedback. There was a plan to develop the website to include specific patient support information.

Understanding and involvement of patients and those close to them

- The nature of the care provided in a critical care unit meant that patients cannot always be involved in decisions about their care. However, whenever possible, the views and preferences of patients were taken into account. We spoke with three patients, who all confirmed that they were involved in decisions regarding their care.
- Patient preferred names were identified on boards at each bed space alongside the patient's consultant details.
- Patient consent was documented in the CIS system, and frequent discussions with relatives were documented. Patients confirmed that explanations were given, and consent was sought before any interventions had taken place.
- During peripheral line insertion procedures, patients had the choice for relatives to stay with them. We reviewed ten satisfaction surveys, and 80% of patients rated the service ten out of ten and contained positive responses.

Emotional support

- Relatives that we spoke with said that they had felt very well supported, and that staff had given clear explanations of treatment. They felt that sufficient time was given by the staff for discussions. During our inspection we saw staff utilising the relatives' room in ICU, to hold a private conversation with the family of a patient who was nearing end of life.
- Counselling services were available and staff knew how to access them. Staff confirmed that this was also a service that could be accessed by them personally if needed. The chaplaincy service was available 24 hours a day.

Are critical care services responsive?

Good

The critical care services were responsive to the needs of their patients. The overall capacity of the critical care service was adequate, and patients received timely care in the unit. If admissions increased, ICU stepped out to MHDU, and there were minimal cancellations of surgery. However, delayed discharges had occurred due to unavailability of step down beds on the wards.

Patients who were discharged from the unit were aware of their discharge plans, and had appropriate records and information to provide ongoing care.

A trigger and response team (TART), and nurse-led peripherally inserted central catheters (PiCC) service, had been developed in order to support the care of critically ill patients within the hospital, and optimise timely treatment to enable patients to remain in the community. Business cases were in progress to expand both services, and the gap in provision was recorded on the risk register.

Service planning and delivery to meet the needs of local people

- ICNARC data showed that numbers were above the England average for elective and emergency surgical admissions, which was corroborated by the lead clinicians. The increase in elective surgery had fostered good relationships between consultant intensivists and other consultants across the trust.

- Airway support was provided by the first on-call anaesthetist, and good working relationships were evident between the intensivists, and the anaesthetic department and burns teams.
- The trigger and response team (TART) consisted of five members of staff, and service provision was provided from 8am to 8.30pm, seven days a week. Cover overnight was provided by the clinical operations manager; however, a business case was underway to increase the service to 24/7. A member of the TART team attended the 'hospital at night' handover.
- The TART team responded to cardiac arrest calls across the trust. There was a sepsis steering group in place that met every two weeks, and a 'Sepsis Six' pack had been introduced as a trust-wide initiative to reduce mortality from sepsis, with focus on early identification and intervention.
- The sepsis CQUIN target of 26% had been missed; however, the trust had reached 19.66%, which showed significant improvement. (CQUIN is the Commissioning for Quality and Innovation payment framework, which encourages the achievement of quality improvement goals.) A sepsis study day was advertised for February 2015, and the lead nurse informed us that this was due to be attended by the chair of the UK sepsis trust.
- The consultant lead for critical care services was a trained paediatric anaesthetist. First response for paediatrics within resuscitation was provided by the burns unit; however, ICU consultants were consulted if children were slightly older.
- There was a protocol in place to stabilise children prior to transfer, dependent on utilising the skills of paediatric-experienced senior anaesthetic staff. A registered sick children's nurse (RSCN) from Phoenix ward is provided to support ICU staff if the situation occurred that a child was on ICU awaiting transfer.

Meeting people's individual needs

- A daily patient assessment was undertaken in the CIS to assess skin condition, and there were two bariatric beds available, and 13 specialist pressure relieving mattresses were in use.
- Staff demonstrated good understanding of the need for an holistic approach. One example of this was a patient who had responsibilities as a carer for her husband with dementia. The nurse in ICU contacted social services to ensure that a carer was organised for the husband, which helped reduce the anxiety of the patient and improved their physiological condition.
- There was no designated speech and language specialist attached to the service. This was assessed as part of the clinical critical care pathway, and as part of the multidisciplinary consultant-led ward rounds. Referral was made for patients when longer-term issues were identified. The use of hearing aids was documented in patient records.
- Staff demonstrated a good understanding of people's social and cultural needs. Translation and interpretation services were available, both by phone and in person. There were picture boards, spelling boards and marking boards available on the unit, to assist with communication with patients. Staff were investigating the use of technology / tablet surfaces for rehabilitation aides.
- Difficulties discharging patients who no longer required ICU or MHDU care meant that the hospital was challenged to comply with single-sex ward areas, and bathroom and toilet facilities, because patients of different sexes could be accommodated in the same area. Staff recognised this alongside the importance of patient rehabilitation. The issue was included on the risk register, and staff had participated in local fundraising to provide a wet room in ITU and a relative's room in MHDU.
- Manual handling team staff were seen reviewing patients in the MHDU to ensure that manual handing techniques and equipment were appropriate and meeting patients' needs. We observed that the teams were engaged with recognising a patient's individual needs.

Access and flow

- ICNARC data between October 2013 and June 2014 showed that the average bed occupancy rate was 10 beds in ICU. There was an ability to step up recovery care for ventilated patients overnight should the necessity arise.
- The number of non-clinical transfers from the hospital's ICU and MHDU to other hospital's critical care units for non-clinical reasons was low.
- The number of elective and emergency admissions was higher than the national average.

Critical care

- The number of delayed discharges were high at 65%, with 20% delayed for more than four hours. The majority of discharges from the unit occurred during the day between 8am and 10pm, in line with national guidelines.
- We spoke with one patient who had been in ICU for three days and then in MHDU for three weeks. He said that he had felt prepared for the move to MHDU. He was impressed with the knowledge and care he had received from the nurses, and felt everything had been explained.
- Delayed discharges were high, which reflected that bed flow management within the trust was under strain. This was confirmed by staff locally, who said that patients' discharge out of the unit was often delayed due to waiting for an available bed on the wards.
- During the inspection, a staff member spoke with the inspection team regarding their concerns about the trust-wide capacity issue resulting in some poor patient experiences, and how it was having a negative impact on the running of critical care services. Whilst there were no confirmed experiences with poor outcomes, the high bed occupancy could support that there was a risk of poor experiences due to low bed capacity.
- There were designated wards that received patients from ICU to enable continuity and consistency of care.
- We were informed that an urgent care hospital flow programme board was accountable to a systems resilience group, where the hospital at night cover was reviewed and actioned.

Learning from complaints and concerns

- Patients confirmed to us that they knew how to raise complaints and concerns, and felt comfortable to do so. One patient stated that he felt that any concerns raised would be welcomed, and staff confirmed the process for complaint handling.
- One member of staff stated that there had been one bullying and harassment complaint in 2013, which had been dealt with appropriately. It was formally investigated and actioned, and both staff were supported throughout.

Are critical care services well-led?

Good

There was strong local leadership in the critical care unit led by the senior consultant and lead nurse. The leadership team ensured that there was shared learning in the team and support for staff.

The challenge of the changing landscape for critical care services was recognised by the team, with the pressures of patient flow and avoiding cancellations paramount. Increasing numbers of admissions from elective and emergency surgery had resulted in a 50:50 ratio of medical and surgical admissions. Leaders were aware of the need to be open and work collaboratively, and there was recognition that an integrated critical care service with MHDU would improve patient care.

There had been an unsettling period due to some short notice changes in consultant staff; however, the team had been proactive in responding, and had undergone an external process of review, undertaken consultant recruitment, and reallocated clinical roles to refocus efforts.

Vision and strategy for this service

- There was a clear vision identified by both the lead clinician and lead nurse, to provide an integrated patient and relative-focused service; however, this was not clearly translated into a written strategy.
- Clinical research had been a low priority, however, a plan for recruitment was implemented, and a new consultant had been recruited to refocus this aspect.
- There was evidence of an ongoing recruitment plan over the next five years, and additional nursing staff had been identified as a requirement for the integration of MHDU into the critical care directorate, which was partially responsible for the extension from January 2015 to March 2015 to allow for staff recruitment.
- There had been significant successful projects within the critical care services, such as the trigger and response team, sepsis intervention, and the peripheral inserted central catheter service, which were well recognised within the units. However, these successes were not shared in a wider aspect across the trust to the extent that they could have been.

Critical care

Governance, risk management and quality measurement

- The critical care service actively participated with the critical care network, and had a nominated consultant lead identified who had participated in peer review, with the aim to drive standards, support quality improvement, and support sharing of best practice.
- There were dedicated non clinical days for the nursing staff allocated weekly to undertake additional roles and audits, such as infection prevention, and staff confirmed that the time was made available.
- Newsletters had been introduced (from August 2014) which provided information regarding learnings. The October newsletter had articles relating to the sepsis bundle, tissue viability, and a health and safety update, which outlined Datix topics and ongoing monitoring of potassium administration following an incident.
- Senior staff were able to identify and discuss the main risks that were on the risk register. The risk assessment framework was provided, which corroborated the staff awareness. The main risks that were identified were the suboptimal position of the peripherally inserted central catheters (PiCC) service, nursing levels for full MHDU integration, bathroom facilities on ICU, and the replacement programme for the computer information system.
- Twenty five sets of notes each month were reviewed by a multidisciplinary team using the global trigger tool, to identify any occasions where care may not have been optimum. Feedback was then given to the senior board, governance meetings and individual area leads. Learning summaries were seen from July, August and September 2014.
- Clinical governance meetings took place, and the agenda and minutes were reviewed, and included learnings from the global trigger tool, incidents, mortality reviews and patient Safety Thermometer.
- Staff were encouraged to participate and join with nationally-recognised organisations, such as the annual ICNARC conference, and the world congress for vascular access for quality assurance and best practice.

Leadership of service

- The critical care service was led by a consultant intensivist and lead nurse, who provided effective team leadership, and were respected by the staff we spoke with. All staff confirmed a friendly and supportive culture.
- Staff were divided into teams, with a band 7 clinical lead for each, and team members were clearly identified on the noticeboards in ICU and MHDU. Time was allocated for team meetings and training days.
- Additional roles and responsibilities were identified for each team lead to enable ongoing staff development, and this was then monitored through appraisal with the lead nurse.

Additional responsibilities included management, infection prevention, facilitator, computer information system, documentation and risk.

- A strong multidisciplinary team approach was evident with regular ward rounds and a Monday 'grand round' providing continuity of decision-making.
- Ongoing development was clear, and all band 6 and 7 nursing staff attend a frontline leadership course.
- The lead nurse and consultant were visible within ICU and MHDU, and staff confirmed that the lead nurse took part in clinical days working on the unit and taking patients, and we observed this during the inspection.

Culture within the service

- Consistent staff levels within the service were evident, with many staff remaining in post for a long period of time and achieving career progression. Three band 7 staff had been with the trust for over ten years.
- Succession planning was evident, with development ongoing of senior band 6 staff to accommodate for the upcoming retirement of three band 7 staff by 2016.
- Staff identified a supportive culture and cohesion within the team across all levels of staff. At times staff have to deal with difficult outcomes for patients, and they confirmed that they support each other, with regular 'huddles' to discuss difficult situations.

Public and staff engagement

- Staff said that they felt involved with the plan to integrate MHDU under the critical care directorate.

Meetings and forums had taken place, and were ongoing to ensure staff had the opportunity to be involved.

Critical care

Innovation, improvement and sustainability

- Staff were motivated to recognise areas of improvement. The team had regularly undertaken events to fundraise for the service. The implementation of the computer information system was strongly led by the senior team, which included raising over £100k.
- The team had recognised that the patient rehabilitation facilities require development, and latest fundraising had achieved £17k towards planned refurbishment of the end bay in ICU into a wet room.
- The nurse-led peripherally inserted central catheters (PiCC) service was not funded initially, but was supported by the lead nurse; staff aspire to develop this further into a complete vascular access service.

Maternity and gynaecology

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

Information about the service

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

The inspection team visited all three locations during the inspection and spoke with 58 staff and six patients. We visited antenatal and postnatal services, as well as the labour ward, and theatres providing obstetric-related surgery, and carried out an unannounced inspection at the weekend. We observed care on Writtle (gynaecology) Ward, and visited both midwifery-led birthing units, which include liaison with the community midwifery teams. There were 4,323 deliveries by Mid Essex NHS Trust last year.

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

Summary of findings

We found that the current safety arrangements in maternity and gynaecology services required improvement. Whilst the total number of reported incidents continues to rise the number of reported staffing issues is low by comparison. The current level of supervisor of midwives investigations, and the number of serious incidences, especially on the labour ward, over 2014, was five which was higher than expected for the size of the trust.

We found that there was limited measurement and monitoring of safety performance, and when concerns were raised or things go wrong, the approach to reviewing and investigating causes was insufficient or too slow.

Training for the unwell patient was being actioned; however, we had concerns during the inspection on Writtle (gynaecology) Ward, where there were delays in escalation of concerns regarding a deteriorating patient at night and prompt treatment, which could put the patient at risk.

Whilst medical staffing was appropriate, the midwife to birth ratio was worse than the recommended figure at 1:33 midwives to births. We saw that there was consistently high usage of agency and bank staff in the labour ward, and especially in Writtle (gynaecology) Ward over the past year, where over 50% of staff on

Maternity and gynaecology

occasions were agency. Agency staff, including locums, did not receive a signed off induction to evidence familiarity and knowledge of core risk practices within the units.

The maternity unit was in line with the England average for the maternity survey, and our data information showed that they generally performed better than the national average in the recommending to Friends and Family Test, although recent response rates had been low.

Changes were made to services, such as the removal of the birthing cap over 12 months ago, which allowed access to women out of the area, resulting in between 11% and 23% increase in demand, without due regard for the increased birth rates and impact on people's needs.

Services were not always planned and delivered with consideration of people's needs. The admission criteria for medical outliers on Writtle (gynaecology) Ward was being continually breached, such as patients at risk of falls being admitted who required constant supervision. This impacted on the staff's ability to provide appropriate sensitive care to termination of pregnancy patients in the side rooms. This did not meet people's needs and was inappropriate.

We raised concerns throughout the inspection regarding the lack of monitoring practices for key clinical indicators, such as waiting times, cancellations and delays that staff had highlighted as the key clinical risks, and also the lack of risk audits being actioned in response to them.

Are maternity and gynaecology services safe?

Requires improvement

We found the current safety arrangements in maternity and gynaecology services required improvement. There were arrangements in place for reporting patient/staff safety incidents and allegations of abuse. Whilst the total number of reported incidents continues to rise the number of reported staffing issues is low by comparison. The current level of supervisor of midwives investigations, and the number of serious incidences, especially on the labour ward, over 2014, was five which was higher than expected for the size of the trust.

The lack of clinical offices in the antenatal and postnatal wards was a concern, especially regarding records storage, private conversations and handovers. Also, the waiting area in the antenatal ward was cramped, and could not cope with demands at times, with standing room only.

Mandatory training, including safeguarding measures, were in place, and staff were positive about the content. Training for the unwell patient was being actioned; however, we had concerns during the inspection on Writtle (gynaecology) Ward, where there were delays in escalation of concerns regarding a deteriorating patient at night, and prompt treatment, which could put the patient at risk. We raised this with the provider at the time of the inspection.

Whilst medical staffing was appropriate, the midwife to birth ratio was worse than the recommended figure at 1:33 midwives to births. We saw that there were consistently high usage of agency and bank staff in the labour ward, and especially in Writtle (gynaecology) Ward over the past year, where over 50% of staff used were agency. The key concern was the length of time this had been going on, as substantial or frequent staff shortages increase risks to people who use services. This was raised with the provider at the time of the inspection.

Incidents

- We looked at incident reporting policies, a database which included maternity incidents raised by staff, and the chief nurse's report for September 2014, and we

found that there were arrangements in place for reporting patient/staff safety incidents and allegations of abuse. There was a specific trigger list for maternity staff guidance to ensure robust reporting measures.

- We spoke with staff at all levels of the maternity and gynaecology departments who were familiar with reporting practices, but it was clear there was under-reporting at times.
- The majority of staff noted increasing numbers of readmissions to the postnatal wards; at least two to four per week, including three readmissions on the previous Saturday evening. Staff acknowledged that through lack of time, and also, in some cases, a nervousness to escalate concerns, they did not always report these.
- We looked at the Datix reported numbers, which were significantly less than those reported by staff. This was a concern, as staff noted too early discharges due to bed pressures, and a theme of poor feeding support causing readmissions, which were not being audited or investigated as the level of concern was not highlighted by the reporting system as significant.
- We looked at the investigations and reports for a cluster of serious incidents in maternity, such as unplanned maternal admissions to ITU, and misinterpretation of cardiotocographs (CTGs), which were discussed at patient safety and quality meetings. There were actions, including additional training for staff in critical care monitoring, and in CTG analysis, being planned to improve this.
- The specialist midwife inspectors noted that the current level of supervisor of midwives investigations had been, and remained, at a consistently high level: currently at five this year, whilst the number of serious incidences, especially on the labour ward over 2014, was higher than expected for the size of the trust.
- We saw minutes from the monthly perinatal mortality meetings, which showed discussions and case reviews by multidisciplinary teams to consider any changes to practice to improve outcomes for patients.
- There were six maternal unexpected admissions to ITU, which is higher than the expected rate. All were investigated, but no theme was highlighted, although the low number of midwives with appropriate critical care experience may have encouraged these actions to safeguard the patients. Additional critical care training is now being actioned.

Safety thermometer

- The maternity dashboard was visibly displayed, which showed the current clinical indicators and governance scorecard for patient safety. We however were concerned about the limited information available on the maternity dashboard.

Cleanliness, infection control and hygiene

- We found no concerns during the inspection of the maternity units and gynaecology ward regarding infection control practices. Ward areas appeared clean, and we saw staff regularly use hand gel between patients. 'Bare below the elbow' and isolation policies were adhered to.
- A recent hand hygiene audit of the delivery suite showed 97% compliance with hand washing. There were 'I am clean stickers' on equipment, curtains and furniture. The wards performed better than others in the maternity survey in relation to cleanliness.
- The maternity dashboard for August 2014 showed on-going non-compliance with emergency MRSA screening in labour, antenatal and postnatal wards. We checked three sets of notes, and screening had been actioned; we also saw leaflets regarding screening for patient information, and patients we spoke with were aware of the screening practices including MRSA.

Environment and equipment

- There were appropriate storage facilities, and staff confirmed that the levels of equipment for safe monitoring were adequate. Resuscitation equipment was in line with national guidance, and we saw that it was checked regularly.

Medicines

- We saw appropriate medication management guidelines, in line with Nursing and Midwifery Councils rules and standards, available for staff reference to promote safe secure and effective management of medicines. This included an agreement by an approved practitioner for the administration and supply of medication (PGD) by midwives within Mid Essex Hospital Services NHS Trust (MEHT).
- There were secure management arrangements for medicines using swipe systems to prevent unauthorised access to medications, and logs of medication errors and themes noted with training actions where

applicable. Staff confirmed and the mandatory training programme showed in-house training was available for all midwives on an annual basis, specifically related to medicines management and drug calculations.

Records

- We saw patient records in unlocked trolleys in the corridor in the antenatal and postnatal wards, as there was no office in which to store them currently. Staff were vigilant, but there was a risk of unauthorised access.
- There had been two breaches of record information practices, which the provider could show discussion and actions being taken to address through hot topics and action logs, such as reminding staff of the importance of ensuring that all paperwork was secured into the mother's notes, and unnecessary paperwork be returned to the patient.
- The lack of available printers in clinical areas also caused concerns, as staff had to run to other areas to prevent unauthorised people having access to the confidential information they had printed off.

Safeguarding

- Staff we spoke with were aware of the named midwife for safeguarding, who attends the safeguarding meetings and approves protocols.
- There was a safeguarding vulnerable adult's policy, which included contact numbers for local safeguarding teams, and staff were familiar with the process for raising concerns.
- We saw through meeting minutes that four referrals had been raised recently by the trust relating to teenage pregnancy, self-harm, neglect and a potential hate crime. Midwives gave other examples where they had raised recent safeguarding issues, such as children at risk being reported on the postnatal ward.

Mandatory training

- The maternity dashboard showed 91.1% compliance with mandatory training.
- Three day inclusive mandatory training sessions included training in relation to safeguarding, domestic abuse, medicine management and care of the high risk patient; all students were encouraged to attend these trust mandatory sessions alongside core staff, and feedback on the quality of updates were good.
- Obstetric emergencies were also practiced by live skills and drills on the labour ward.

Assessing and responding to patient risk

- The trust provide a trigger and response team (TART) to enhance the care of acutely ill patients in hospital, by supporting appropriate and prompt management of patients at risk of deterioration, thereby reducing clinical risk and enhancing patients care. Currently, this is provided during the day and doctors take responsibility overnight.
- We had concerns during the inspection on Writtle (gynaecology) Ward, where there were delays in escalation of concerns regarding a deteriorating patient at night and prompt treatment which could put the patient at risk.
- We looked at recent audit results of the midwifery early warning system (MEOWS), dated 11 November 2014, which supported our concerns. The results evidenced consistent inaccuracies in the recording of observations, such as in the MEOWS chart, where 65% of documentation of urine and vaginal blood loss was not being completed; 27% of MEOWs scores were not recorded; 22% of staff recorded the oxygen saturation results; and 13.33% were not escalated properly.
- There were actions noted to improve the scores, including additional training and review of the charts, with dissemination of findings and education to all staff through a maternity women's and children's newsletter, risk management hot topic, mandatory training and the supervisors of midwives.
- We were concerned about the limited measurement and monitoring of safety performance overall. There were management systems in place but they did not appear to focus on the key risks for maternity such as capacity impacts and medical outliers. When we interviewed senior managers, they were not clear on the key risks for both maternity and Writtle ward. They also could not provide assurances that contingency planning or new ways of working were being considered to support quality improvements.
- Staff told us about regular delays in women having induction of labour, long waiting times in antenatal clinics and elective sections being postponed due to lack of capacity in labour ward and the post natal ward. When we asked for the monitoring statistics we were told that they were not routinely collected which is a concern as staff saw these as key areas of risk.

- We raised concerns throughout the inspection regarding the lack of monitoring practices for key clinical indicators such as waiting times, cancellations and delays that staff had highlighted as the key clinical risks and also the lack of risk audits being actioned in response to them. We made constant requests for data information which was not available during the inspection. It was recognised by senior managers and the maternity risk and audit teams that the lack of a maternity IT system impacted on their ability to robustly and consistently capture clinical data to support safe clinical care and that this required improvement.

Midwifery and Gynaecology Nurse staffing

- The midwife to birth ratio was worse than the nationally recommended figure, at 1:33 midwives to births. We saw that there was consistently high usage of agency and bank staff in the labour ward, and especially in Writtle (gynaecology) Ward over the past year, where over 50% were used at times.
- Staff told us that there was often only one core staff member on a shift in Writtle Ward; the remainder were temporary staff, which put a lot of responsibility on the band 5 and 6 nursing staff, especially due to the high numbers of medical outliers on the ward daily, which added to the clinical demands.
- Shifts were not always covered, which increases risks to people who use services; and both nursing staff and doctors we spoke with felt that the ward was unsafely staffed at times.
- The trust acknowledged that staffing had recently been impacted by long and short-term sickness and maternity leave. There were difficulties at times being able to cover all shift requirements. In the two months prior to our inspection, 126 midwifery shifts were not covered in the labour ward, 44 in the postnatal ward, and 22 in the antenatal ward. The key concern was the length of time that this had been going on, as substantial or frequent staff shortages increases risks to people who use services. This was raised with the trust at the time of the inspection.
- The impact on staffing in the maternity wards from lifting the birth cap indicated that changes were made to services without due regard for the impact on people's safety. There were inadequate plans in place to assess and manage risks associated with increased demands or emergency situations, such as increased demands at weekends on the antenatal ward, postnatal ward and day assessment unit, without consideration for ward clerk support and increased levels of clinical staff to manage this safely.
- We were informed by the head of midwifery that six new midwives had commenced orientation on 3 November 2014 and a supernumerary post will be added to the numbers. Also, 18 midwives were due to be interviewed on 1 December 2014 for eight positions, and six full time additional posts had been approved for Writtle (gynaecology) Ward. Further recruitment plans were due to be submitted for approval.
- The Annual Report of the supervisors of midwives for the year ending 2014 showed that a key feature was now that the ratio of supervisors of midwives was 1:15, making the trust compliant with national expectations.

Medical staffing

- Doctors we spoke with noted that the right medical staffing levels and skill-mix across all clinical disciplines were sustained at all times of day and week to support safe, effective patient care and levels of staff wellbeing.
- There was 66 hours of consultant cover, with full on-call support out of hours and at weekends. We saw that the medical staffing for the unit was appropriate for the current levels of activity.
- The main risk was the distance which doctors had to travel, especially at night, to get to the gynaecology ward, which was across the other side of the hospital. This had been recognised by the provider and was on the risk register.
- There were a lower proportion of registrars and a higher proportion of middle career doctors compared to the England average.

Major incident awareness and training

- Staff were aware of the Royal College of Obstetricians and Gynaecologists (RCOG) guideline, which includes the potential closure of the maternity unit, with contingency planning to ensure that any decision to close the unit was appropriate and consensual.
- There were other escalation policies available to staff, including intrapartum NICE Guidelines and an abduction policy. Staff we spoke with were confident regarding reporting mechanisms, and that support from senior managers and the head of midwifery would be good in the event of a major incident.

Maternity and gynaecology

Are maternity and gynaecology services effective?

Requires improvement

The outcomes of people's care and treatment were not always monitored regularly or robustly. It was unclear what the process was for deciding what to audit and whether it was risk-based. Staff we spoke with were not actively engaged in audit, and the majority of senior midwives did not currently have time to be involved.

The maternity dashboard indicated that the proportion of elective and emergency sections was 29%, which is higher than the national average. Actions were being taken by the trust to reduce this, but high scores of 32% were recorded for July and August, so more work is needed.

The clinic organisation and counselling support for women undergoing termination of pregnancy, including miscarriages, was good, and pain management practices were appropriate.

The contracted staff had the right qualifications, skills, knowledge and experience to do their job, although some of the medical outliers on the gynaecology ward were admitted despite being outside of the agreed criteria, which staff said was challenging and outside of their competency at times.

We saw that agency staff, including locums, did not receive a signed off induction to evidence familiarity and knowledge of core risk practices within the units. Given the high usage and reliance on temporary staff in the maternity and gynaecology ward, this should be in place.

Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005, and the Children's Acts 1989 and 2004.

Evidence-based care and treatment

- We spoke with the risk manager, audit supervisor and governance officer regarding identifying trends to improve evidence-based care. The new maternity IT system that was supposed to go live in 2013 had not, so the maternity departments still have to collect a lot of data by hand. This makes trend analysis difficult.
- The risk with this lack of analysis is that trends raised by staff to us during the inspection, such as increased postponed inductions, waiting times, and delayed Artificial Rupture of Membranes (ARM) services, take longer to identify, thus slowing down the rectification of problems, which means that the outcomes of people's care and treatment were not always monitored regularly or robustly.
- We looked at local audit activity and found that whilst there was a comprehensive database of regular audits being actioned, it was unclear what the process was for deciding what to audit and whether it was risk-based.
- Staff we spoke with were not actively engaged in audit, and the senior midwives did not have time. This had been recognised by the risk department, and actions were being taken, including reviewing previous audits to measure their effectiveness in what was reviewed, and measuring outcome improvements to patients. They were also currently reviewing the audit meetings to improve the focus on evidence-based care and risk.
- It was recognised by senior managers and the maternity risk and audit teams that the lack of a maternity IT system impacted on their ability to robustly and consistently capture clinical data to support safe clinical care through risk based audit and that this required improvement.
- Whilst NICE/Royal College guidelines were easily accessible on the shared drive, the system for formally reviewing guidelines was recognised by the risk management team as not being robust, as there was currently no regular formal process.

Pain relief

- We saw that the current methods of pain relief offered were appropriate.
- There were good information leaflets regarding pain relief during birth available to women, and patients confirmed that they were offered regular pain relief during labour. We saw the recording of pain scores in three patient records we reviewed, and noted that the last audit on pain score completed included 73% of cases.

Nutrition and hydration

- Breast feeding rates at Broomfield Hospital for babies at 10 days old were at 62%; the target is 75%. Health

visitors noted that at 6-8 weeks breastfeeding rates were at 48.7%. There were maternity support workers on the postnatal ward who had undertaken further training in helping mothers with breastfeeding issues.
- All women receive a call regarding breastfeeding follow-up on discharge from hospital, and were allocated a breastfeeding support worker. Mothers who bottle feed their babies could go to health visitors in the community for advice.
- There was written information regarding Essex support groups which cater for women who are breastfeeding, as well as for women whom are pregnant and wishing for more information. These groups covered Chelmsford, Maldon, South Woodham Ferrers, Burnham-on-Crouch, Braintree, Witham and Halstead.
- Staff noted that the increase in postnatal re-admissions were often associated with early discharge and poor feeding support, although there were no audit outcomes to evidence this.

Patient outcomes

- The maternity dashboard indicates that the proportion of elective and emergency sections is 29%, which is higher than the national average. Actions were being taken by the trust, but high scores of 32% were recorded for July and August 2014, so more work is needed.
- There were three unexpected admissions to NICU (the neonatal intensive care unit); 12% were related to poor feeding.
- The clinic organisation and counselling support for women undergoing termination of pregnancy, including miscarriages, was good. Outpatient care for medical termination of pregnancy was also good. There were allocated side rooms for medical or surgical termination above nine weeks; the service did not always ensure appropriate placement in a planned side room to support these patients' needs sensitively. Disposal of foetal tissue was in line with national guidance.
- We saw that elective and emergency monthly cumulative totals for caesarean section had been consistently high at 29% which was above the national average of 26%. New initiatives were being actioned to address this, although there were still significantly high rates of 32%, both in July and August, which some staff referred to as a lack of junior doctor confidence being a causative factor.

Competent staff

- Within Mid Essex there were 15 supervisors of midwives (SoM). The purpose of supervision of midwives is to protect women and babies by actively promoting excellence in midwifery care.
- We spoke with students and new midwives joining the trust, who confirmed that they were allocated a named supervisor in their induction period; this is for an initial period of six months. They then have the ability to be able to choose a SoM, which is good practice. The rationale for this is to ensure supervisory support for all midwives.
- The contracted staff had the right qualifications, skills, knowledge and experience to do their job, although some of the medical outliers on the gynaecology ward were admitted despite being outside of the agreed criteria, which staff said was challenging and outside of their competency at times.
- We saw that agency staff, including locums, did not receive a signed off induction to evidence familiarity and knowledge of core risk practices within the units. Given the high usage and reliance on temporary staff in the maternity and gynaecology ward, this should be in place.
- The GMC national training scheme survey 2014 results indicated that regional teaching and access to educational resources for doctors is better than expected. Doctors we spoke with confirmed this.
- The safety and quality dashboard for August 2014 indicated appraisal rates in the maternity and gynaecology departments at around 70%. Staff said that they were supported to gain additional qualifications and maintain their continual professional development. The band 7 staff all had lead roles, with additional training to support them.

Multidisciplinary working

- We found by observing ward areas, listening to focus groups, and individual doctors, midwives, support workers and administration staff that there were detailed and timely multidisciplinary team discussions and handovers to ensure patients' care and treatment was co-ordinated and the expected outcomes achieved.
- Care and treatment plans were recorded, and communicated with all relevant parties to ensure continuity of care.

Maternity and gynaecology

- Staff we spoke with, including community midwives and students, were aware of the importance of joined up working with health visitors, GPs and school nurses, to support patients care pathways, both in hospital and back in the community.
- Staff do not meet frequently enough to provide effective care. There was a lack of formal team meetings for staff in the maternity and gynaecology wards. There was a heavy reliance on staff using email and memos as the main tools for obtaining updates on risk management and effective practice changes.
- Midwives and care support workers rotate regularly across the department to maintain their skills, but also provide flexible cover where needed. The community teams had not been able to rotate recently due to work pressures, and had raised concerns regarding de-skilling. This was being actioned and we were informed that shortly the rotation would continue and be back on track.
- We saw reports that showed that SoMs in Mid Essex work closely with the local higher education institutes (HEI). There is a strong bond between provider and education allowing a positive working relationship; this is evident in SoM engagement with student teaching programmes, leading on critical care (MOMAS) courses at the HEI, and involvement in education forums with the university. The SoM team continues to meet the local supervising authority (LSA) Standards for Supervision.
- Transitional care of babies from the neonatal unit to postnatal care was good. Staff reported good support, especially since the increased antibiotic regime changes regarding management of sepsis in babies, which involved the neonatal nurses providing this treatment on the postnatal ward.

Seven-day services

- The SoM team ensure there is access to a SoM at all times, 24 hours a day, seven days a week by participating in a 24 hour on-call rota, which ensures that midwives have continual access to a supervisor of midwives (SoM).
- Consultants cover 8am to 8pm Monday to Friday, and 9am to 12 noon at weekends, with full on-call cover outside of these times.

Access to information

- We saw and women confirmed that they carried their hand held notes with them when attending appointments at MEHT. This means that staff could access the information they need to assess, plan and deliver care to people in a timely way; particularly when people move between services or during transition.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent to care and treatment is obtained in line with legislation and guidance, including the Mental Capacity Act 2005, and the Children's Acts 1989 and 2004. There was a Mental Capacity Act and DoLS policy for staff reference linked to the safeguarding procedure.
- The learning disabilities nurse was able to assist with mental capacity assessments with regards to serious medical interventions, care reviews and change of accommodation.
- There was also a specialist mental health midwife to support vulnerable women.

Are maternity and gynaecology services caring?

Good

We found by observing ward areas, listening to focus groups and individual doctors, midwives, support workers and administration staff that staff in all roles were patient-centred, responded compassionately when people needed help, and supported them to meet their basic personal needs as and when required. However, we saw on Writtle Ward that staff struggled at times due to staffing limitations and the numbers of medical outliers on the ward.

The maternity unit was in line with the England average for the maternity survey, and our data information showed that they generally performed better than the national average in the recommending to Friends and Family Test, although the response rate currently was low.

We saw good information for parents regarding their pregnancy and baby needs, which covered all the key stages of care, treatment and support throughout their birth journey. Patients we spoke with in all three units were well informed, and felt involved in decision-making practices regarding their care.

Maternity and gynaecology

There were appropriate support systems in place to meet people's emotional needs.

Compassionate care

- We found by observing ward areas, listening to focus groups and individual doctors, midwives, support workers and administration staff that staff in all roles were patient-centred, responded compassionately when people needed help, and supported them to meet their basic personal needs as and when required.
- However, we saw on Writtle Ward that staff struggled at times due to staffing limitations and the numbers of medical outliers on the ward.
- The Care Quality Commission (CQC) had received several complaints regarding staff attitude recently; however, we saw that staff put effort into treating patients with dignity and most patients felt well-cared for as a result. There were 'please do not enter' signs on the curtains, and staff were polite when addressing people.
- Staff were aware of a midwife with an interest in bereavement in post, and they were familiar with bereavement protocols and counselling support opportunities for parents where required. A bereavement room furnished by the Stillbirth and Neonatal Death Charity was in place to provide a private compassionate setting for bereaved parents.
- The maternity unit was in line with the England average for the maternity survey, and our data information showed that they generally performed better than the national average in the Friends and Family Test, although recent response rates in labour and postnatal wards were below 10%.

Understanding and involvement of patients and those close to them

- We saw good information for parents regarding their pregnancy and baby needs, which covered all the key stages of care, treatment and support throughout their pregnancy and birth journey.
- Patients we spoke with in all three units were well informed and felt involved in decision-making practices regarding their care. One patient told us "I knew what was happening and the staff were so caring"; another noted "I understood what choices I had and felt involved in the decisions made".
- Specialised antenatal classes were available for parents expecting twins, triplets or more. The aims of the classes were to offer patients confidence and competence in the ability to manage this unique situation, including breastfeeding support.

Emotional support

- Spiritual care and chaplaincy teams were in place providing spiritual care to patients, families and staff of all faith backgrounds, and none, 24/7, throughout Broomfield Hospital.
- We saw that assessments for postnatal depression were actioned. Staff could refer patients to health visitors regarding local postnatal support groups they could join where necessary.
- There was a specialist mental health midwife in post, and a regional mental health centre on the Broomfield Hospital site, which included allocated beds in a mother and baby unit for additional support for vulnerable women. This was noted as good practice.
- There was good joined-up care and support from the screening midwives and fetal medicine teams to support parents with foetal abnormalities. There was a family planning lead nurse who could support both patients and staff with aftercare counselling and family planning following termination of pregnancy.

Are maternity and gynaecology services responsive?

Inadequate

We rated the maternity and gynaecology services as inadequate in regard to responsiveness of the service to meet patients needs. We found that safety was not a sufficient priority. There was limited measurement and monitoring of safety performance as the IT system was not working and a significant amount of data in maternity had to be collected using paper based methods. This meant that changes were not always identified in a timely way. Changes were made to the service without due regard for the impact on people's safety. The removal of the birthing cap over a year ago, which allowed access to women out of area, resulting in between 11% and 23% increases in demand, without due regard for the increased birth rates and the impact on people's needs. There were long waiting times in the antenatal clinics at times, delayed inductions,

and postponed elective caesarean sections, due to capacity issues in both the labour ward and postnatal wards. We could not establish the level of impact as these key performance indicators were not routinely monitored to establish the impact and promote changes to improve flow, delays or cancellations. Therefore actions to address these issues were not timely or effective.

Services were not always planned and delivered with consideration of people's needs. The admission criteria for medical outliers on Writtle (gynaecology) Ward was being continually breached, such as patients at risk of falls being admitted, which required constant supervision. This impacted on the staff's ability to provide appropriate sensitive care to termination of pregnancy patients in the side rooms. This did not meet people's needs and was inappropriate.

People who use the service, including patients with complex needs, were asked about their spiritual, ethnic and cultural needs. Their care and treatment was planned and delivered to reflect these needs, as appropriate.

People we spoke with knew how to raise concerns or make a complaint. Staff told us that they encouraged people who use services, those close to them, or their representatives, to provide feedback about their care, although the response rates were not always good. Complaints procedures and ways to give feedback were available.

Service planning and delivery to meet the needs of local people

- **The removal of the birthing cap over a year ago, which allowed access to women out of area, resulted in between 11% and 23% increases in demand without due regard for the increased birth rates and impact on people's needs. However there was little evidence that action had been taken to address the increase in the numbers of women attending the maternity service for example the facilities of the building were not taken into account when planning the increased numbers of women attending, nor had midwifery staffing been enhanced appropriately. These issues impacted upon not only the responsiveness of the service but the safety of the service.**
- **We interviewed the head of midwifery and the director of women and children's services, and noted there were inadequate service plans in place to assess and respond to the risks associated with this, such as capacity management.**
- **Services were planned and delivered without consideration of people's needs in both maternity and gynaecology services.**
- **Appropriate placement of medical patient outliers is important to ensure that their care is met and does not impact on other service user's needs. We spoke with staff and the director of women and children's services, and found that the admission criteria for medical outliers on Writtle (gynaecology) Ward was being continually breached, such as patients at risk of falls being admitted, which required constant supervision. We established that this had impacted on the staff's ability to provide appropriate sensitive care to termination of pregnancy patients in the side rooms. This was also raised by a relative during the inspection. This did not meet people's needs and was inappropriate.**
- **The lack of clinical offices in the antenatal and postnatal wards was an issue, especially regarding private conversations and handovers.**
- **The waiting area in the antenatal ward was cramped, and could not cope with demands at times, with standing room only, and we saw children running around in the corridors.**

Access and flow

- The majority of staff we spoke with confirmed that people were frequently and consistently not able to access services in a timely way for an initial assessment, diagnosis or treatment. People experienced unacceptable waits for some services.
- There were long waiting times in the antenatal clinics at times, delayed inductions, and postponed elective caesarean sections due to capacity issues in both the labour ward and postnatal wards. We could not establish the level of impact as these key performance indicators were not routinely monitored to establish the impact and promote changes to improve flow, delays or cancellations. Therefore actions to address these issues were not timely or effective.

Maternity and gynaecology

- The distance between the gynaecology ward and the labour ward made it difficult for the doctors to respond in a timely manner. This had been raised and consideration for moving the gynaecology ward given, but not approved.
- We requested the current percentages of women seen in the labour ward within 30 minutes by a midwife, and the percentage seen by a consultant within 60 minutes, to understand the responsiveness of the service. This information was not currently being recorded.
- We saw examples of mothers being encouraged to move to the midwife-led units (MLU) when additional feeding support was required prior to discharge, to free up beds on the postnatal unit. We spoke with two transfers who were very happy with the support being provided at the MLU; they felt the transition plans took into account their individual needs, circumstances, on-going care arrangements and expected outcomes.
- We were told of regular delays in women having induction of labour, long waiting times in antenatal clinics, and elective sections being postponed due to lack of capacity in the labour ward and the postnatal ward. When we asked for the monitoring statistics, we were told that they were not routinely collected, which is a concern, as staff saw these as key areas of risk.

Meeting people's individual needs

- To improve the postnatal services to women out in the community, all healthy mothers and babies are visited once at home following their discharge from hospital. Thereafter they are invited to attend appointments at the WJC Birthing Unit in order for the midwife to undertake their postnatal care.
- Community midwives are attached to every GP surgery in the locality to ensure maternity access to all patients, which supports some women who are reluctant to travel into the hospital for their care and would prefer a more local service
- People who use the service were asked about their spiritual, ethnic and cultural needs. Their care and treatment was planned and delivered to reflect these needs, as appropriate.
- We looked at maternity information leaflets and noted references to 'Please ask if you require this information in other languages, large print, easy read accessible information, audio/visual, signing, pictorial and change picture bank formats'. There were also welcome signs displayed in other languages.
- Staff were aware of the learning disability lead and a dementia specialist nurse in post with training awareness on the trust intranet site. We were told that communication resource folders and pictorial menus have been distributed to all wards. We also noted that there was a specialist midwife to care for women with substance abuse health issues.

Learning from complaints and concerns

- People we spoke with knew how to raise concerns or make a complaint. Staff told us that they encouraged people who use services, those close to them, or their representatives, to provide feedback about their care, although the response rates were not always good. Complaints procedures and ways to give feedback were available.
- We saw that the numbers of written complaints were monitored and had reduced each year since 2010/11. There were 27 maternity formal complaints this year, which was low. Complaints received mainly focused around: waiting times, communication and unprofessional discussions, such as staff discussing personal matters in front of patients. Some actions around staff awareness were noted to address these points.

Are maternity and gynaecology services well-led?

Requires improvement 

The leadership of the service for maternity and gynaecology require improvement to ensure that the services are safe and responsive to the needs of patients. The removal of the birthing cap had not been clearly planned or its impact recognised. This led to patients receiving a less than responsive service. The pressures on the gynaecology service from medical outliers whilst recognised was not dealt with appropriately leading to a service which was potentially unsafe and not responsive to the needs of women. Whilst these issues were recognised they had not been appropriately managed and the changes to services not led so that staff felt supported and able to cope with the changes. Maternity staff understood the vision and strategy, but were not clear on action plans and business cases regarding how maternity services were being planned, developed or approved.

Maternity and gynaecology

We raised concerns throughout the inspection regarding the lack of monitoring practices for key clinical indicators, such as waiting times, cancellations and delays that staff had highlighted as the key clinical risks, and also the lack of risk audits being actioned in response to them. We made constant requests for data information which was not available during the inspection. It was recognised by senior managers and the maternity risk and audit teams that the lack of a maternity IT system impacted on their ability to robustly and consistently capture clinical data to support safe clinical care and that this required improvement.

Staff were clear that the head of midwifery was a strong leader with a hands-on approach, and would take action where significant risks were highlighted. Staff satisfaction regarding culture within the service was mixed. Some were well supported and felt listened to. Others did not feel actively engaged or empowered, and concerns were raised during the inspection of a bullying culture from the senior management team within midwifery.

The trust held its first OSCAs (outstanding service and care awards) event in January 2014 to recognise and reward members of staff who provide outstanding service and patient care. Staff at the Early Pregnancy Unit at Broomfield Hospital were nominated for a national award, thanks to the excellent care they gave during a patient's difficult pregnancy, which is noted as good practice.

Vision and strategy for this service

- We saw posters displayed regarding the vision and strategy for maternity services.
- The senior executive team provided inspectors with a statement of vision and values encompassing key elements of the NHS constitution, such as compassion, dignity, respect, and equality with quality a key priority. The majority of maternity staff understood the vision and strategy, but were not clear on action plans and business cases regarding how maternity services were being planned, developed or approved.

Governance, risk management and quality measurement

- The director of women and children's services told us about difficulties currently being experienced in relation to the attempted roll-out of the maternity IT system, as to whether the system was fit for purpose, and what the best outcomes for the trust would be in respect of carrying this system forward.
- We raised concerns throughout the inspection regarding the lack of monitoring practices for key clinical indicators such as waiting times. We made constant requests for data information which was not available during the inspection. It was recognised by senior managers and the maternity risk and audit teams that the lack of a maternity IT system impacted on their ability to robustly and consistently capture clinical data to support safe clinical care and that this required improvement.
- We found that the arrangements for governance and performance management did not always operate effectively. We looked at examples of board papers, patient safety and quality committee meetings, the chief nurse's report, risk registers, quality monitoring systems and incident reporting practices. These showed that there were management systems in place, but they did not appear to focus on the key risks for maternity, such as capacity impacts and medical outliers on Writtle Ward.
- When interviewed, the director of women and children's services was not clear on the key risks for both maternity and the Writtle (gynaecology) Ward, and could not provide assurances that contingency planning or new ways of working were being considered to support quality improvements.

Leadership of service

- Staff told us that the Head of Midwifery had a hands-on approach and would take action where significant risks were highlighted. The band 7s all had lead roles and handled the day-to-day operational management of the departments overseen by two grade eight staff.
- Historically, the HoM has reported to the human resource manager who is also the director for women and children's services, as opposed to the chief nurse. It is arguable how appropriate this is and how the structure benefits from this. There is a question as to whether this effects good communication between the chief nurse and HoM regarding governance and risk management practices as highlighted above.
- When we spoke with the director of HR we found that they had limited knowledge of the issues relating to maternity services and we were not assured that the structure was appropriate or effective. We understand there is a divisional structure review currently.

Culture within the service

- Staff satisfaction regarding the culture within the service was mixed. Some were well supported and felt listened to. Others did not feel actively engaged or empowered.
- We received information from several whistleblowers before and during the inspection, which indicated the culture is top-down and directive. We found that some staff were wary of speaking with us during the inspection, and others told us that they felt bullied by line managers and senior members of the midwifery team.

Public and staff engagement

- Response rates to the national trust-wide staff survey were low at 30%. Staff noted effective team working and making a difference to patients as good. Most questions were in line with the England average for the maternity survey.
- Good working relationships with the Chelmsford children's centre staff and SoMs were reported. Most recently, they have been involved with helping with the 'natural birth project 2%'. It is hoped that this relationship will help with recruitment of maternity service users to the labour ward forum and the Chelmsford Partnership Board meeting in the future.
- The MSLC (maternity services liaison committee) has been very recently reintroduced, in September 2014, focusing on what women want from maternity services in their area, including looking at best practice, and getting organisations and service users involved in projects and services within the community to support this. Service users were being encouraged to join, but staff have said that it is proving difficult to recruit women who are representative of the population.
- The overall results of the maternity services/CQC patient survey evidenced that the majority of women (95%) were satisfied with the experience received from MEHT maternity services; an additional audit has been collated in the form of the Trust Patient Council Questionnaire Survey 2014, to obtain further service users comments

Innovation, improvement and sustainability

- The maternity service has recently been awarded level one accreditation by the Baby Friendly Initiative and is planning to go for level two.
- Professionals had noticed that elective C-section rates had increased significantly due to misguidance on natural birthing, control and choice, sexual function concerns, media attention and fear of natural birth. The supervisory team were taking the lead on a project to increase the normal birth rate. This involves every area of maternity. This is called 'project 2%' and involves increasing the home birth rate, the rate of deliveries in midwife-led units, and the amount of normal deliveries on the high risk units. However, further work is needed to encourage 'normal birth', as the emergency and elective rate of sections remains higher than the national average.
- Maternity services have recently gained the distinction of being certified as a provider of high quality health and social care information by the Information Standard scheme.
- Staff at the Early Pregnancy Unit at Broomfield Hospital were nominated for a national award, thanks to the excellent care they gave during a patient's difficult pregnancy, which is noted as good practice.

Services for children and young people

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

Information about the service

Services for children and young people comprise of a pre-assessment and day surgery ward, and inpatient wards including a paediatric burns unit, neonatal unit and outpatient clinic. We inspected Wizard Ward (the day surgery unit), Phoenix inpatient Ward, the neonatal unit, and the paediatric burns intensive care unit. We also inspected services provided to children and young people in the X-ray and outpatients departments. During our inspection we spoke with 11 families and 23 staff.

Summary of findings

There were arrangements in place to implement good practice, learning from any untoward incidents, and an open culture to encourage a focus on patient safety and risk management practices. Families told us that they felt happy to use the service, and felt supported by the nursing and medical staff. There were effective arrangements to identify and manage risk, and keep patients safe. We saw good examples of care being provided, with a compassionate and dignified approach.

National guidance was being implemented, and monitoring systems to measure performance were in place. The number of staff receiving mandatory training and appraisals was high.

The children and young people's service understood the different needs of the communities it serves, and acted on these to plan and design services. The paediatric department encouraged children, their relatives, and those close to them, to provide feedback about their care, and were keen to learn from experience, concerns and complaints.

The paediatric departments could demonstrate that risks to the delivery of high quality care were identified, analysed and mitigated systematically, before they became issues which impacted on the quality of care.

Services for children and young people

Are services for children and young people safe?

Good

There were systems in place for reporting and investigating incidents, and there was evidence that learning from incidents occurred at a local level within teams. All areas we visited were well maintained and clean.

Medicines were safely managed and administered. Staff were confident about how to safeguard children; they were aware of the correct procedures to follow, had access to guidance and received appropriate training. Infection prevention and control measures, such as good hand hygiene, were consistently practiced.

Records were managed securely to ensure confidentiality. There were sufficient numbers of staff employed who had the knowledge, qualifications and skills to provide safe care. The majority of staff had completed their mandatory training.

Incidents

- We spoke with a variety of staff, including receptionists, student nurses, radiographers, and medical and nursing staff. All staff members were aware of their responsibilities in relation to reporting incidents, and were able to describe the actions they would take if an incident occurred. The actions described reflected the trusts incident reporting policy.
- Staff told us that they reported incidents using an online system called Datix, and that they had received training to use the system as part of their induction, which we saw evidence of.
- Staff explained that they reviewed all incidents reported within the children and young people's service on a daily basis during their morning briefing session, to ensure that preventive measures were adopted at the earliest opportunity. Staff were able to show us examples of Datix data they received during the meeting.
- Staff told us that they felt supported to report incidents and were able to give examples of feedback they had received following reported incidents, such as changes to criteria regarding escorting patients to theatre. Another example given related to a concern about the safety of new needles provided for preparing medicines. Staff had reported these as being blunt and unsafe for use, and this concern had been acted upon with the needles being withdrawn from use.
- There was a safe paediatric group attended by members of the senior management team. Serious untoward incidents (SUI) was a standing agenda item. We saw minutes of the meetings held during 2014, and evidence of discussion and agreed actions in response to SUI's. This meant that the service had a means to learn from incidents, and the knowledge and authority to introduce measures throughout the paediatric service to minimise the risk of incidents reoccurring.

Cleanliness, infection control and hygiene

- All the areas and the equipment within the wards inspected were found to be clean. Families we spoke with commented on the high standard of cleanliness they had observed.
- Good hand hygiene was practiced by staff in all clinical areas we inspected, including the need to practice the 'bare below the elbow' principle in accordance with the trust's infection prevention and control policy.
- Awareness of hand hygiene was well promoted to visitors through the display of information and posters describing the need for visitors to clean their hands before entering the units. During the inspection we observed staff actively reminding visitors to use the hand cleansing solution provided before entering the clinical areas.
- Hand hygiene audits provided showed that there had been a 99% compliance rate during the past year with hand hygiene standards in all paediatric departments.
- Staff were observed to use appropriate personal protective equipment to provide care, such as gloves and aprons. These were removed and disposed of between treatments for different patients as per local policy.
- A green sticker system was used to indicate to staff that equipment such as beds had been cleaned and were safe to be used.
- The infection prevention and control (IPC) team were able to show us evidence, such as training schedules, of the on-going training they provided to staff to ensure safe practice.

- IPC data provided was reviewed and discussed with the IPC team. There had not been any acquired MRSA or C. difficile incidents within the paediatric service in the previous six months.
- We looked at areas where clinical treatment was provided, and saw that there were appropriate facilities for the safe disposal of sharps items such as needles. Guidance was clearly displayed advising staff what actions should be taken in the event that they injured themselves with a dirty (used) needle, to ensure the appropriate checks and treatment were provided
- Toys were checked and cleaned on a daily basis to ensure cross infection was minimised, and staff were able to show us evidence of the routine checks made.

Environment and equipment

- The environment and equipment used within the units we inspected were found to be spacious and well lit. Corridors were kept free from clutter.
- Equipment was available for the treatment of patients on the wards, such as resuscitaires and anaesthetic. Equipment was found to be labelled as having had the relevant safety checks completed prior to its use, with items in need of repair clearly labelled.
- There were effective security systems in place to ensure controlled authorised access to children's wards, such as keypad controlled ward doors, security cameras and intercoms, to enable staff to make safety checks prior to granting entry to visitors.
- There were appropriate arrangements for the segregation and safe disposal of waste.
- Staff told us that they had completed risk assessments of areas where children were treated, but were unable, when asked, to produce evidence of these.
- Appropriate resuscitation equipment was available to staff in each ward visited. There was evidence to show that this had been checked on a daily basis to ensure the equipment was fit for use. Staff were able to show that they were familiar with the equipment, and we saw evidence that staff had received training to locate and use the equipment safely and effectively.

Medicines

- Medicines were stored securely in locked trolleys, cupboards and fridges, in accordance with regulatory requirements, and at the appropriate temperature, except for one incident on Wizard Ward, where Ametop and Octenasin drugs were found stored in an unlocked desk draw. This was immediately remedied when brought to the attention of staff.
- There were records to show that temperatures were checked daily to ensure medicines were stored at the optimum temperature in accordance with the manufacturer's recommendations.
- Medicines were observed to be administered safely in accordance with local medicines management policy.
- Staff wore specific coloured aprons to indicate to other staff that they must not be interrupted whilst administering medicines.
- We observed medicines being prepared and administered in the neonatal unit, including the antibiotic Gentamicin. Staff used the specific prompt sheet provided to ensure the safe use of Gentamicin.
- Controlled Drugs (CD's) were safely stored in accordance with regulatory requirements. There were arrangements in place to check stock levels daily to ensure that the stock correlated with the amount recorded in the drug register. We completed a random check of CD stock levels and records were found to be correct.

Records

- Patient records were stored securely, and there were systems in place to obtain records urgently and to return records to the medical record department. This process was supported by the provision of a satellite medical records library close to the children's wards.
- We looked at six sets of patient records in different wards once the agreement of the families had been obtained. Each file cover was clearly marked as confidential, and the file contained guidance about good record keeping practice, such as ensuring that entries were legibly written, timed, dated and signed.
- Records contained risk assessments that were completed prior to admission during the pre-assessment session. For example, information was obtained to identify if a child had any allergies or was currently taking medications.
- The daily nursing summary sheets used on Phoenix Ward contained prompts to remind staff to ensure that risk assessments were done, such as whether cot sides were required, and if pressure ulcer/skin damage assessments had been completed to ensure safe care.

- The files were maintained in a secure format to minimise the risk of records becoming separated or misfiled.
- We observed that different disciplines only had access to the relevant patient information required to do their jobs, in accordance with the Caldicott 'need to know' principles. For example, the receptionist received patient admission lists, but these did not include details of the reason for admission or other clinical details. This control was in place to ensure patient confidentiality.
- There were specific secure bins provided for the safe disposal of confidential paper waste.
- There was evidence to show that staff received training during their induction, and on-going training regarding information governance.
- Some staff, such as ward receptionists, had also received training to effectively use tracking systems for the safe management of medical records.

Safeguarding

- Safeguarding systems were well embedded in the service. Staff were able to show us how they could access up-to-date safeguarding guidelines, were able to discuss safeguarding arrangements, and could demonstrate how contact details were clearly displayed in the wards.
- We reviewed training records in each ward and saw there was 100% compliance with safeguarding training.
- Information was displayed for visitors to advise what they should do and who they could contact if they had a safeguarding concern.

Mandatory training

- Staff were able to describe the mandatory training they received. They told us that this included topics such as equality and diversity, health and safety, information governance, and hand hygiene.
- There was evidence to show a high level of level of compliance with mandatory training. The completion rate was over 90%. We saw that there were systems in place to monitor and report progress, with mandatory training to ensure that a high level of compliance was maintained.
- We spoke with two trainee doctors who reported that they had received four days of induction, which they felt had appropriately equipped them to perform their jobs safely.

Assessing and responding to patient risk

- Staff used a paediatric early warning score system when completing observations, such as pulse and respiration, to alert them if a child's condition was deteriorating and medical assistance was required.
- Most staff we spoke with were able to describe the process they would use if the resuscitation team were required. However, some staff on Wizard Ward appeared uncertain of the process. We asked who would attend a call and whether there would be a paediatric doctor or anaesthetist, but staff were unsure and gave mixed responses.
- Staff in all other paediatric services inspected were able to clearly describe the resuscitation process, and tell us who the team comprised of, and that it would include a paediatric doctor. The emergency team contact number was clearly displayed above the ward phones, with the exception of Wizard Ward.
- Staff received paediatric life support (PLS) training to ensure that there were always sufficient staff on duty with the appropriate resuscitation skills.

Nursing staffing

- Staff reported they felt they had sufficient numbers of staff with the right level of experience and qualifications to provide safe care.
- We reviewed the duty rotas and were able to see the actual skill mix for each shift was appropriate to ensure safe care was provided.
- From interviews with staff we established that the turnover rate for staff was low, and were able to see from the staffing rotas that there were few vacancies, and the nurse manager was able to provide evidence that these posts were actively being recruited to.
- We looked at staff rotas and saw there had been minimal use of bank or agency staff. Staff told us this was mostly due to there seldom being vacancies, and existing staff were willing to help cover unplanned absences such as sickness.
- The paediatric burns unit did not always have a paediatric trained nurse on duty. To address this situation, arrangements were in place for adult trained nurses to attend the paediatric burns course at Great Ormond Street Hospital.

- Formal detailed handovers took place on each shift. Staff used a prompt sheet to act as an aid during handover to check all aspects of care had been addressed
- There had been occasions when there was no children's nurse on duty during children's outpatient clinics.

Medical staffing

- The number of doctors employed at Broomfield Hospital was slightly lower than the national average within each grade. The main area of concern was the proportion of junior doctors (16%) employed, which was significantly higher than the national average of 7%.
- We spoke with several doctors and the senior management team about medical staffing arrangements. There was recognition that the out-of-hours cover (nights and weekends) was limited. There was only one paediatric registrar available at night for the whole service, which was spread over a wide geographical area.
- Junior doctors spoke well of the support they received and the commitment of the consultants.
- A paediatric registrar attended the ward round in the burns unit every morning.
- Although there was not a dedicated paediatric burns intensive care unit (PICU), a paediatric intensivist had been employed. Strong links had also been developed with Great Ormond Street Hospital PICU, including joint consultant appointments. A daily teleconference took place with the consultant each morning to review each child's care.
- Doctors and staff told us that they worked well as a team and felt communication within the team was effective.

Are services for children and young people effective?

Good

National guidance was used to inform practice and develop policies which were complied with. There were systems to measure performance, and this was used to improve the effectiveness of care. There were appropriate numbers of staff with the relevant qualifications, skills and experience. Staff received continual professional development and appraisal of their performance. There were multidisciplinary team discussions and handovers, to ensure patients' care and treatment was co-ordinated, and the expected outcomes were achieved. Consent processes to provide treatment were correctly practiced.

Evidence-based care and treatment

- We observed good compliance with policies, such as medicines, and infection prevention and control policies.
- Policies and procedures were referenced and developed in relation to relevant NICE and Royal College of Paediatrics and Child Health (RCPCH) guidelines.
- There was a clear process for the review and ratification of policies to ensure they were fit for purpose; however, there did not appear to be a consistent system to use and manage policies. We saw that staff used a mixture of hard copy and electronic policies, with some of these being out of date.
- Staff were aware of the importance of adherence to local policies and procedures, and how to access them.
- Local audits were discussed at the safe paediatric surgery group meetings. For example, the effectiveness of pain relief was audited, with recent results indicating that pain scores were low, but it had been recognised that this result pre dated the removal of codeine, and reduction in the recommended dose of paracetamol for children.
- Staff had reported that patient feedback had suggested there was a significant decrease in the overnight pain control once patients reached home, especially for the more painful procedures such as tonsillectomy and circumcision, and a further audit was proposed and agreed to resolve this. We saw minutes of meetings, which included plans to audit the effectiveness of the revised pain control that had been introduced in response to the first audit.
- Broomfield Hospital had established links with Great Ormond Street Hospital to attend training and share learning with them. This showed that there were working links with specialists to provide and improve practice.
- We observed good use of the online-based system of surgical safety checklists in the operating theatre we visited. This included the use of the World Health Organization (WHO) surgical safety checklist, which is designed to prevent avoidable errors, such as the wrong site being operated on. The use of safety check

procedures were well practiced, involving the whole care team when receiving patients in the theatre department to ensure the right patient had the right procedure.
- It was noted that the electronic versions of several drug protocols, including the Gentamicin policy, were several years out of date. This meant that staff did not always have access to up-to-date information to provide safe care. However, we saw that all the wards had copies of up-to-date Paediatric British National Formularies to refer to.

Pain relief

- We saw good outcomes from pain audits, which showed that the patient's pain had been considered, assessed, and appropriate action/care taken and documented.
- Processes were in place for assessing and managing pain.
- There were child-friendly pictures to help children assess their level of pain, and families spoken with were happy about pain management.
- We observed oral pain relief administered, and staff monitored its effectiveness.
- Clinical guidelines had been developed in conjunction with the trust wide pain service, and link nurses were in place. Link nurses attend study days provided by the pain team.

Nutrition and hydration

- Staff told us, and notes of audit outcomes confirmed, that patients were weighed on admission, and at agreed times during their stay.
- There were charts displayed to assist staff with calculations of intravenous fluids in relation to a child's weight.
- There were dedicated rooms for mothers to breast feed.
- Although we did not observe meals being provided during our inspection, we saw that care plans included information on children's likes and dislikes.
- Families we spoke with told us that staff involved them in planning and providing care, including the provision of fluids and nutrition.

Patient outcomes

- We saw that the trust was participating in national paediatric audits, such as the RCPCH national neonatal audit programme (NNAP) and the national paediatric diabetes audit (NPDA), with action plans in place where gaps were highlighted. Minutes of divisional meetings included reviews of national guidance, policy updates and national audits, to support improvements in patient outcomes.
- Multiple admission rates were audited. This audit related incidents where there had been two or more emergency admissions within 12 months among children and young people with asthma, epilepsy and diabetes. The results for April 2013 to March 2014 showed that Mid Essex Hospital Services Trust had admission rates mostly better than the England average.

Competent staff

- The paediatric burns unit did not always have a registered children's nurse on duty. To mitigate this situation an arrangement had been put in place for adult trained nurses to go to Great Ormond Street Hospital to attend their paediatric burns course. Staff were also rotated between the burns unit and the intensive care unit to obtain paediatric experience.
- A play therapist and nursery nurse visited the burns unit every morning to ensure that every child was adequately supported and provided for.
- There had been scenario training in the past three months, where serious clinical events were simulated. Staff feedback about these events was positive and they found this type of training beneficial.
- Most staff we spoke with reported that they had received appraisals on an annual basis, and we were able to see evidence that supported this.
- There were adequate arrangements to ensure agency bank staff received appropriate orientation to the wards.
- There was an induction pack designed specifically to help orientate new temporary staff members when required.
- There were records to show that staff had had their competencies assessed to ensure safe practice, such as assessing staff competency to use equipment correctly and safely.
- A mentoring system was in place. Staff were able to name their mentor, and we saw rotas to evidence the allocated mentor regularly worked the same shift as the staff member.

Multidisciplinary working

- There was collaboration amongst services to support children and young people's care and treatment, and action practice changes, where necessary, to ensure the

effectiveness of care delivery. Staff had contacts with social services, district nurses, health visitors and school nurses to ensure that appropriate support was available to children and families on discharge or transfer.
- There was evidence of multidisciplinary attendance at handovers and meetings that included specialities involved in a patients care.
- Play specialists and nursery nurses were used to support patients and were considered a valued part of the ward team. For example, they would provide support to children within the burns unit. Broomfield Hospital had a comprehensive up-to-date policy regarding the safe transfer of patients to other services or hospitals.
- One family we spoke with explained how their child was diagnosed during the early stages of pregnancy at another hospital as having a cleft palate. They described how pleased they had been with how well the referral system to the Broomfield cleft palate service had worked, and how quickly their child was treated. Broomfield Hospital provides a specialised cleft palate and lip service which is provided within the plastics service. This is one of only nine services in England**.** The family said "we are delighted with the result and how smoothly everything went".

Access to information

- Staff had access to electronic information, such as policies, national guidance and minutes of some meetings.
- If children were admitted out of hours, a colour coded temporary file was automatically created until the child's previous medical record (where applicable) could be obtained to ensure that all information was appropriately collated.
- Staff were able to demonstrate that they could easily access information when required, and had the benefit of having team briefs each day at the beginning of their shift.
- We saw that there was good discharge information available to families.

Consent

- Staff had access to an up-to-date consent policy and appropriate consent forms that reflected national guidance.
- We looked at six sets of records and noted consent forms were correctly completed.
- We observed appropriate checks of the consent were undertaken prior to a patient leaving the ward and receiving a patient in theatre prior to treatment.

Are services for children and young people caring?

Good

Services for children, young people and families were good and caring. We saw good examples of care being provided, with a compassionate and dignified approach. Patients and families were involved in planning their care, and making decisions about the choices available in their care and treatment. The families we spoke with told us that they would recommend the service to family and friends.

Compassionate care

- Throughout our inspection we witnessed children and their parents being treated with compassion, dignity and respect.
- Guidance for staff displayed information about how to ensure that people's dignity was respected.
- We observed that call bells were answered promptly, and parents we spoke to said that they would recommend the service to family and friends.

Understanding and involvement of patients and those close to them

- Children, young people and their families were appropriately involved in, and central to, making decisions about their care and the support needed.
- We found by looking at care plans, observing care, reviewing clinical guidelines, and talking to families and staff that care was planned, to achieve best practice as set down by national guidelines.
- Parents told us that they felt involved in decisions, and that they were well informed regarding treatment and discharge arrangements. Thank you letters and positive comments were displayed, which supported the feedback from families.
- We saw that verbal and written information that enabled children and their families to understand the care, was available in all areas inspected, in ways that met their communication needs.

- We observed how the theatre team welcomed a child and parent into the anaesthetic room and provided an explanation and choices of treatment. For example, the child was asked, using language they could understand, which type of initial anaesthesia they would prefer, such as a needle in their hand or gas.

Emotional support

- All the families told us that they had confidence in the care provided, and staff did all they could to reassure them and answer their questions.
- The wards we visited had muted phones to help minimise noise levels and provide a calm atmosphere.
- Parents were given the opportunity to accompany their child to the theatre department and from recovery, and their choices were respected. We observed staff explaining what to expect and reassuring families that they would be accompanied by a nurse on each occasion.
- Nursery nurses visited units with children where there were no dedicated paediatric staff, to ensure children's needs were met, and their environment was stimulating and made as child-friendly as possible.
- To help support children to manage and cope with their injuries, a Children's Burns Club had been established. Staff reported that this had proved popular with families.

Are services for children and young people responsive?

Good

The children and young people's service understood the needs of the community it serves, and acted on this to plan and design services. There were good mechanisms for information sharing, and willingness from staff for flexible working around responding to the needs of parents, children and young people.

The paediatric department encouraged children, their relatives and those close to them, to provide feedback about their care, and were keen to learn from experience, concerns and complaints.

Service planning and delivery to meet the needs of local people

- We saw good mechanisms for information sharing, and willingness from staff for flexible working around responding to the needs of parents and children.
- Since the appointment of a consultant specialist in epilepsy, the demand on radiological services, particularly the use of the magnetic resonance imaging machine, had doubled. To manage this effect, the department had reorganised the bookings system to provide a whole day dedicated to children, to avoid unnecessary waiting times and utilise the service effectively.
- We saw that where initial recruitment initiatives had not been successful, alternative arrangements had been introduced to ensure continuity of safe care. For example, where a paediatric lead had been sought for the recovery department, in the interim until the post was filled, there has been in-house teaching and training provided to ensure a cohort of recovery staff developed paediatric care skills.

Access and flow

- The executive team had seen an increased pressure on paediatric beds. We saw evidence that steps had been taken to maximise the use of the pre assessment and children's day surgery unit (Wizard Ward) to ease the pressure on inpatient wards, and avoid elective paediatric cases being cancelled.
- Families told us how they were able to take advantage at short notice of cancellations on the admissions list. They explained that they were contacted and were able to bring their child in for treatment as they had already been pre assessed.

Meeting people's individual needs

- Staff explained that young people up to and including those of 16 years, were given the option to be admitted to Wizard Ward (the children's day surgery unit), or be admitted to the adult surgical unit. However, if the young person had special needs, they were admitted to Wizard Ward to ensure that their needs were met by staff with the relevant experience and skills.
- We spoke with an anaesthetist about the use of safety measures to ensure that the right operation was performed. They described a situation where a young person with autism refused to have their operation site

marked pre operatively. To overcome this situation, the theatre team carried out a risk assessment to ensure the person's individual wishes were respected and needs were safely met.
- Staff had access to translation services when required.
- There were dedicated play areas that had been brightly painted and equipped with toys in some of the departments such as X-ray and outpatients.
- Child-friendly literature for various age ranges was available, providing information about procedures such as an MRI scan.
- In the high dependency areas parents were able to stay at the bedside, and a family room was available for relatives. Facilities were available for parents to stay overnight if they wished.
- There were a range of toys and play materials provided for children to use in each ward.
- Posters and information leaflets were displayed throughout the wards for families to access, giving information such as how to access support services, as well as providing health promotion leaflets.

Learning from complaints and concerns

- People we spoke with knew how to raise concerns or make a complaint. Staff told us that they encouraged people who use services, those close to them, or their representatives, to provide feedback about their care.
- Staff said that they shared learning from concerns raised by families on the ward during handover.
- Complaints procedures and ways to give feedback were accessible.
- The Patient Advice and Liaison Service was situated centrally in the main reception area, away from the wards and clinical departments, to ensure ease of access and privacy when required.
- There had been few complaints - for example, only one complaint in some areas, and numerous compliments received by the children's wards over the past year.

Are services for children and young people well-led?

Good

The paediatric departments could demonstrate that risks to the delivery of high quality care were identified, analysed and mitigated, before they became issues which impacted on the quality of care. In most instances there was evidence of good team-based working, characterised by a co-operative, inter-disciplinary approach to delivering care, in which decisions were made by teams as well as managers.

Vision and strategy for this service

- There was a vision and strategy for the trust overall. Staff computer screen savers displayed the key aims of the trust and patient feedback results.
- We saw through the minutes of meetings, and staff we spoke with confirmed, that they had been consulted with regard to service developments and design plans. However, there were exceptions to this. We learnt that the radiology services had not been involved in the plan to appoint a new consultant to lead the epilepsy service for children. This appointment had made a significant impact on radiology services, particularly MRI scans. As a consequence, there was now a waiting list despite the fact that the dedicated half day list had been extended to a full day list.

Governance, risk management and quality measurement

- We looked at examples of reports of governance meetings, quality monitoring systems and incident reporting practices. These showed that there were management systems in place, which enabled learning and improved performance, and which were continuously reviewed where required.
- We looked at minutes of the meeting of the safe paediatric surgery group, which showed monitoring and reporting of key performance indicators, audits, policy changes and risk management practices, to sustain services and improve care.
- The performance and delivery of children's services was mapped efficiently on a dashboard, with audit outcomes, for staff and board members reference. These monitoring systems show that the board and senior managers were informed on quality issues, risk, and general performance regarding children and young people across the organisation.
- Staff were aware of the key performance outcomes for the paediatric service.

- There was consistency between what frontline and senior staff said were the key challenges/problems facing the service, such as increased demand on paediatric beds, and the lack of facilities for adolescents.
- The risk register reflected what individuals said was on their worry list, such as medication incidents.
- The senior nursing lead explained that they had developed and introduced a process to minimise the level of medication incidents, which was used for nursing and medical staff alike; its aim being to improve performance and to support continued reporting and shared learning from incidents. At the time of the inspection this had not been formalised to ensure that it was consistently applied, but senior nurses we spoke to were able to describe the process.

Leadership of service

- Staff appeared knowledgeable about the trusts plans, and reported being positive about the planned changes and improvements made.
- Staff told us that there was visible leadership across the organisation to support the strategies, and senior managers were visible in the department for day-to-day operational management.
- Staff reported that they felt there was strong leadership and support for junior staff members at ward level.
- Through discussion with staff we noted that there were good levels of retention of staff in paediatric services, although senior nursing staff were unable to identify any succession planning they had used within this speciality.

Culture within the service

- Staff told us that there was a feeling of openness, where they felt able to report incidents without fear of a blame culture.
- Nursing staff told us that they felt valued, and were able to contribute to the development of the service.
- Staff were aware of the trust's whistleblowing policy, and knew how to raise a concern. Staff told us that they had not had the need to raise a concern, but said they felt they would be supported if they needed to discuss a concern with their manager.

Public and staff engagement

- During our inspection, we saw a number of cards and letters from patients and their relatives, thanking staff for the care they had received.
- We observed that people were encouraged to provide feedback about the service provided.

End of life care

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

Information about the service

The Mid Essex Hospital Services NHS Trust (MEHT) provides care to 380,000 people living in and around the districts of Chelmsford, Maldon, Braintree and Witham. Patients with palliative or end of life care needs were being nursed on general wards within Broomfield Hospital, Farleigh Hospice, or at home. The trust had delivered end of life or palliative care to 462 patients between April and October 2014.

The trust's palliative care team consists of 2.78 whole time equivalent (WTE) band 7 and one WTE band 6 specialist nurses. The team provide, co-ordinate and plan care for patients at the end of life on the wards, and are available Monday to Friday, 9am-5pm, but not on Bank Holidays. Out-of-hours cover is provided 24 hours a day, seven days a week by one of four palliative care consultants.

We visited eight wards and five units where end of life care was provided, together with the bereavement office, mortuary and chaplaincy multi-faith centre. During our inspection we spoke with the organ and tissue transplant co-ordinator, and interviewed a total of 31 members of staff. These included the clinical director for palliative care, doctors, service managers, nurses, health care assistants, mortuary technicians, staff in the bereavement office, and two chaplains. We spoke to seven patients and five relatives. We observed interactions between patients, their representatives and staff, and looked at care records. Before our inspection we reviewed performance information from and about the trust.

Summary of findings

We found that overall, the service required improvement due to there being no board member with end of life care responsibility, and poor communication. We also found that access to the service was poor. We found that improvements were required regarding safety, access to the service, and in responding to patient's needs. The trust did however recognise that there were limited resources in the palliative care team.

End of life care for patients was supported by a specialist palliative care team. Since the phasing out of the Liverpool Care Pathway, the trust did not follow a specific end of life care pathway. We were advised that two wards were primed to pilot an adapted Basildon care plan in January 2015; however, the senior nurses of both wards selected told us that they were unaware of the proposed pilot or new care pathway.

Staff who worked on wards where they were likely to nurse end of life patients did receive four hours training on 'the symptoms and principles of palliative care'. However, staff told us that although the training was very good, they still did not always recognise when patients required specialist end of life care input.

There were inconsistencies in the completion of 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms. It was not always clear whether discussions with the patient and their representative had taken place.

The caring and responsive approach shown by the chaplaincy, and the services provided to bereaved

End of life care

families by staff in the mortuary, were outstanding. Staff within both services went beyond the call of duty to support families, particularly those bereaved of children and babies.

Are end of life care services safe?

Good

End of life care took place on general ward areas throughout the trust and requires improvement. Most medicines were appropriately prescribed, but were not always administered when they should have been.

Anticipatory medications were prescribed for patients who required end of life care. DNA CPR forms showed variable degrees of completion, and had not always been appropriately signed in a timely manner by a consultant. One patient with a completed DNA CPR form told us that they could not remember being asked for their consent. On one ward we visited, four of the five DNA CPR forms we looked at had been incorrectly completed. DNA CPR forms were not being audited at the time of the inspection, as we were told that resources were not available.

There was a medical end of life lead for the trust, but there was currently no formal strategy for end of life care or an end of life care pathway. However, we were advised that this was being formulated. New staff on induction were receiving one hour mandatory training in palliative care and another three hours on 'the symptoms and principles of palliative care' during preceptorship. A member of the palliative care team told us that this was inadequate.

Incidents

- Incidents were reported through the trusts electronic reporting system, Datix.
- The specialist palliative care team told us that there were very few reported incidents relating to end of life care.
- There was no risk register specific to end of life care.

Environment and equipment

- The environment within the mortuary had been updated over recent years. Ten new fridge spaces were added in 2010, and 20 more bariatric fridges were added in 2014. The capacity for the unit in total is now 87 fridge spaces, including 20 bariatric and five deep freezers.
- The mortuary was clean when we visited. The environment was modern. We observed cleaning protocols and saw documented evidence that these were being adhered to. We saw that the 'Tristel-Fusion'

system was used to sterilise all equipment. The head mortuary technician told us that they followed standard operating procedures for receiving potentially infected bodies. We tracked the process and found it to be robust.

- Staff told us that equipment required to care for patients at the end of their life was available when it was needed. However, the trust was still using some Grasby syringe drivers within the hospital which are due to be phased out nationally by March 2015. McKinleys syringe drivers, that are considered to be 'best practice', were only available within the community at the time of the inspection. Inpatients requiring subcutaneous medication administration received this via B-Braun syringe drivers.

Medicines

- Staff told us and we saw that patients who required end of life care medicines were written up for anticipatory medicines (medication that they may need to make them more comfortable).
- We saw the syringe driver medication prescription chart was printed on a separate loose form, and was not part of the normal prescription chart.
- We checked many medication administration records and found that intravenous (IV) and subcutaneous analgesia was often administered up to four hours late. Late medications were not being reported on Datix. There was also a lack of evaluation documented in patient's notes of the effect of analgesia that had been administered. Patients were not always receiving their regular medication when they should have done.

Records

- We looked at 25 DNA CPR forms across the hospital. On the emergency assessment unit (EAU) five randomly selected DNA CPR forms were chosen, only one of which had been completed in line with national guidance published by the General Medical Council (GMC) and Resuscitation Council UK.
- One stated 'Patient has an Advance Directive' but there was no document to prove this. One stated 'Patient had a previous DNA CPR completed ten years ago' with no documentation of the previous decision in their notes.
- Two stated that the matter had been discussed with family, with no evidence documented in the patient's notes to back this up. On another ward a patient with a completed DNA CPR form told us that they could not remember being asked the question. There was nothing written on the DNR CPR form or in the notes that would suggest that the patient had any memory issues or lack of understanding.

Safeguarding

- The trust had a safeguarding of vulnerable patients policy.
- Safeguarding training was mandatory, and new staff received safeguarding awareness training on induction.
- Most of the staff we spoke to told us that they had received training in safeguarding adults. The trust had a safeguarding lead and most of the staff we spoke to told us that they knew who the lead was.
- The staff we spoke to told us that they knew how to make a safeguarding referral, and were able to give examples of when they would make a safeguarding referral.

Mandatory training

- End of life/palliative care training was included as part of the trust's mandatory training programme. New staff received one hour of training on 'the symptoms and principles of palliative care' during induction, and a further three hours at preceptorship training after they had been in post for six months.
- The palliative care team offer on-site training where required by staff, and drop in sessions at the office. However, we were told by a member of the palliative care team that these had been poorly attended due to time constraints.
- There is an online e-learning package provided by the CCG via the community trust; however, we were advised that time is not always available for staff to complete the package. Most of the staff we spoke to said that they needed more training as they were still missing the signs for recognising a patient requiring end of life care.

Assessing and responding to patient risk

- There was a recognised early warning tool being used to identify when patients were deteriorating. Specialist support was available for staff on the wards from the palliative care nurse specialists when required.
- Staff who worked on wards where they were likely to nurse end of life patients did receive four hours training

on 'the symptoms and principles of palliative care'. However, staff told us that although the training was very good, they still did not always recognise when patients required specialist end of life care input.

Nursing staffing

- The trusts palliative care team consists of 2.78 whole time equivalent (WTE) band 7 and one WTE band 6 specialist nurses.
- The team provide, co-ordinate and plan care for patients at the end of life on the wards, and are available Monday to Friday, 9am-5pm, out of hours support is available via the local hospice.

Medical staffing

- There was a designated medical lead for end of life care at Broomfield Hospital. Specialist medical support for people requiring end of life care was provided by five consultants in palliative care.
- The care of each patient who was at the end of their life was managed by the consultant who was most relevant to that patient's condition, with input from the palliative care consultant where required.

Major incident awareness and training

- The mortuary was engaged in resilience for the trust and was part of the major incident plan. The environment enabled the isolation of high risk, infectious and contaminated patients. The mortuary staff were clear on the procedures to manage such an event.

Are end of life care services effective?

Requires Improvement

Service at the end of life require improvement, as there was no guidance on the use of an end of life care plan in place, minimal training was given to staff, and there was no identification of patients who may not have been in the last days or hours of life, but who would benefit from the expertise of the specialist palliative care team. In line with national guidance, the trust had withdrawn the Liverpool Care Pathway. At the time of our inspection, there was no specific end of life care pathway used within the trust, and staff were not clear about what guidance they should be following. We did not see a specific care plan relating to end of life care. The end of life care medical director told us that the team were working on developing an end of life care pathway for use throughout the trust due to be piloted in January 2015.

Evidence-based care and treatment

- Following the withdrawal of the Liverpool Care Pathway the trust had not yet put an end of life care pathway in place. The clinical director for end of life care told us that the end of life care strategy group had been working on a replacement care pathway that they were due to pilot on two named wards in January 2015. However, the senior nurses on both of the named wards told us that they were unaware of the proposed new care pathway, or their part in a pilot, at the time of our inspection.
- We spoke with staff about what guidance was used with regards to caring for patients at the end of their life. Staff were unable to tell us about current guidance relating to end of life care.
- There was no end of life care plan in place, minimal training was given to staff, and there was poor identification of patients who may not have been in the last days or hours of life, and who would benefit from the expertise of the specialist palliative care team.
- The specialist palliative care team received a monthly data report on patients they had seen, and trust audits were performed. The team participated in a national biannual audit (National Council of Palliative care) and outcomes from this had been used in a business case to support the service.

Pain relief

- There was no prescribing guidance to ensure that anticipatory prescribing took place. This meant that pain relief may not always be administered in a timely manner.
- Nursing and medical staff told us that they would contact the specialist palliative care team for advice about appropriate pain relief if required.
- The specialist palliative care team did not undertake local audits to assess the effectiveness of pain management.
- On discharge, some patients B-Braun syringe drivers, which were used in hospital, were discontinued. Stat doses of analgesia were given to keep patients comfortable whilst awaiting district nurses to set up a McKinley syringe driver at home.

End of life care

- We looked at medication prescription charts, and found delays in administering PRN analgesia (PRN medication is to be used 'as necessary'). One family told us that their relative had been asking for analgesia for nine hours. Delays in PRN medication were not audited.
- We saw evidence that some patients had been referred to the pain team.

Nutrition and hydration

- The trust had taken part in the National Care of the Dying Audit 2014, with the conclusion being "inadequate focus on issues around clinically assisted hydration/nutrition including related communication when dying was not recognised".
- Throughout the trust, a national assessment tool was used to assess patient's nutritional status and identify what interventions were required.
- We observed that patients had access to drinks, and the majority of patients were able to reach their drinks. However, there were some patients who would not be able to reach their drinks without support.

Patient outcomes

- Mid Essex Hospital Services NHS Trust (MEHT) had participated in the National Care of the Dying Audit 2013/14. The trust performed well in six of the seven key performance indicators and scored worse in two. These related to having a member of the board representing the service and feedback to families.
- Staff we spoke to were not always clear about identifying when a patient should be referred to the specialist palliative care team.

Competent staff

- New staff were provided with an induction programme, where they undertook one hour of mandatory training on 'the symptoms and principles of palliative care', and a further three hours approximately six months into their role.
- Staff told us that they received annual appraisals, and they had regular supervisions within their ward areas.
- The specialist palliative care team told us that they gave on-the-spot training for staff where required, and provided drop-in sessions within the palliative care department for staff.
- Staff told us that the training they received in palliative care was good, but insufficient, as they were still missing signs of patients who were requiring end of life care. Staff said they were aware of the e-learning package for end of life care, but that the pace of work on the wards did not allow them time to sit down and complete the learning package.
- A member of the specialist palliative care team told us that the amount of training that staff receive currently is inadequate.
- All staff spoken to said that they could get support from the palliative care team when they needed it.

Multidisciplinary working

- The trust had taken part in the National Care of the Dying Audit (May 2014). The results showed that the trust was identified as being significantly below the national average in relation to multidisciplinary recognition of patients in their last hours or days of life.
- We saw evidence that some wards had a multidisciplinary ward round.
- The trust did not have or use the electronic palliative care co-ordination system to identify patients who were receiving palliative care.

Seven-day services

- The specialist palliative care team were available Monday to Friday, five days a week, excluding Bank Holidays. Advice and support was available out of hours from the local hospice.
- Out-of-hours cover was provided 24 hours a day, seven days a week, by one of five palliative care consultants.
- The chaplaincy service provided multi-faith pastoral and spiritual support seven days a week, and were contactable 24 hours a day, via their on-call system.

Access to information

- Staff had access to electronic information, such as policies, national guidance and the minutes of some meetings.
- If patients required support they could access the palliative care team out of hours, or review the information available on the intranet for guidance. Staff on the wards were able to demonstrate that they could easily access information when required.
- There was information available for relatives on end of life care, which was accessible in each ward.

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

End of life care

- Mental Capacity Act training was mandatory across the trust.
- We saw that consent to treatment was obtained appropriately from patients who had capacity to give consent.
- We saw no evidence of any patient having their liberty deprived.
- We looked at many DNA CPR forms across the hospital. On the emergency assessment unit (EAU) five randomly selected DNA CPR forms were chosen, only one of which had been completed in line with national guidance published by the GMC and Resuscitation Council UK. One stated 'Patient has an Advance Directive', but there was no document to prove this. One stated 'Patient had a previous DNA CPR completed ten years ago', with no documentation of the previous decision in their notes. Two stated that the matter had been discussed with their family, but there was no evidence documented in the patient's notes to back this up. On another ward a patient with a completed DNA CPR form told us that they could not remember being asked the question. There was nothing written on the DNR CPR form or in the notes that would suggest that the patient had any memory issues or lack of understanding.

Are end of life care services caring?

Good

End of life services were caring. We saw that patients were treated mostly with compassion, dignity and respect. Most of the patients and their representatives spoke positively about their care and told us they felt included in their care planning. The caring approach of the mortuary and chaplaincy staff we observed was outstanding.

Compassionate care

- Throughout our inspection we observed patients being treated with compassion, dignity and respect.
- Patients told us they were treated respectfully by the staff. One recently bereaved relative told us "it all happened so fast from diagnosis to collecting the death certificate. We did not have time to prepare for this, however the treatment our relative received in the last days of their life was second to none".
- Patients told us that their privacy was respected and staff respected their dignity.
- All the staff we spoke with showed an awareness of the importance of treating patients and their representatives in a sensitive manner.
- One patient told us "I have no complaints the nursing care is excellent". We had mixed reviews from talking to relatives. One relative of a recently bereaved person told us "the care on some wards here is non-existent however the ward my relative died on could not have done more for them or us as a family. They were truly fantastic".
- The mortuary service were also involved in repatriation of people who pass away overseas, and had recently increased its fridge capacity to enable this. The privacy, dignity and care shown to recently bereaved relatives and to the bodies received was outstanding. The team of mortuary technicians were highly qualified and experienced.
- We spoke to a bereaved family who had recently visited the mortuary. They told us "they have made this horrible time of our lives more bearable. We didn't feel at all rushed. We were told to take all the time we needed and were given every comfort available. They truly are a professional team of people".
- We saw many thank you cards and letters addressed to the chaplaincy. One read "please don't ever underestimate the comfort, peace and hope that you bring to people at the lowest points in their life". Another read "thank for all you did for … and all our family. You are very special".
- Patients and their representatives we spoke with were not always complimentary regarding the care they had received.

Understanding and involvement of patients and those close to them

- The trust had participated in the National Care of the Dying Audit (October 2014). The results showed that the trust was identified as being below the national average in relation to health professional's discussions with both the patient and their relatives/friends regarding their recognition that the patient was dying. The survey also identified the trust as being significantly lower than average for communication regarding the patient's plan of care in the dying phase. Discussions with relatives occurred infrequently (13 out of 27 patients).

End of life care

- The survey identified the trust as having very poor documentation on wishes and preferences for patients 'Place of death', with poor recognition and communication with families when dying was not recognised.

Emotional support

- The senior mortuary technician told us “we will do anything we can to make the viewing as pleasant an experience as possible for the bereaved family”.
- The bereavement staff explained the process for families who lost loved ones, and provided viewing and funeral support for babies from 20 weeks old to adults.
- A local survey of bereaved relatives' views showed that 24% of bereaved relatives did not feel they were involved in decisions about the care of treatment of their family member, and 24% did not feel adequately supported during the patients last two days of life.

Are end of life care services responsive?

Not sufficient evidence to rate

End of life care services required improvement to ensure that their individual needs were met. Patients who had identified a wish to be cared for in their own homes had experienced delayed discharges of over two weeks. We were advised that this was due to the specialist palliative care team having no end of life care facilitator to help enable a smooth and swift discharge process. The specialist palliative care nurses did not express any concerns about end of life care on the wards; however, they told us that at times, they felt patients who required end of life care were not always identified when they should have been. Of the patients referred to the specialist palliative care team, 35% did not require specialist input.

Patients who were referred to the palliative care team were triaged to be seen according to their needs. The specialist palliative care team were committed to ensuring that patients receiving end of life care services had a positive experience. The specialist palliative care team were available 9am to 5pm, Monday to Friday, excluding Bank Holidays. Specialist support was available after hours via a consultant on-call system. The specialist palliative care team worked closely with patients who were at the end of their life and their representatives to ensure care was carried out in the patients preferred place. There was a multi-faith prayer room, with ablution area, segregation screen and prayer mats for people of the Muslim faith. We saw copies of the Holy Bible and a removable cross for Christians. There were copies of the Koran and other multi-faith books. The responsiveness to the needs of mothers who had lost children or babies, by the mortuary and bereavement staff, was outstanding practice.

Service planning and delivery to meet the needs of local people

- Since the withdrawal of the Liverpool Care Pathway, the trust had no end of life care plan.
- The trust’s 'end of life steering group' was working on an action plan to identify how they were going to respond to the National Care of the Dying Audit.
- There were no specific consultation groups in place for patients and the public to contribute to the development of the end of life care services in the trust.

Meeting people’s individual needs

- There was good multi-cultural support available via the chaplaincy. However, figures from the National Care of the Dying Audit 2014 showed that 'the assessment of spiritual needs of the patient and their nominated relative or friend was 14% at MEHT compared with 37% nationally'. Nurses told us that they were not allowed to ask patients what religion or faith they were, and therefore they were having to rely on the patients volunteering the information.
- There were no information leaflets available for DNA CPR, fluids or nutrition. However there was literature was provided by the department titled 'Bereavement Information' and 'Coping with Grief'. The books contained a step-by-step approach on what relatives should do next.
- There was a multi-faith prayer room, with ablution area, segregation screen and prayer mats for people of the Muslim faith. We saw copies of the Holy Bible and a removable cross for Christians. There were copies of the Koran and other multi-faith books.
- The bereaved suite in the mortuary department was appropriately decorated and comfortable for grieving relatives. There was just one viewing room within the mortuary that was adapted to accommodate multi-faiths. We saw a variety of items, including cribs in a variety of sizes, teddy bears and dolls.

End of life care

- A staff member on the ICU told us that they had facilities for up to two relatives to stay, and would provide food and drink for the duration if required.
- Most wards and departments we visited had side rooms for patients receiving end of life care, and facilities for close family members. We saw quiet rooms with tea and coffee-making facilities.
- We were told by staff that controlled medications (CDs) were not being prescribed correctly on patient discharge. Staff told us that this happened up to six times a day, but they did not report it on Datix due to the work required.
- There was no evidence to prove that patients increased needs were recognised or evaluated, and a plan of care developed.
- The responsiveness to the needs of mothers who had lost children or babies, by the mortuary and bereavement staff, was outstanding practice.

Access and flow

- Patients were referred to the specialist palliative care team if they had been identified as requiring end of life care. However, 35% of people referred to the team had not required specialist intervention.
- The specialist palliative care team told us that they were not receiving timely referrals, as they were taking around 3-4 days from decision to referral.
- The specialist palliative care team worked closely with patients and families to get the patient discharged to their preferred place of care. There was no end of life care facilitator in post at the time of our inspection. The specialist palliative care nurses told us that the discharge process is inefficient and lengthy.
- Patients who had identified a wish to be cared for in their own homes had experienced delayed discharges of over two weeks. We were advised that this was due to the specialist palliative care team having no end of life care facilitator to help enable a smooth and swift discharge process. One relative of a patient who wanted to die at home told us “the fast track discharge system is very slow. It has already taken over two weeks”.
- Where possible, side rooms were prioritised for patients at the end of their life. This provided privacy for patients and their families.

Learning from complaints and concerns

- Where complaints had been reported and referenced care at the end of a person’s life the lead nurse for the palliative service would be consulted on the complaint investigation for response.
- Between September 2013 and September 2014 there had been nine complaints of which six were upheld or partially upheld.
- Learning from incidents was only identified in five of the nine complaints raised about end of life care and on the information provided to us by the hospital some of the learning from complaints was weak. For example in one complaint about a doctors attitude the learning point identified was for the doctor to attend an Advanced Communications Skills Course. In another complaint about poor care at end of life and use of the Liverpool Care Pathway the learning identified was ‘Discuss at next ward meeting the relatives perception of the patients appearance.’
- We were not assured that all learning from complaints relating to care at the end of a person’s life were being robustly learnt from.

Are end of life care services well-led?

Requires Improvement

Services for patients at the end of their lives required improvement. Although there was a medical director for end of life care, there was no member on the board with end of life care responsibility. There was inadequate auditing of essential risks areas that had been identified in the National Care of the Dying Audit and by staff for example DNR CPR forms. Communication across the trust about the vision and strategy for this service requires improvement

Vision and strategy for this service

- There was no formal end of life strategy or end of life care pathway. All the staff we spoke to appeared motivated to provide good care for patients, but felt there was lack of direction and co-ordination, with no documented end of life care pathway for more than 12 months since the phasing out of the Liverpool Care Pathway.
- The mortuary and chaplaincy service had clear visions for their services.

End of life care

- There was no appointed executive or non-executive director for end of life care. The Director of Nursing saw end of life care as a priority as did the clinical director who covered end of life care however there was no formally appointed board champion to see the end of life agenda move forward.

Governance, risk management and quality measurement

- There were very few audits and quality measures in place to monitor the effectiveness of end of life care throughout the trust.
- There was no evidence of a trust-wide audit programme to assess compliance with the 'Quality Standard for End of Life Care for Adults' (NICE 2011, updated 2013) and other national guidance.
- There was no risk register for end of life care.

Leadership of service

- Most of the staff we spoke to had been aware of the specialist palliative care team, but some were not aware who the clinical director was for end of life care.
- Staff within the specialist palliative care service spoke positively about the specialist palliative care team.
- Staff we spoke to throughout the trust had been aware of the specialist palliative care team and reported positive working relationships with them.

Culture within the service

- We observed that staff were respectful to each other within their specialities and across all disciplines.
- The mortuary and chaplaincy staff culture was very positive and enthusiastic about the provision of care at the end of a person's life. This was evidenced and demonstrated through their approach to patient care.

Public and staff engagement

- There was a lack of effective engagement with the staff in the trust on decisions about end of life care.
- Although staff knew how to refer to the specialist palliative care team, there was a general lack of knowledge amongst staff as to whom and when they should refer to members of the team.
- Only one of the wards we inspected had a named end of life link nurse.
- We were advised by the clinical director for end of life care that a great deal of work had been done by the end of life steering group on a revised Basildon care of the dying person plan. We were informed that this was about to be piloted on two wards in January 2015. The senior staff on both of the proposed wards told us that they had been given no information regarding the pilot, and had no knowledge of the trusts revised care pathway.

Innovation, improvement and sustainability

- The specialist palliative care team acknowledged that there was a lot of work to be done to improve end of life care services throughout the trust.
- The mortuary had won a trust award for innovation and excellence for the delivery of clinical services in 2014. The senior mortuary technician showed us innovations they had devised to improve the safety of the department. Whilst this service was not directly linked to the overall end of life strategy, the innovative ideas, including the design of the department, entrance and viewing room, leaflets and viewing accessories, were implemented to achieve excellence in care.

Outpatients and diagnostic imaging

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

Information about the service

Mid Essex Hospital Services NHS Trust provided an outpatient service of approximately 196,000 first appointments and 398,000 follow-up appointments over the 12 months prior to the inspection. Outpatient clinics at Broomfield Hospital were across a wide range of specialisms, including ophthalmology, dermatology and cardiology.

Diagnostic imaging services included plain film X-ray, ultrasound, interventional, CT and MRI.

We also inspected sexual health services based at the Fairfield Centre.

Over the inspection days we spoke with 22 patients across the services. We visited all outpatient services, including the sexual health centre in the Chelmsford city centre. We also spoke to a wide range of staff at all levels, including nurses, managers, administrative staff, radiographers, occupational therapists, physiotherapists and other allied health professionals, who make up the vital members of the healthcare teams.

We received feedback from our listening event and staff focus groups. We also reviewed trust policies and procedures, and performance data.

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 clean; however, some areas were in need of refurbishment. 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. There was a shortage of key staff, in particular, qualified nursing staff for outpatients, ultra sonographers, consultant musculoskeletal radiologists, and consultant ophthalmologists. 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. 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.

We found concerns within the outpatient clinics about the length of time patients were waiting for follow-up appointments. We observed clinics running late, and patients reported that they often had to wait a long

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time. There was a decline in the percentage of patients waiting less than 62 days from urgent GP referral to first definitive treatment for all cancers in the first quarter of 2104.

There was good local leadership and a positive culture within the services. Pathology services felt there was a lack of senior clinical leadership to drive the service forward. Sexual health services demonstrated a patient-focused culture. Feedback from their patient satisfaction survey was excellent.

We found that improvements were required by the trust to ensure a robust feedback mechanism to all staff on incidents and 'lessons learnt.' Key staff needed to be recruited to ensure the correct skill mix for clinical work and leadership. Shortfalls within the 62 day target needed to be improved.

As a service the sexual health service was very good with excellent examples of innovative care seen. The service was clean and staff adopted good infection control techniques. Patients were supportive of the service which received positive feedback. The service continually met targets to see and treat patients. The service was well led nursing and medically with all staff engaged in the vision for improving the sexual health provision in mid Essex.

Are outpatient and diagnostic imaging services safe?

Good

Services in the outpatient and diagnostic imaging department were safe. Staff in the outpatient departments we spoke with were aware of the incident reporting procedures, and learning from incidents was evidenced and resulted in improvements to the service. The departments were clean and audit showed that this was normal practice. Equipment was regularly serviced and available. Medicines were stored appropriately and records available for appointments. There were sufficient staff in place to assure safety within the various departments. Some staff felt unable to report incidents and were not aware of feedback however this was not the majority of staff within these departments.

Incidents

- Most of the staff were aware of how to follow the trust's policies and procedures for reporting incidents, including 'near misses'. Staff in both outpatients and diagnostic imaging were supported by senior staff to use the online reporting system. Staff within the pathology services felt that they were not encouraged to use the reporting system and received negative feedback when they did.
- 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.
- We discussed a recent 'never event' (serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken) in diagnostic imaging. The correct procedures for reporting and follow-up were in place. Learning from the 'never event' was evidenced with a modified surgical check list now in use by all relevant staff. Staff confirmed that all serious incidents in diagnostic imaging would be reviewed within twenty four hours. All radiation incidents were investigated in line with local policy
- During the year 2013/14 one 'never event' had been recorded. This related to a drug dispensing error in

pharmacy for an outpatient receiving chemotherapy. 'Never events' are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

- We saw that the recommended actions and learning from a sample of incidents had been completed in accordance with the investigation outcomes. Diagnostic imaging produced a monthly newsletter to all staff, with lessons to be learnt from incidents and near misses. Staff within the outpatients department were less aware of feedback from incident reporting.
- We looked at the Root Cause Analysis Investigation Report for the significant backlog of radiology reporting that had been on the Radiology Risk Assurance Framework since 2010, and which has more recently been an area of focus for the executive team. The lack of reporting was not compliant with the Ionising Radiation (Medical Exposure) Regulations 2000, IR(ME)R. Significant improvements have been made in the reporting backlog, and since November 2013 the department has been using an outsourcing company to report 1,000 plain films per week. Three full reports have been completed, with one progressing to a Serious Untoward Incident (SUI). It was noted that the rate of harm caused by the backlog was lower than that expected due to missed findings in the primary reports of competent qualified radiologists. Lessons have been learnt throughout the department and with the executive team. MEHT radiologists have committed to additional reporting sessions each month and the department are maximising the use of reporting radiographers where possible.

Cleanliness, infection control and hygiene

- All the outpatient and diagnostic imaging areas we visited were found to be exceptionally clean.
- The sexual health service was exceptionally clean and well organised we observed staff adopt excellent hand hygiene techniques in this area.
- We noted that the majority of 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. All staff we spoke with had completed infection control training.
- There was an ample supply of alcohol hand gel dispensers, although some were more clearly labelled as to their usage than others.
- Infection prevention and control policies were accessible to all staff on 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 department. No issues or concerns were identified.
- Staff in the pain clinic showed us evidence that the trust abscess rate following an epidural was 0%, as compared to the national average of 8%.

Environment and equipment

- Equipment in all the departments was regularly serviced, tested and appropriately cleaned. Diagnostic imaging employed a full time radiology engineer, who attended to all first line maintenance needs of the equipment and managed the maintenance contracts.
- We saw labelling on equipment to demonstrate that testing had been completed and on which date.
- Some areas of diagnostic imaging were in need of refurbishment, and plans were in place to redevelop the interventional rooms to update the equipment and the environment.
- 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.
- The decontamination policy and procedure was in place for all scope equipment. We viewed the training records of staff, and noted a traceability sticker in the patient notes to ensure the ability to track back to which scope was used.

Medicines

- The medicines used within diagnostic imaging were managed through the pharmacy. Contrast agents used for some radiological investigations were ordered by the CT radiography and kept in a locked cupboard. The nurses within the diagnostic imaging department managed the controlled drugs, which were kept within a locked cupboard within the interventional room. We saw that the correct protocol for storing and administering the controlled drugs was in place and followed. All staff required to undertake injections completed an accredited course.
- 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

- Concerns were raised by staff in pathology services around handwritten request forms and samples. Staff felt that introducing electronic requesting would improve quality and reduce the failure rate.
- There did not appear to be any issue with patient records in the outpatient clinics. The notes we looked at were in good order.
- Issues with lost referral forms in diagnostic imaging had been addressed. All referral forms transferring across sites were uploaded on the CRIS (Computerised Radiology Information System) before leaving the department. This meant that staff had access to an electronic version at all times.
- We did not see any breaches of confidentiality of patient information during our visits to all the departments.
- Staff told us some information, such as X-rays, were accessed electronically.
- Patient X-ray reports were sent electronically to the GPs.

Safeguarding

- A senior member of staff in diagnostic imaging told us how staff completed different levels of safeguarding training depending on their role. They felt staff were very aware of their responsibilities. In accident and emergency, the radiography staff worked closely with the paediatric interest group to ensure close monitoring of any concerns. All the staff we spoke with across the departments were aware of the process to follow if they wished to report any concerns, and could identify issues of abuse and neglect. The diagnostic imaging administration team explained the safeguarding process for children who did not attend for appointments twice in a row.
- Good safeguarding procedures were in operation within the sexual health service. Protocols were being developed to address issues such as domestic violence and exploitation. The team worked closely with other safeguarding services and the police.
- Staff in the allied health professional focus group were all aware of the safeguarding team in the hospital. One person said “they empower you in the process”. Staff felt they could report any concerns and could ask questions freely.
- Within the sexual health service female genital mutilation (FGM), domestic violence and exploitation protocols were still being developed. We discussed this with the safeguarding team who assured us that they would look at the referral process.

Mandatory training

- Staff said they were up to date with their mandatory training and the training records we looked at confirmed this. Staff felt the training was very good. Staff were supported to use the e-learning system.
- We examined the trust mandatory training register for staff working in outpatients which supported that staff had received appropriate training.

Assessing and responding to patient risk

- Staff were present in clinic rooms and waiting areas, and were able to respond to patients who appeared unwell and might need assistance.
- Staff were able to summon emergency medical support if required.

Staffing

- 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.
- Allied health professional staffing within some of the pathology services was stable. Some roles were difficult to recruit to.
- Allied health professional staffing within diagnostic imaging was good, with a wide range of skill mix. Advanced practice roles were widely used throughout the service. Agency usage was limited, but a permanent set of bank staff were used as required. A comprehensive induction programme was offered to all staff.
- Managers of the administrative staff we spoke with felt that increasing demand was putting pressure on the team. They were working well with two apprentices taking part in the trust-wide scheme as well as bank staff.

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Medical staffing

- Staff told us that there was no clinical scientist consultant in post. The post had been vacant for four years. The staff felt that they had little clinical leadership, as this post was a vital member of the team.
- There was a shortage of musculoskeletal radiologists, but senior staff did not report any issues with running sessions or reporting.
- A locum dermatologist was in place for a while to cover staff shortage, but the post has now been filled.
- Consultants in sexual health services all received an annual appraisal, and were supported in their revalidation process.

Major incident awareness and training

- Staff we spoke with were aware of the trust's major incident policy. The diagnostic imaging administration staff kept an up-to-date record of telephone numbers to use in case of emergency.
- On the day of the inspection, an internal major incident in accident and emergency was raised. The senior staff in diagnostic imaging responded in line with trust requirements to support the service wherever possible.
- Staff were aware of the business continuity plan for the trust and how to access it.

Are outpatient and diagnostic imaging services effective?

We saw good evidence of multidisciplinary working across the services. Staff were well supported with appraisals and access to training.

We saw evidence-based practice in operation, and staff demonstrated a willingness to learn and improve outcomes for their patients. The services were adhering to NICE guidelines and Royal College guidance where required. The service participated in local and contributed to national audits.

Evidence-based care and treatment

- We saw that trust policies were based on and developed to include nationally-recognised guidance, such as NICE and Royal College guidelines.
- Guidelines from the National Institute for Health and Care Excellence (NICE) for the management of glaucoma had been updated and put into practice in the outpatients department. The change highlighted the need to audit previous patients who had not received timely reviews. Incident reports were submitted, and all patients were offered the opportunity to discuss their treatment plan with a consultant.
- 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.
- Delays in waiting times for a first appointment for ophthalmology clinics were being addressed, but the delay meant that patients were waiting longer than acceptable for assessment and treatment.
- There was no evidence of patient outcome surveys in the outpatients department apart from within the pain relief service. This service collated a number of services on their effectiveness as a service.
- 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.
- Following the updated guidelines on glaucoma, a consultant ophthalmologist is now supernumerary in the clinic, and supports others as required. This has avoided unnecessary repeat appointments.
- Sexual health services were involved in local and national audits. The district audit group met three times a year and was attended by the service.

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 new member of staff told us that they had just completed the trust induction programme and a full department induction. They felt they were now better equipped to understand the trust and to do their job well.

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Multidisciplinary working

- We found good evidence of strong multidisciplinary working across the services. We found that doctors, nurses and allied health professionals worked well together. Examples given included radiographers attending orthopaedic trauma meetings daily, allied health professional-led unit meeting on the burns unit every two months, and the dementia team - involving occupational therapists, speech and language therapy, and nurses - meeting twice a month.
- Staff within the outpatients department told us the multidisciplinary working was effective and professional. One member of staff said “it is great team work here”.

Seven-day services

- Diagnostic imaging provided a 24-hour, seven day a week service.
- Outpatient services operated a five day a week service, with extra clinics arranged in the evenings and at weekends when required.

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 coming from a care home, to ensure 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.
- We observed a consultation in one clinic. A full explanation was given by the consultant and the mother gave verbal consent on behalf of her young child.

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.

Compassionate care

- We observed a wide range of staff of differing professions and grades interacting and speaking with staff 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 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 “I am very satisfied with the care”.
- The diagnostic imaging staff told us that if hospital transport was delayed for collecting patients from the department, they were offered food and drink, which was available from the A&E fridge.
- 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.
- Whilst we did not speak with patients using the secual health service during our inspection we viewed the feedback the trust had gathered confidentially around the service. Feedback on the service was extremely positive with the majority of patients very happy with the service they receive.

Patient understanding and involvement

- We spoke with seven 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.

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- We observed one nurse giving a full and clear explanation of the follow-up process following the administration of eye drops.
- Self check-in kiosks were available to all patients at Broomfield Hospital outpatients. Support was available for patients that needed extra help or wanted to check-in verbally.

Emotional support

- A clinical nurse specialist (CNS) was present in the ear, nose and throat (ENT) clinic when bad news was being delivered. The CNS was then assigned as the patient's key worker. It was confirmed that a CNS is available in all specialties to support those receiving bad news.
- Patient experience meetings were held in outpatients, giving patients the opportunity to raise any concerns, and to receive appropriate support or signposting to support.
- Increased psychological support was available in the pain clinic. Patients can attend a pain management programme. This was well supported in the community by physiotherapists, etc.
- No on-site psychology support was available to sexual health patients. Counselling support was available weekly for patients with HIV.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

The outpatients department was not fully responsive to the needs of patients. Clinics over-ran, and some patients had to wait a long time to be seen by medical staff. We found that 3,619 patients were awaiting appointments in outpatients of which 1,528 were for ophthalmology and 1,108 were for dermatology. These patients were not on the waiting list but were on a pending list to be added to the waiting list. The trust was aware of these patients and were taking steps to reduce the numbers, which following our inspection had reduced from around 24,000 to 3,619 patients. The targets for appointments for patients with cancer were being met.

Patients mostly 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. One person was very unhappy with the responsiveness of his consultant for referral for surgery. On the day of the inspection, they received the referral they had been requesting for some time.

Service planning and delivery to meet the needs of local people

- The trust had transferred all outpatient bookings to a central system at the hospital. Most patients we spoke with were happy with the communication relating to their booking. One relative said that there had been a missed appointment due to an incorrect home address. They said this had now been rectified.
- Changes had been made as to the way urgent ophthalmology appointments were booked. A specific email address had been set up for urgent referrals from the community. Nurses carried an iPod, and an automatic response was sent to the referrer. The nurse showed the referral to the on-call doctor, and an appointment was made straightaway.
- Additional clinics were provided where possible to ensure that patients were seen in a timely way.
- The outpatients director of operations met monthly with the local clinical commissioning group (CCG) to discuss service planning and referral pathways for patients. The breast clinical nurse specialist attended this meeting recently to discuss the appropriate referrals for patients needing the fast track two week appointments. This regular meeting aimed to meet the needs of local people better, by ensuring that patients were referred appropriately.
- Concerns were raised by the sexual health team about the lack of an integrated service, as contraception services were commissioned from the community provider. This meant that there was a potential for a lack of co-ordinated care.
- Within the sexual health HIV service the target to see and screen a patient within 48 hours was consistently met each month for more than 12 months.

Access and flow

- The trust was meeting almost all of its referral to treatment times (RTT) according to figures submitted from April 2013 to June 2014. However at the time of our inspection we found approximately 24,000 patients who were waiting on a pending list for appointments. We brought this to the attention of the trust and senior managers who were aware of these patients and were

taking action to reduce the numbers. We received a report which explained the actions taken and that the number of patients had reduced to 3,619. The trust is taking action to reduce this number to ensure that patients are seen and treated in a timely manner.

- Waiting times for diagnostic tests were below the England average. Senior staff told us they accommodated any patient who had the potential to breach the targets whenever possible.
- The percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment for all cancers was above the England average for the majority of 2013. The percentage figures had significantly fallen in the first part of 2014, meaning that patients were waiting longer for urgent treatment. Latest figures show that the trust has achieved 83.4% against this target, as opposed to the desired target of 85%. Further work needs to be done to achieve the target.
- We looked at the outpatient survey for clinic waiting times in October 2014. This showed an average waiting time of 30 minutes for clinics. On the day of our inspection, we observed longer delays in clinics. One patient told us they had waited over an hour on the morning of the inspection for the fracture clinic, and another said "it always runs late in orthopaedics. One time I waited over two hours".
- Senior staff told us the ophthalmology clinics often over-run due to the nature of the clinic, with sight tests, eye drops, etc. to be performed. Appointment letters have been changed to ask the patients to attend thirty minutes earlier, to accommodate the extra requirements of the clinic. This has reduced the waiting times.
- We saw that clinic delays were displayed on the monitors in the sub-waiting areas to give patients information about their appointment times.
- There was good signage throughout the outpatients and diagnostic imaging departments. Staff within the sexual health team felt that the trust could do more to signpost patients to the service.
- We noted and patients commented that the fracture clinic and pain clinic were a considerable distance from the main car park. However, we did see plenty of wheelchairs available. Staff told us that they are able to find assistance for patients who need help to access the clinics.
- The sexual health service had reached their 48 hour access target by providing evening and Saturday clinics.

Meeting people's individual needs

- There was limited information displayed in pictorial form, or in languages other than English. The eye department was clearly signed with an image of an eye. The emergency X-ray department was clearly signed with text and images.
- The self check-in points had a choice of languages available.
- All the services we inspected used a telephone interpreter service for other languages. This was easily accessible.
- Staff across the service had looked at ways in which to meet the individual needs of patients with learning difficulties.
- Within the sexual health service 50% of attendees were under 25. We found that there was a good range of leaflets and supporting information for people in this age group.
- Some of the patients at Broomfield Hospital were not happy with the length of time it had taken to get an appointment. The outpatients' director of operations had designed a new outcome form for the booking staff, to ensure that clinic appointments comply with the 18 week referral to treatment targets, with the aim of reducing appointment waiting times.

Learning from complaints and concerns

- Information about the Patient Advice and Liaison Service (PALS) was clearly visible across the services, and their office was prominent within the main outpatients area at Broomfield Hospital.
- Staff we spoke with were all aware of the complaints procedure, and were confident in dealing with complaints if they arose.
- Administrative staff within the diagnostic imaging department told us that they had learnt from a previous complaint about bullying, and they felt that they worked well as a team.
- Evidence was given by the sexual health team about responding to a patient complaint about signage on the clinical room doors.

Are outpatient and diagnostic imaging services well-led?

Outpatients and diagnostic imaging

Requires improvement

The managers of all 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.

Staff felt that they had increasing workloads, but that there were plans in place to improve staffing. Most staff felt that the senior executive team were more visible now. One staff member said the vision of the trust is clearly “quality and patient safety”.

Vision and strategy for this service

- The managers of all services demonstrated a strong vision for the future of their services. They were aware of the challenges they faced, but had plans in place to develop services and staff.
- Staff told us about lunchtime sessions with the chief executive. Not many staff had attended, but those staff who had attended spoke positively about the experience.
- We heard from many differing staff across the services that the chief executive had an ‘open door’ policy.

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, overall, very happy with the service.
- There was no clinical director in post for the outpatients department at the time of the inspection. There were no clinical governance meetings in place. The director of operations assured us that this was in the process of being set up.
- 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 the 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.
- One of the clinical directors told us about the 'never event' that had occurred in the Ultrasound department within Radiology for a outpatient referral from orthopaedics. We were concerned that because the patient had pain with the joints on both of their sides, it was seen as almost acceptable that the joint on the wrong side of the body had been injected, as the patient was satisfied that they were eventually going to be pain free on both sides. This was because there was a plan to readmit them to the hospital to have the right joint injected.

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.
- At the allied health professional focus group, staff were positive about their teams, and were pleased to have an opportunity to share details of the good work they were engaged with.
- Staff in pathology services were concerned about the lack of clinical leadership, and felt that the department could not move forward without it.

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 patients' best interests at the forefront of their day-to-day interactions.
- Several staff told us how they had seen a change in culture at the trust. One person said “there is a much better ethos now. The chief executive smiles and says hello”.

Public and staff engagement

Outpatients and diagnostic imaging

- The staff were pleased with the recent 'Challenge 2014' events, held across the trust to increase activity and encourage team building. Some staff were disappointed, however, that some of the activities, such as swing-ball, had been stopped.
- Staff we spoke with felt engaged with the trust-wide improvements.

Innovation, improvement and sustainability

- The services we looked at, in particular pathology services and diagnostic imaging, relied on the goodwill of staff to be flexible with shifts and take on extra hours. The staff demonstrated a commitment to their jobs, but this is most probably not sustainable in the long term.
- 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 had replied to an email as regards making savings with innovative ideas. They had received an initial response, but no further follow-up.
- We saw good examples at a departmental level of innovative changes; ideas included a two week wait referral form in a different colour to enable easy identification, and the development of one-stop clinics in urology, and symptomatic mammography, whereby patients can have their examination and report on the same day.

Outstanding practice and areas for improvement

Outstanding practice

- The caring and responsive approach shown by the chaplaincy and the services provided to bereaved families by staff in the mortuary were outstanding. Staff within both services went beyond the call of duty to support families, particularly those bereaved of children and babies.
- The burns service was outstanding with innovative and pioneering approaches to care delivery and outcomes for people with burns which had been reflected in national research papers.
- Outcomes for patients with serious burns comparable among the best in the world and were consistently exceptional. This was evidence through a cohort study undertaken by St Andrew's in 2012.
- Pathways for breast reconstruction and hand therapy were outstanding.
- The trust's abscess rate following an epidural was 0% as compared to the national average of 8% which was an excellent outcome for patients.
- The 'trigger and response team' team were an exception team supporting acutely unwell patients throughout the hospital. The team were recognised throughout the hospital as being very responsive.
- The mortuary team were innovative and passionate about providing a good patient experience at the end of their life.
- Individual specialist staff in the trust including the learning disability nurse, specialist nurse for dementia care and the manual handling advisor were identified as being outstanding and highly responsive to patient and staff needs.
- The nurse-led peripherally inserted central catheters (PICC) was developed within the critical service without initial funding, has seen great success and improved patient outcomes.
- There were outstanding examples of local leadership and innovation in the intensive care unit.

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

- Ensure that only registered nurses are included in the nursing numbers and ensure that staffing numbers are maintained on the EAU by suitably qualified and registered staff.
- Ensure that incidents are appropriately reported and investigated on the EAU.
- Ensure that the adaptation staff working in the hospital are provided with support, supervision and competency training as well as mentor support.
- Improve governance and assurance processes around the use of adaption staff throughout the hospital to ensure that they work within the scope of their role.
- Immediately improve inpatient deterioration recognition across all inpatient areas, particularly on Writtle Ward.
- Immediately work to reduce the number of patients who are on a waiting list for a follow-up outpatient appointment.
- Reduce the number of hospital-acquired pressure ulcers.
- Ensure medicines are administered in a timely way, especially for patients receiving intravenous antibiotics and time critical medicines.
- Ensure care documentation, including care plans and risk assessments, are undertaken in a timely way, accurately, are fully completed, and reviewed when required.
- Ensure that nursing handovers are robust and identify patients at risk.
- Ensure that there are sufficient and appropriately skilled nursing and medical staff on duty at all times to meet patients' needs in a timely manner.
- Ensure nurses have the appropriate/specific skills to care for all the patients in their ward areas.
- Improve treatment times for patients with prostate cancer to ensure a higher percentage of patients receive their required treatment within 62 days.

Outstanding practice and areas for improvement

- Improve governance systems to include formalised and minuted mortality and morbidity meetings across the directorates.
- Ensure that systems for providing staff with feedback on incidents, and sharing learning from incidents, are embedded throughout the trust.
- Develop a strategy for the improvement and delivery of end of life care.
- Improve staff training and awareness on mental health, so that the provision and care for patients in urgent and emergency services with mental health conditions improves.
- Ensure patients with mental health concerns are risk assessed on arrival at the emergency department.
- Review staffing levels on the reception desk in the emergency department.
- Ensure that patients are referred to in a dignified and respectful way, and not as bed numbers, particularly on Danbury Ward.
- Ensure all items of equipment that require annual service and maintenance are maintained on time.
- Ensure patient prescription charts for medicines are signed when medicines are administered, particularly in the emergency department and emergency assessment unit.
- Ensure medicines cupboards are kept secure at all times.
- Ensure that intravenous (IV) fluids are stored securely to minimise the risk of tampering.
- Improve staff knowledge and understanding of what constitutes a safeguarding referral for adults.
- Ensure that all safeguard referrals for adults in the emergency department are completed and actioned in a timely way.
- Work to improve safety, and reduce incidents with a serious impact, on the labour ward.
- Reduce the number of elective surgeries, including elective caesarean cancellations.
- Improve hand washing techniques, and infection control practices and techniques, in the emergency department, emergency assessment unit and on Writtle Ward.
- Ensure that only clinically appropriate patients are admitted to Writtle Ward, also ensuring that the medical outliers criteria for Writtle Ward is not breached.
- Review the decision to lift the birth cap on the maternity service, and determine a safe way to manage the increase in the number of women attending in labour.
- Improve the standard of 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms completion throughout the trust.
- Implement an approved end of life care plan and pathway for patients.
- Review the pathology referral system to ensure that all referrals are managed safely.
- Review the need for a dedicated link co-ordinator for the health team at HMP Chelmsford, to co-ordinate prisoner visits.
- Improve governance arrangements and quality assurance, particularly in incident reporting, risk registers and incident investigations.

Action the hospital SHOULD take to improve

- Ensure quality dashboard data is consistent across the directorate and is in a format that is easily accessible to patients and relatives.
- Provide day rooms for care of the elderly wards.
- Decrease number of agency and bank staff by improving recruitment and retention of nursing staff. This would improve access to training.
- Work and balance staff skill mix across areas to ensure skilled experienced staff are on duty where possible.
- Improve the incident reporting culture for staff trust wide to increase the number of incidents reported overall.
- Review staffing and management structures for end of life care.
- Ensure that recruitment plans, to increase the amount of permanent burns nurses, are agreed and actioned to ensure that the high usage of agency and bank staff is reduced.
- Ensure that there is a paediatric trained registered nurse, consultant and anaesthetist available at all times within the Burns service.
- Review Burns specific policies and procedures to ensure that there is evidence of regular review and ratification.
- Review mechanisms for using feedback from patients, so that there are opportunities for reviewing and improving service quality.
- Improve patient confidentiality throughout the wards particularly when staff are discussing patient care.

Outstanding practice and areas for improvement

- Ensure that cardiac monitor alarms are not muted without ensuring that patient is safe.
- Ensure that staff are provided with feedback and informed of learning from incidents.
- Ensure that patients with mental health concerns are appropriately observed and monitored.
- Ensure the corridor within the emergency department which leads from the ambulance doors and the resuscitation area is kept clear of obstructions at all times.
- Improve shift and nursing handovers in the emergency department to ensure all staff are informed of the required information
- Safely plan and increase consultant cover in the emergency department from 11 to 16 hours per day as recommended by the College of Emergency Medicine.
- Improve patient care within the emergency department around sepsis and head injuries in line with College of Emergency Medicine guidelines.
- Improve implementation of the escalation protocol in the emergency department.
- Improve ambulance handover times within the emergency department.
- Improve local staff engagement throughout the all services within the hospital.
- Safely work to reduce the number of emergency caesareans performed in maternity.
- Consider reviewing the case mix on Danbury ward to ensure those receiving oncology and end of life care are with an appropriate patient group.
- Consider reviewing nursing shift lengths to minimise the number of 13.5 hour shifts staff undertake.
- Improve audit and evidence based care and treatment in maternity services.
- Provide formal team meetings in the maternity and gynaecology wards for staff.
- Review cultural concerns and alleged bullying culture by management within the maternity service.
- Improve 18-week maximum referral to treatment (RTT) waiting standards for general surgery and trauma and orthopaedics.
- Review Executive and non-executive leadership arrangements for end of life care to drive the end of life care agenda through the trust.
- Improve the incident reporting culture trust wide.
- Develop a maternity specific trigger list to ensure robust reporting measures.
- Improve the culture and leadership on EAU.
- Improve the incident reporting culture relating to safe staffing levels.

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.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment. The trust had not ensured that where mental capacity assessments on patients were required that these were undertaken to inform best interest decisions for care and/or treatment. Regulation 18 (1) (b) HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision. The trust has not updated risk assessments, risk registers and policies and procedures relevant to patient care within the department. Therefore the trust has failed to regularly assess and monitor the quality of the services provided. The trust is inadequately analysing the quality of serious incident investigations that resulted in, or had the potential to result in, harm to a service user because the investigations missed key items of information and there was a lack of lessons learnt from incidents and embedding of lessons learned from incidents. The trust did not have appropriate strategies in place for the provision of end of life care.

This section is primarily information for the provider

Compliance actions

Regulation 10(1)(a) and 10(2)(b) and (c)(i) HSCA 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing** **There were an insufficient numbers of suitably qualified, skilled and experienced trained nurses and midwives.** **Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010. Staffing.**

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.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of service users. The trust is failing to carry out assessments of needs to ensure the care delivered meets their needs and is planned for appropriately. The trust is failing to take proper steps to ensure that care plans are regularly updated to reflect people's changing care needs so that people in your care are receiving care that meets their needs and ensures their welfare and safety and reflects, where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment. The trust is failing to plan and deliver care that meets the needs of people who are at risk of pressure ulcers and failing to provide them with foam mattresses with pressure-relieving properties. Care planning does not meet the individual needs of the service users and ensure their welfare and safety. The trust is failing to deliver treatment that reflects guidance issued by NICE in relation to pressure sores. Regulation 9 (1) (a) and (b) (i), (ii) and (iii) HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of service users.

The enforcement action we took:

We served a warning notice on 06 February 2015. This notice was served under Section 29 of the Health and Social Care Act 2008.