This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Mid Essex Hospital Services NHS Trust provides acute services from its main Broomfield hospital site and two other sites across Chelmsford, Maldon, Braintree and Witham. Services include urgent and emergency care, medical care (including older people's care), surgery, maternity and gynaecology, critical care, services for children and young people, end of life care, outpatients and diagnostic imaging. The trust provides local elective and emergency services to around 380,000 people living in and around the local area. There are 21 inpatient wards and 502 inpatient beds at the main Broomfield hospital site.

A list of the acute hospitals at the trust is below.

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Details of any specialist services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broomfield Hospital</td>
<td>Court Road, Broomfield, Chelmsford, Essex, CM1 7ET</td>
<td>Regional plastics, head and neck and upper gastrointestinal (upper GI) surgical services and a supra-regional burns service.</td>
<td>Chelmsford and surrounding areas.</td>
</tr>
<tr>
<td>St Michael’s Hospital</td>
<td>142 Rayne Road, Braintree, Essex, CM7 2QU</td>
<td>Maternity unit and outpatient clinics.</td>
<td>Braintree and surrounding areas.</td>
</tr>
<tr>
<td>St Peter’s Hospital</td>
<td>Spital Road, Maldon, Essex, CM9 6EG</td>
<td>Birthing centre and a range of therapy services including blood tests.</td>
<td>Maldon and surrounding areas.</td>
</tr>
</tbody>
</table>
The trust also includes Braintree Community Hospital which covers the whole of Mid Essex and includes a variety of services including x-rays, MRI scans, CT scans, ultrasound, day surgery, endoscopies, physiotherapy, nursing and rehabilitation services.

(Source: Trust Website)

The trust provides a county-wide plastics, head and neck and upper gastrointestinal (GI) surgical centre to a population of 3.4 million and a world renowned supra regional burns service at the St Andrew's Centre, which serves a population of 9.8 million. In 2017/18 the Trust had a total turnover of over £308m and employs over 5,000 staff.

Mid Essex Hospitals NHS Trust remains a non-foundation trust. The trust began working closely with Southend University Hospital NHS Foundation Trust and Basildon and Thurrock Hospitals NHS Foundation trust in 2014. In 2015 the Essex Success Regime was announced and further collaborative working has been undertaken since this time. The transition of change for the leadership teams commenced in 2016 and work to develop a joint clinical strategy began in late 2015. The partnership between the three trusts was formalised as of 1 January 2017 and shared governance arrangements took effect from March 2017.

Is this organisation well-led?

Leadership
The executives of the trust had the knowledge skills and competencies to deliver care. However, there was significant churn in the site leadership team which delayed implementation of improvement in key areas. Strategies and infrastructures were yet to be fully developed and embedded.

A new Joint Working Board (JWB) was formed as part of the collaboration between Mid Essex Hospital services NHS Trust (MEHT), Basildon and Thurrock University Hospitals NHS Foundation Trust and Southend University Hospital NHS Foundation Trust (the trust refer to the partnership as MSB group, which is used within this report) to drive the joint strategy and reconfiguration. The JWB had an overall chair and consisted of the joint chief executive officer (CEO) for the three trusts, three trust chairs, two non-executive directors from each trust and the three managing directors (one from each site). The JWB also included the chief nurse, chief medical officer, chief financial officer, chief human resources director, chief information officer, deputy CEO and chief transformation officer, chief estates and facilities officer (due to take up post in December 2018) and chief commercial director who were collectively termed as the Joint Executive Group (JEG). Each member of the JEG was responsible for delivery in their areas across the MSB group.

The MEHT trust board remained ultimately accountable for local delivery and had delegated strategic responsibility to representatives from each trust on the JWB.

The trust board at MEHT consisted of the CEO, JEG, the trust chairman, the managing director and five non-executive directors. This board met quarterly and was supported by the JWB who met monthly to discuss not only strategy but the performance of each trust. The MEHT trust board was supported by the site leadership team to manage the day to day operations of the trust. The site leadership team consisted of the managing director, director of nursing, medical director, director of finance, head of human resources trust secretary and head of communications. At the time of our inspection, three of the site leadership team were recently in post (one of whom was interim) and there was a vacancy for head of estates and facilities.

Board Members

Of all board members working at the trust as at June 2018, 12.5% were Black Minority Ethnic (BME) and 50.0% were female.
Proportions of all board members who are BME and female, broken down by type, are in the table below.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>6.3%</td>
<td>31.3%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>6.3%</td>
<td>18.4%</td>
</tr>
<tr>
<td>All board members</td>
<td>12.0%</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Board Diversity tab)

Leaders that we spoke with acknowledged that the current leadership structure was complex and in a state of transition which could be unsettling for some staff. There was a clear plan in place to develop the leadership structure in line with the needs of the MSB group model. This included streamlining key areas of responsibility such as governance and safeguarding.

Leaders generally had the skills, experience and integrity needed for their roles both on appointment and on an on-going basis. Members of the trust board demonstrated the skills, knowledge and experience required of senior leaders. However, some members of the site leadership team whilst having the experience to be appointed into the role were still developing their knowledge and skills in relation to senior management posts. At the time of our inspection, there was no formal leadership development programme, succession plan or talent management programme in place that recognised the distinct needs of the MEHT leadership team. There were plans in place to implement these as part of the developing MSB group ‘People and Organisational Development strategy’, however this was yet to be formalised. In the interim, there were development systems in place for leaders at all levels which linked to the draft group developmental programmes. For example, the trust had arranged for leaders throughout the organisation to be involved in several developmental opportunities aimed at reviewing quality improvement capability and capacity as preparative work for the development for an over-arching group quality strategy. This included sessions on: ‘The Model Hospital’ (NHS Improvement, 2017) contribution in an iQUASER review (a national tool developed to help trusts assess their quality improvement capacity and capability), learning from the Gosport Enquiry, improvement analytics and freedom to speak up sessions. Further sessions were planned, which included a session on making data count. The senior team believe that this had helped those newly in post to review strategies, frame works and improved decision-making abilities of the site leadership team.

The senior leadership team were aware of the current priorities and challenges and identified actions to address them. All leaders told us their key priorities to address current and future challenges included workforce retention and recruitment, managing the financial deficit and patient safety including sepsis, managing the deteriorating patient and infection prevention and control. However, workforce and leadership capacity and external factors sometimes impacted on the ability to complete necessary actions. For example, senior staff told us the inconsistent approach to safeguarding had been partially due to vacancies within the safeguarding team and changes in the way that safeguarding processes were accepted from the local authority. The site level director of nursing (DoN) was responsible for safeguarding at the trust, however this post had been vacant since June 2018 and an interim DoN had been in post since August 2018. The trust did have an action plan in place to address the issues around safeguarding, however this was yet to be fully implemented. Another example was the significant challenges with access and flow, whilst the trust acknowledged that staffing could impact on areas such as discharge planning, they also were acutely aware of the significant challenges within the wider health and social care economy. Limited community and social care resources meant that sometimes patients who were medically
fit for discharge remained as an inpatient while arrangements were put in place for their safe discharge. The trust had appointed a head of clinical improvement and matron for patient flow and clinical improvement during 2018 to support workstreams aimed at improving access and flow processes. At the time of our inspection, the plans for clinical reconfiguration had been referred to the Secretary of State for approval by the Southend Oversight Scrutiny Committee. Senior staff were concerned about the impact that the referral would have on the workforce and the impetus to continue with pre-merger work.

Our review of four sets of personnel files and the group policy demonstrated that the trust had a comprehensive Fit and Proper Persons Requirement (FPPR) process in place to ensure that directors were fit to carry out their responsible roles in accordance with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The process included comprehensive pre-employment checks that included enhanced Disclosure and Barring Service (DBS) checks, insolvency and bankruptcy checks, disqualified director register checks and occupational health checks. There were further checks on appointment through self-declaration and on-going assurance through an annual declaration and a spot audit process conducted by the chair of the JWB.

Leaders had developed a programme of engagement to ensure executive visibility throughout the trust. This included ensuring that members of the site leadership team worked within the operational areas of the trust for a part of the week. Some senior leaders told us they were in the hospital for 50% or more of their working time. Staff told us that some of the senior leaders were highly visible and approachable and had been instrumental in making improvements to services. For example, the implementation of the Emergency Village had been supported by the chief nurse and medical director. They had led the change to culture in empowering staff to make changes within their own area of responsibility.

Vision and strategy

The overall future strategy for the proposed merger and clinical reconfiguration had not been translated into meaningful and measurable plans at all levels of the trust. Staff were not always aware of their role in achieving the overarching strategy.

There was not an overall strategy in place for the trust as a single organisation. The trust strategy had not been refreshed since it had been developed in conjunction with staff in 2015. Staff at all levels told us that this was due to the plans for the proposed merger and clinical reconfiguration. The current strategy for the trust was focussed on the approval for the implementation of the clinical reconfiguration strategy in line with the Sustainability and Transformation Partnership (STP) and development of the MSB group.

Senior leaders told us that whilst the organisation was on ‘a journey’ in terms of form, the vision for the trust remained the same which was ‘To be a healthcare organisation that puts patient care first and whose reputation for excellence and innovation inspires our patients, staff and population we serve’. Most staff we spoke with were aware of the trust’s values which stated, ‘At our best we are a Kind, Professional, Positive Team’ and this was displayed throughout the hospital.

The business case for the future group model and the clinical reconfiguration had been developed after a considerable consultation period with all relevant stakeholders and changes made to the original plan as a result of feedback from staff, patients and the local community. Staff we spoke with were aware of the plans for the future and generally supported the plans for a merger but less clear about how they contributed to the overall delivery of a strategy. Some staff felt that whilst the strategic drive needed to focus on the future to achieve sustainable quality, this meant there had been limited flexibility to develop individual services until the merger and clinical reconfiguration were approved (as reported in some well-led core service reports). This had been on-going since December 2016 and potentially impacted on staff morale and performance. Senior leaders were aware of this and encouraged divisional leads to develop annual business cases that were to include requirements for areas of development. The leadership team acknowledged that there was a need to develop a new vision and overall strategy for the MSB group, however work on this had
not yet commenced. In the interim, the senior leadership team were focussed on the development of the underpinning strategies that were needed to deliver the future models. This included a group ‘People and Organisational Development Strategy’. Senior leaders were clear about the future for the trust and committed to the provision of services that were aligned to wider plans for the health and social care economy.

The clinical strategy had been developed across the three hospital trusts with wider stakeholder engagement and in line with STP plans. The clinical strategy was guided by the following principles, which were to:

- Consolidate services for the most severely unwell
- Consolidate smaller and unsustainable specialities
- Separate emergency and elective where possible
- More services closer to the patients’ home.

The proposals for clinical reconfiguration in line with the clinical strategy went to public consultation in November 2017 and March 2018. This was led by the relevant clinical commissioning groups (CCG). In July 2018 the joint CCG approved the 19 recommendations made by the MSB group. However, in October the Southend peoples Scrutiny Committee voted to refer the reconfiguration to the Secretary of State. The trust and MSB group had undertaken many consultation events with stakeholders and the public to inform and collate their views on proposals. The group was now awaiting the outcome of the referral to the Secretary of State.

Whilst there was a focus on working towards the strategies for the group model there were some strategies that were still being developed at trust level. For example, the medicines optimisation strategy. The key priorities identified for medicines optimisation were:

- Cost effectiveness
- Digital Enabling
- Reconfiguration of Clinical Pharmacy Services
- Collaborative working across ESR (Essex Success Regime)

Progress against development and delivery of strategies was regularly reviewed at board level.

Culture

Leaders across the trust worked to promote a positive culture that supported and valued staff. However, there were some staff who felt that human resources issues were not managed in a timely manner and that this had a negative impact on them personally. Some teams continued to work in silos and the culture in some areas was not that which the trust strived for.

There was a mixed culture at the trust. Most staff we spoke with were proud to work at MEHT and loyal to the hospital. We found that some staff were positive about the planned merger whilst others were not so sure about the outcomes for them personally. The trusts senior leadership team were aware of the impact of the proposed changes and were proactively working with staff to provide information to them. The trust had established a people and organisational development team (POD) who were working with staff to increase resilience and to embrace change. However, senior leaders recognised that this would not be a quick solution as changing staff culture would take time.

We heard from several staff that the previous HR department did not resolve their issues in a timely manner and for some staff this was distressing. Some staff felt that the processes in place to explore grievances was not supportive or equitable. Senior leaders acknowledged that some improvements were needed due to historical poor performance within the HR services. There was a new trust head of HR in place who was working with the MSB group HR director to review and strengthen HR processes and provide support to ensure that resolution was achieved.
in a fair and timely manner. A member of the HR team now worked closely with the individual directorates to provide advice and support. However, we were not assured that there was sufficient recognition of how deeply the previous leaderships inactivity to resolve grievances and other HR processes had affected some members of staff.

Some action was taken to address performance and behaviour that was inconsistent with the vision and values, however, further work was needed. Several senior members of staff spoke about the previous culture of the organisation which was still impacting in pockets across the trust. In 2014 we found that there was an oppressive culture at the trust. This was acknowledged and whilst this improved during the following two years there were pockets of this culture remaining. The senior leadership team were working with the local team to change the culture amongst the clinical staff to ensure that there was embedded multidisciplinary working and a culture of improvement. We found that some areas continued to work in silo's although in many areas this was improving.

We spoke to staff representatives who felt that the churn at senior site leadership had meant that the improvements promised were not always delivered. They acknowledged the culture of the organisation was unhelpful in driving improvement in a number of areas. However, recognised that the development of leaders within the organisation would improve relationships between staff.

There were mechanisms in place to ensure that staff at all levels received the development they needed including high quality appraisal and career development conversations. However, staff told us this was not always possible due to staff shortages and capacity. The trust annual target was 90% completion rate. In the last financial year 2017/18 the trust did not meet their target and achieved 78% completion. At the time of our inspection, the trust had improved on the previous year’s performance and had achieved 79% completion rate with an expectation that each division would achieve 90% completion rate by the end of the 2018/19 financial year. The trust had a band 6 development programme which was fully established and we heard from band 7’s that this was encouraging innovation. However, the significant vacancies within band 5 nursing staff had delayed the implementation of a roll out to band 5 nurses.

In the NHS staff survey 2017 (table below) the trust scored worse than the national average in relation to questions related to staff health and well-being. Senior leaders we spoke with were disappointed with these results and acknowledged that this reflected the trust’s position as staff sometimes worked under extreme pressures due to demand and staff shortages. Work was immediately undertaken to understand how the leadership team could support staff health and well-being in the form of a ‘Get Healthy…Stay Healthy’ campaign. This included quarterly surveys related to health and well-being and ensuring that staff were aware of the support mechanisms in place throughout the trust. The survey looked at a number of areas including smoking cessation, nutrition and hydration, physical and mental wellbeing as well asking for areas on which the trust could improve. Action plans were drawn up from this survey and fed into the ‘Get Healthy…Stay Healthy’ annual work-plan and monitored through the governance process. The trust had received mixed scores in the NHS staff survey in relation to bullying and harassment. In response to this, senior leaders implemented the ‘Respect’ campaign in May 2018 which was led by the chief HR director.

The trust had implemented a number of initiatives to try and improve culture and encourage open and transparent conversations. For example, the site team and the senior leaders had introduced and led the ‘Moving Forward at Mid’ sessions which were held in the atrium daily. We attended several of these sessions and found that staff were engaged in these sessions and felt able to speak up to voice concerns or to commend other staff. There was an open and positive atmosphere amongst staff attending this meeting. There were significant numbers of staff of all grades at the meeting and all appeared to feel that they could speak up.

There were policies and processes in place to support and encourage staff to raise concerns including whistleblowing. However, the trust recognised and had plans in place to improve staff’s confidence in existing processes. For example, the trust had followed some of the recommendations from Freedom to Speak Up review by Sir Robert Francis into whistleblowing in the NHS in 2015. This included the requirement for all NHS trusts to appoint a Freedom to Speak
Up Guardian (FTSUG) and report to the independent National Guardian's Office (NGO) to ensure that there is a consistent approach to listening to and acting appropriately to whistle-blowing concerns. The trust had an FTSUG in place and policy to support the process. The FTSUG was introduced in March 2017 and was conducted by the trust's head of governance. There was an executive and non-executive director responsible for monitoring and reviewing the process. The trust submitted data to the NGO for 2017/18 which showed that from July 2017 to April 2018 there were nine cases raised. Most of the concerns raised related to staff behaviour and this was being taken forward by the new HR team and the MSB group People and Organisational Development team. The trust had reviewed the process in June 2018 and recommendations to improve the service included having dedicated resource to deliver the role of FTSUG.

The trust had a ‘Being Open and Duty of Candour policy’ in place. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. However, we were not assured that all staff were aware of the principles of duty of candour. Our conversations with staff during the core service inspections demonstrated that not all staff were aware of the duty of candour regulation and their responsibilities. The trust told us that all staff received information to increase awareness of duty of candour at corporate induction events and further training was delivered to those responsible for investigating incidents as part of root cause analysis training. The new director of nursing had introduced a cycle of audits of compliance to legislation and trust policy in July 2018. A report of the first audit was produced in September 2018 and recommendations included providing staff with more training, particularly those with responsibility for investigating incidents and improving documentation of meetings and initial conversations. The recommendations were going to be included in the trust’s Serious Incident Improvement Plan which was still in draft format at the time of our inspection. From June 2017 to May 2018 the trust applied duty of candour 92 times.

We spoke with the leaders of all directorates and found that everyone felt empowered to make changes within their own directorate. They felt that they could enact change to deal with issues that they had highlighted and did not have to await permission to do so.

**Staff Diversity**

The trust was actively working to promote equality and diversity within the organisation. There were mechanisms in place and being developed to ensure equity, particularly for those with protected characteristics under the Equality Act, 2010.

The trusts equality and diversity group met bi-monthly and had been established since 2011. The group had evolved over the years and the main objective was ‘To drive and promote a culture of inclusion within the trust...’. The trust had also introduced an equality and diversity steering group in 2016 to support the work of the already established equality and diversity group. The equality and diversity steering group held formal meetings every six weeks. Examples of agenda items were outcomes and impacts of surveys with regards to equality and diversity action plans and gender pay reporting. A number of actions were in place and planned to promote equality and diversity. This included ensuring that there were equality and diversity champions across the trust and a representative from each division. At the time of our inspection, informal discussions were taking place with volunteers in relation to these roles. The trust had introduced cultural listening events called ‘In our shoes’, which was between staff members and patients and aimed for people to see situations differently ‘in their shoes.’ ‘In our shoes’ reflected on how other people see situations differently, and encouraged staff to consider other people’s perspectives and types/styles of communication they use. These sessions were popular with staff and there were plans for further events.
As of March 2018, Mid-Essex Hospital Services NHS Trust employed 5,043 people, of which 4,099 self-declared their ethnicity. Of these, 17.5% self-declared as BME and the remaining 82.5% self-declared as white.

The Workforce Race Equality Standards (WRES) were introduced in 2015. WRES provides a framework for NHS Trusts to report, demonstrate and monitor progress against a number of indicators of workforce equality, and to ensure that employees from BME backgrounds receive fair treatment in the workplace and have equal access to career opportunities. All NHS providers are required to implement the WRES and the trust had a comprehensive WRES action plan which was published on the trust’s public website.

Performance against four key indicators for 2017/18 and the previous year are in the table below.

<table>
<thead>
<tr>
<th>Key indicator</th>
<th>Performance 2017/18</th>
<th>Performance 2016/17</th>
<th>Trust narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce.</td>
<td>Non-Clinical BME 5.7% White 94.3% Clinical BME 15.1% White 85.0% Medical BME 54.9% White 45.1% Total BME 17.5% White 82.5%</td>
<td>Non-Clinical BME 6.4% White 93.6% Clinical BME 14.6% White 85.5% Medical BME 47.1% White 52.9% Total BME 17.6% White 82.4%</td>
<td>There are no significant statistical differences in the total figures between the reporting years.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key indicator</th>
<th>Performance 2017/18</th>
<th>Performance 2016/17</th>
<th>Trust narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relative likelihood of staff being appointed from shortlisting across all posts.</td>
<td>White vs BME 1.78</td>
<td>White vs BME 1.88</td>
<td>There has been a reduction in the gap between the two categories over the past year, however, there remains a greater likelihood of white staff being appointed from shortlisting across all posts.</td>
</tr>
<tr>
<td>Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation (based on data from a two-year rolling average of the current year and the previous year).</td>
<td>BME Vs White 1.03 BME 1.3% White 1.2%</td>
<td>BME Vs White 1.46 BME 1.4% White 0.9%</td>
<td>There has been a reduction in the gap between the two categories over the past year.</td>
</tr>
<tr>
<td>Relative likelihood of staff accessing non-mandatory training and CPD.</td>
<td>White Vs BME 1.11 BME 81.6% White 90.9%</td>
<td>White Vs BME 1.02 BME 67.5% White 69.0%</td>
<td>The findings indicate that there has been a decline in BME staff accessing non-mandatory training and CPD.</td>
</tr>
</tbody>
</table>

(Source: Trust workforce race equality standard report 2017/18)
NHS Staff Survey 2017 – results better than average of acute trusts

The trust has six key findings that were better than the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Equality and diversity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key finding 20: Percentage experiencing discrimination at work in last 12 months.</td>
<td>11%</td>
<td>12%</td>
</tr>
<tr>
<td><strong>Errors and incidents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key finding 30: Fairness and effectiveness of procedures for reporting errors, near misses and incidents.</td>
<td>3.81</td>
<td>3.73</td>
</tr>
<tr>
<td><strong>Violence, harassment and bullying</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key finding 22: Percentage experiencing physical violence from patients, relatives or the public in last 12 months.</td>
<td>14%</td>
<td>15%</td>
</tr>
<tr>
<td>Key finding 23: Percentage experiencing physical violence from staff in last 12 months.</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Key finding 24: Percentage reporting most recent experience of violence.</td>
<td>74%</td>
<td>66%</td>
</tr>
<tr>
<td>Key finding 27: Percentage reporting most recent experience of harassment, bullying or abuse.</td>
<td>47%</td>
<td>45%</td>
</tr>
</tbody>
</table>

NHS Staff Survey 2017 – results worse than average of acute trusts

The trust has 20 key findings worse than the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Appraisals and support for development</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key finding 11: Percentage appraised in last 12 months.</td>
<td>79%</td>
<td>86%</td>
</tr>
<tr>
<td>Key finding 12: Quality of appraisals.</td>
<td>3.03</td>
<td>3.11</td>
</tr>
<tr>
<td><strong>Errors and incidents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key finding 28: Percentage witnessing potentially harmful errors, near misses or incidents in last month.</td>
<td>35%</td>
<td>31%</td>
</tr>
<tr>
<td>Key finding 29: Percentage reporting errors, near misses or incidents witnessed in last month.</td>
<td>89%</td>
<td>90%</td>
</tr>
<tr>
<td>Key finding 31: Staff confidence and security in reporting unsafe clinical practice.</td>
<td>3.63</td>
<td>3.65</td>
</tr>
<tr>
<td><strong>Health and wellbeing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key finding 17: Percentage feeling unwell due to work related stress in last 12 months.</td>
<td>40%</td>
<td>36%</td>
</tr>
<tr>
<td>Key finding 18: Percentage attending work in last 3 months despite feeling unwell because they felt pressure.</td>
<td>53%</td>
<td>52%</td>
</tr>
<tr>
<td>Key finding 19: Organisation and management interest in and action on health and wellbeing.</td>
<td>3.51</td>
<td>3.62</td>
</tr>
</tbody>
</table>
### Working patterns

<table>
<thead>
<tr>
<th>Key finding</th>
<th>76%</th>
<th>72%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage working extra hours.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Job satisfaction

<table>
<thead>
<tr>
<th>Key finding</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff motivation at work.</td>
<td>3.88</td>
<td>3.92</td>
</tr>
<tr>
<td>Staff satisfaction with level of responsibility and involvement.</td>
<td>3.87</td>
<td>3.91</td>
</tr>
<tr>
<td>Effective team working.</td>
<td>3.70</td>
<td>3.72</td>
</tr>
<tr>
<td>Staff satisfaction with resourcing and support.</td>
<td>3.28</td>
<td>3.31</td>
</tr>
</tbody>
</table>

### Managers

<table>
<thead>
<tr>
<th>Key finding</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition and value of staff by managers and the organisation.</td>
<td>3.39</td>
<td>3.45</td>
</tr>
<tr>
<td>Percentage reporting good communication between senior management and staff.</td>
<td>32%</td>
<td>33%</td>
</tr>
<tr>
<td>Support from immediate managers.</td>
<td>3.72</td>
<td>3.74</td>
</tr>
</tbody>
</table>

### Patient care and experience

<table>
<thead>
<tr>
<th>Key finding</th>
<th>89%</th>
<th>90%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage agreeing that their role makes a difference to patients/service users.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effective use of patient/service user feedback.</td>
<td>3.58</td>
<td>3.71</td>
</tr>
<tr>
<td>Percentage experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.</td>
<td>33%</td>
<td>28%</td>
</tr>
</tbody>
</table>

### Violence, harassment and bullying

<table>
<thead>
<tr>
<th>Key finding</th>
<th>29%</th>
<th>25%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage experiencing harassment, bullying or abuse from staff in last 12 months.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017)

### Workforce race equality standard

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key Finding and question numbers have changed since 2014.

To preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.
Of the four questions above, the following questions showed a statistically significant difference in score between White and BME staff:

KF21. Percentage of staff believing that the trust provides equal opportunities for career progression or promotion.

Q17b. In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues?

(Source: NHS Staff Survey 2017)

Friends and Family test

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

The trust scored below the England average for recommending the trust as a place to receive care from August 2017 to July 2018.
Sickness absence rates

The trust set a target of 4.2% for sickness absence rates. Performance against this target by core service from May 2017 to April 2018 for all staff is in the table. Overall staff sickness rates were 4.5% during the period, not meeting the trust target.

<table>
<thead>
<tr>
<th>Ward / Clinical Area</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider wide</td>
<td>18,979.6</td>
<td>355,344.1</td>
<td>5.3%</td>
</tr>
<tr>
<td>Maternity</td>
<td>3,579.6</td>
<td>70,503.6</td>
<td>5.1%</td>
</tr>
<tr>
<td>Medical care (including older people’s care)</td>
<td>15,150.9</td>
<td>304,434.5</td>
<td>5.0%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>1,816.9</td>
<td>37,130.9</td>
<td>4.9%</td>
</tr>
<tr>
<td>Other</td>
<td>8,501.8</td>
<td>179,851.1</td>
<td>4.7%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>2,073.1</td>
<td>51,048.7</td>
<td>4.1%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>2,609.4</td>
<td>65,612.1</td>
<td>4.0%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>1,787.4</td>
<td>48,403.5</td>
<td>3.7%</td>
</tr>
<tr>
<td>Surgery</td>
<td>9,554.3</td>
<td>299,146.3</td>
<td>3.2%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>724.3</td>
<td>23,942.7</td>
<td>3.0%</td>
</tr>
<tr>
<td>End of life care</td>
<td>159.1</td>
<td>5,348.5</td>
<td>3.0%</td>
</tr>
<tr>
<td>Critical care</td>
<td>1,068.2</td>
<td>36,367.8</td>
<td>2.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>66,004.5</strong></td>
<td><strong>1,477,134.1</strong></td>
<td><strong>4.5%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

General Medical Council – National Training Scheme Survey

In the 2018 General Medical Council Survey the trust performed the same as expected for all indicators.
**Governance**

There was a governance system in place which was yet to be embedded. Information to measure performance and inform decisions on areas for improvement was not always available or accurate.

The trust was developing processes and systems of accountability to support the delivery of the strategy and quality sustainable services. Some systems were already in place including sub-board committees, divisional committees and team meetings. A trust governance improvement plan was in place and the senior team had implemented a plan to achieve a consistent approach to governance across the MSB group, however this was yet to be embedded. Senior leaders acknowledged that there was 'a long history of variable performance at the trust' and 'weaknesses in management and accountability' which had potentially impacted on the trust's performance. However, they felt that the recent appointment of key positions within the trust such as the managing director would have a positive impact on the implementation and embedding of a more robust governance structure. The trust had established a Recovery Steering Group which was chaired by the CEO, this group monitored and reviewed the governance arrangements at the trust.

**Board Assurance Framework**

The trust had its own Board Assurance Framework (BAF) and a collective BAF had been populated with the MSB group risks.

The trust provided their BAF, which details four strategic objectives within each and accompanying risks. The strategic objectives are:

1. Achieving clinical and service excellence.
   1.1 Achieve governance and regulatory standards for high quality, safe and effective patient care.
   1.2 Deliver the very best care in the right place, at the right time, with the right staff.

2. Providing quality leadership.
   2.1 Grow our own high performing leadership teams who inspire all staff to achieve excellence.
   2.2 Establish and communicate the direction of the organisation for the next five years in the context of the Essex Success Regime.

3. Building effective relationships.
   3.1 Work with health and education partners to understand the health and social care needs of our community and deliver new and innovative models of care.
   3.2 Develop our health professionals of the future.

   4.1 Achieve a sustainable financial future.
4.2 Turn research into practice and incorporate innovative ways of working into business as usual.

(Source: Trust Board Assurance Framework – May 2018)

The trust board was supported by a finance committee (bi-monthly meetings), quality and safety committee (monthly meetings) and audit committee (quarterly meetings). Trust board meetings were held quarterly to review the performance of the trust. The JWB were supported by a joint finance and resource committee (quarterly meetings) and a joint quality and safety committee (quarterly meetings). The JWB met monthly to review the performance of all three sites. To ensure that the non-executive directors were aware of the on-going performance of the trust, board papers were shared with all members of the trust board irrespective of if they attended the JWB meeting. The managing director had a site leadership team in place who were professionally responsible to the JEG. The managing director, JEG and site leadership team held weekly performance and accountability meetings. However, we were not assured that the information needed to inform decisions and ensure actions were completed was being effectively shared at all levels. For example, on review of the Board of Directors Meeting minutes from May 2018 and September 2018 we found it difficult to establish whether issues raised in May had been enacted and reported back to the local site board. An example of this was the discussion around infection prevention and control where it was noted that there was a deterioration of standards due to a “complacency in practice by staff”. There was also a note that there were “environmental factors such as the condition of hand basins and sealants on some of the wards inspected.” However, there was no action assigned to these issues and in the September minutes the only reference to infection prevention and control was a note as to the staffing improvements within the infection control team. We discussed infection prevention and control with the Director of Infection Prevention and Control. We were told that the churn within the infection control team had led to a “fragile governance.” However, the seconded individuals into this team had reinvigorated the infection control committee despite poor “buy in” from staff. This issue remained a concern for the senior leaders at the trust. The detailed mitigation for the risk sat within the corporate risk assurance framework and was reflected in the performance element within the BAF. The complex structure for the monitoring of risks meant that tracking issues from ward to board was difficult.

The systems in place to ensure that policies and guidance were up to date was not robust. During our core services inspection we found policies and guidance in use which were out of date and due for review. This meant that staff might not be delivering care based on the most recent guidance or best practice. Our interviews with staff and review of the trust’s ratification process demonstrated that staff responsible for reviewing and updating guidance were not always following the trust process. When we raised our concern, senior leaders took immediate action to explore the issues and provided assurances that this would be addressed.

Medicines optimisation was integrated into the trust governance structure. However, staff told us medicines optimisation was not given sufficient representation at executive level. This created a potential gap in escalation of concerns or areas for improvement. The pharmacy governance board reported to the medicines optimisation and medicines safety group and the trust patient safety group who reported to the trust board. Performance was monitored through the pharmacy governance board to the clinical support services board and escalated to the trust board via the performance and accountability meetings and JEG. There was no member of the pharmacy leadership team in attendance at the performance and accountability meetings. Staff felt that this created a potential gap in reporting lines between committees and that there was not the necessary level of medicines expertise involved in the decision-making process.

Management of risk, issues and performance
Risks, issues and poor performance were not always addressed appropriately or quickly enough.
The trust had its own risk register and BAF. The trust had agreed a risk appetite which set the framework for the risk register and BAF. Risk management was a standing agenda item on the JWB meetings and at the local trust board meetings. We reviewed the September 2018 Board of Directors Meeting minutes and found that there was sufficient challenge by the non-executive directors and chair of the trust. The joint board was working towards having standardised documentation throughout the groups but this was yet to be further refined and embedded. There was an action plan in place to improve risk management processes across the group including improving staff understanding of risk identification, recording and scoring.

Each directorate held its own risk register which local teams added to and discussed at performance meetings. Relevant risks were escalated via divisional board meetings and site directors to be approved for entry into the corporate risk assurance framework. A risk report was prepared for the site leadership team which included updated and new risks identified. The CEO chaired a weekly recovery steering group which had several strands of work identified to manage the risks.

Divisions had governance meetings at specialty and directorate-level. This was then reviewed at a monthly divisional board. The division was led by a triumvirate including the divisional director, divisional associate director of nursing and divisional associate director. Quality and safety was on the agenda at each of these meetings and there were reporting templates in place that facilitated discussions and decision making. Each division had dedicated governance resource to produce the data dashboards and reports used at each level. Following monthly divisional board meetings, the triumvirate attend a monthly performance and accountability meeting with the trust executive. This meeting included discussion on performance across quality and safety, operational performance, and finance. An action log was kept of actions required following this meeting. We tracked through three different directorates and found that we could identify where issues had been raised and addressed. These meetings were reported via the senior management group. A weekly quality and safety dashboard was also reviewed at the site directors meeting where the necessary actions and mitigations were decided.

The trust recognised that its mortality rates were poor and was actively seeking to address coding issues as the cause of death had not always been recorded accurately. The trust had developed an app to assist doctors in completing cause of death of patients. A number of systems and processes had been put in place to reduce the SHMI including training sessions on the awareness of deteriorating patients, tracking of cardiac arrest outcomes. Senior staff stated that the medical base was engaged in all pieces of work and that this was demonstrating improvement.

Mortality reviews were undertaken through structured judgement reviews for approximately 26% of deaths. The key learning at the end of June 2018 had been that there needed to be improvement in ensuring that patients at the end of their lives were cared for in their preferred place of death. Across the three sites 110 deaths are reviewed each month of which a random selection of around 25% are reviewed under the structured judgement framework.

Patient safety and quality dashboards were produced for review at all levels from ward to board designed to support real-time information and monitoring, and support a culture of continuous improvement. Safety huddles in each clinical area were in place to review safety and quality issues. Assurance was provided to the board via the patient safety and quality committee. Key groups reporting here were the patient safety and patient experience groups each of which had a number of sub-groups that reported to them. The board performance report was received by the patient safety and quality committee and reviewed by the board.

Peer reviews were undertaken across sites to provide further objectivity and provide the local team with a view on compliance. The trust had a peer review in spring 2018 and developed an action plan to address areas of concern. We saw that whilst some progress had been made in light of the action plan not all actions had been completed. We saw some areas of good practice throughout our core service inspections however this was not yet embedded throughout the trust.

The chief pharmacist managed the pharmacy risk register, which also hosted corporate medicines risks. The top 3 items on the pharmacy risk register were:
1. Falsified medicines directive (due to go on to corporate risk register)
2. Ambient temperature monitoring and safe and secure storage of medicines (also on corporate risk register)
3. Lorenzo e-Prescribing.

The team conducted regular medicines storage audits and quarterly controlled drug audits, the results were sent to the director of nursing for dissemination. Audit results were also included in the medicines optimisation and medicines safety group report. There were concerns that there was an accountability gap in ensuring the implementation of learning and actions was taken from these audits. Staff acknowledged that there were issues in following up on audit results and implementing action plans.

Current challenges to quality and sustainability of medicines optimisation services include:

- Recruitment: recruitment to senior management positions had been difficult.
- 7 days working: although this was in place in some wards, it still needed to be rolled out to most wards.
- The availability of pharmacy staff to support the implementation of e-Prescribing which was due to commence in January 2019. Currently e-Prescribing was live in one outpatient clinic only at the Broomfield site.

The chief pharmacist informed us that implementation of e-Prescribing would help with prescribing and reducing medicine related errors. This would also help monitor administration and other aspects of medicines optimisation that were more difficult to monitor from paper charts. The chief pharmacist acknowledged that an improvement was needed in reviewing adherence and reflection in clinical practice. The pharmacy department had an electronic prescription tracking system.

Divisional specific medicines risks were recorded on the relevant local risk register. The medicines safety group reviewed national safety alerts relating to medicines. They would review the alert and manage the implementation of the alert.

**Finances Overview**

The 2016-17 financial year, saw the trust delivering within its control total, through a late in the year action plan to ensure this was achieved. During 2017-18 the trust deficit increased significantly, having an original control total position of £33.6m which deteriorated through the year. A recovery plan was put in place which limited the increased deficit to £52.9m, with £3m recovery savings delivered in the final quarter of the year.

During 2018-19, the implementation of Lorenzo as the trusts patient record system caused some visibility issues which compounded the financial position and a deficit plan for 2018-19 was agreed with NHSI which includes a challenging Cost Improvement Plan (CIP) savings target of £19.4m, or 6.5%.

Currently pharmacy budget savings were being met, staff told us this was an indication of clinician involvement in achieving and monitoring the medicines optimisation strategy in relation to cost effectiveness.

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£303.6m</td>
<td>£305.2m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£24.3m)</td>
<td>(£52.9m)</td>
</tr>
<tr>
<td>------------------</td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£327.9m</td>
<td>£358.2m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>(£26.6m)</td>
<td>(£55.1m)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

Trust corporate risk register

The trust provided a document detailing their five highest profile risks. Each of these have a current risk score of 20 or higher.

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Risk level (target)</th>
<th>Last review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>546</td>
<td>Performance and National Targets: failure to deliver national and locally agreed targets</td>
<td>25</td>
<td>8</td>
<td>May 2018</td>
</tr>
<tr>
<td>1245</td>
<td>Deliver Financial Plan for 2018/19: trust fails to deliver planned position as at 31 March 2019.</td>
<td>25</td>
<td>2</td>
<td>May 2018</td>
</tr>
<tr>
<td>485</td>
<td>Workforce Shortages: inability to attract staff, recruit and sustain employment in key posts due to an increasingly shrinking and highly competitive market.</td>
<td>25</td>
<td>6</td>
<td>May 2018</td>
</tr>
<tr>
<td>538</td>
<td>CQC registration: compliance with Care Quality Commission Fundamental Standards</td>
<td>20</td>
<td>9</td>
<td>May 2018</td>
</tr>
<tr>
<td>1144</td>
<td>Informatics - Performance reporting: EPR implementation to deliver wide scale clinical system improvement associated with multiple risks arising from large scale change management.</td>
<td>20</td>
<td>4</td>
<td>May 2018</td>
</tr>
</tbody>
</table>

(Source: Trust Board Assurance Framework – May 2018)

Information management

The trusts information management systems had improved access to information but has had a number of issues which have led to validation issues.

The trust had recently implemented the Lorenzo system which is a flow based electronic patient record system. This was to support both operational and clinical activity. The information team could pull data from the IT systems to populate reports to ward areas through to board. The implementation of Lorenzo had led to some data quality issues which the data quality team were attempting to resolve. However, this had led to problems investigating mortality and morbidity issues and referral to treatment times. We heard how members of the senior team were working
with these systems to produce accurate data. An example of this was work undertaken by the medical director to ensure that medical coding is captured accurately.

The data quality team actioned regular reports to review data that may be of poor quality such as patients without an NHS number or GP details and responded to calls from users where errors had been made or found. The trust undertook data quality audits in line with the requirements of the information governance toolkit to help improve compliance. A suite of KPIs were being developed to ensure a more visible approach to data quality across the trust.

The trust had reviewed their information governance processes in light of new EU General Data Protection Regulation which came into force in May 2018. The information governance manager worked as part of the information team to help ensure data integrity. Incidents related to information risks were reviewed across the MSB group to share learning and identify trends. The Senior Information Risk Owner report provided an overview to the senior team and an annual plan for improvements.

We saw through board minutes and the interviews held with board members that there was appropriate challenge of data provided to the board as assurance.

**Engagement**

*People who use services, the public, staff and external partners are engaged and involved to support high-quality sustainable services.*

The trust actively engaged with the people it served. Engaging with all stakeholders including patients, families and staff was listed as a priority in the trust’s 2017/18 quality account and was led by the director of nursing. There were a number of different approaches to engaging with patients, carers and their loved ones. These included the friends and family test and volunteers undertook Red 2 Green (Red2Green programme is designed to measure days when patients remained in hospital and did not have any positive interventions) surveys to establish if patients felt informed about their care. The patient council undertook ward visits to speak to patients about standards of care they receive. This was fed back to ward managers and the matrons so that concerns could be acted upon in a timely manner. The trust also held eight listening events from April 2017 to March 2018 for staff to hear about what it was like for patients in their care called “In your shoes”. Following the listening event actions plans were developed and these were monitored by the patient experience group. For example, at a listening event in the ‘Emergency Village’ patients told the trust that they ‘did not always feel informed about what was going to happen next or their care plan’. A suite of images was developed and displayed on a large screen in the emergency department waiting room, with information explaining the journey through the department.

The patient experience group was chaired by the director of nursing and actively sought feedback from a number of forums to learn from patients’ experiences of the trust. This group included representatives form HealthWatch, Support 4 sight and Action for family carers. The patient experience group monitored the action plans which were developed as a result of consultations with the public. Other speciality engagement sessions had been utilised in order to gain feedback on services and proposed plans.

The ‘Moving forward at Mid’ meeting which occurred daily enabled staff to provide feedback directly to the site and senior leadership teams. It also enabled the sharing of good practice across departments. Staff reported that the senior leadership team were visible and approachable and that they could raise issues with them without fear.

The trust had actively participated with all stakeholders through the public consultation around the reconfiguration of services. A number of public meetings had been held in order to seek the views of the public and stakeholders. The trust estimate that around 4,000 people inputted into the proposed reconfiguration of services. The senior team described amendments made to reflect the
views of stakeholders and the public. The senior team were also able to describe how the impact of external stakeholders’ issues were felt within the trust.

Learning, continuous improvement and innovation

Systems for the continued learning and development are in place but are yet to be fully embedded.

The trust had a portfolio of transformational programmes to encourage sharing of learning and innovation across the three sites. This aimed to reduce inconsistency across the sites and improve care.

The trust had invited the East of England Clinical Senate to review clinical reconfiguration plans in order to ensure that the future services are underpinned through evidence and best practice.

The trust was using apprenticeship schemes to support continuous learning in both clinical and managerial areas. Senior leaders told us there was an in-house innovation programme which scanned for potential innovations in order to benefit patients and staff. This was a ‘Dragons den’ style workshop to support staff to come up with new ideas. The trust worked with its research and development department in order to ensure that there is a pragmatic evaluation of new models of care.

The trust was undertaking a number of research projects with NHS England and NHS Improvement. These included the NHS Clinical Entrepreneurs Programme and the Health Services Management Research with the local university. There was a dedicated site improvement and change management function which was currently being recruited into.

The chief pharmacist explained that continuous learning, improvement and innovation was sustained by the pharmacy team gathering patients’ views through patient survey in inpatient and outpatients, complaints and National patient survey.

In one of the respiratory wards, a pharmacy technician and ward pharmacist came up with the idea of using a device called ‘in check dial’ in asthmatic patients. This monitors patient inhaler technique and respiratory flow and checks whether the correct device was prescribed for the patient based on their respiratory flow. Patients would then be counselled and advised on the best device for them. Staff told us this would be evaluated with the view to rolling out further and request funding for it.

Complaints process overview

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3</td>
<td>98.5% (2017/18)</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>25 working days</td>
<td>80%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>60 working days</td>
<td>80%</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>2,992 (June 2017 to May 2018)</td>
<td>N/A</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)
Number of complaints made to the trust

The trust received 638 complaints from June 2017 to May 2018. Medical care received the most complaints with 169.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care (including older people's care)</td>
<td>169</td>
<td>26.5%</td>
</tr>
<tr>
<td>Surgery</td>
<td>131</td>
<td>20.5%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>90</td>
<td>14.1%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>78</td>
<td>12.2%</td>
</tr>
<tr>
<td>Other</td>
<td>63</td>
<td>9.9%</td>
</tr>
<tr>
<td>Maternity</td>
<td>34</td>
<td>5.3%</td>
</tr>
<tr>
<td>Provider wide</td>
<td>22</td>
<td>3.4%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>22</td>
<td>3.4%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>13</td>
<td>2.0%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>11</td>
<td>1.7%</td>
</tr>
<tr>
<td>End of life care</td>
<td>3</td>
<td>0.5%</td>
</tr>
<tr>
<td>Critical care</td>
<td>2</td>
<td>0.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>638</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Compliments

From June 2017 to May 2018, the trust received a total of 684 compliments. A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>166</td>
<td>24.3%</td>
</tr>
<tr>
<td>Medical care (including older people's care)</td>
<td>142</td>
<td>20.8%</td>
</tr>
<tr>
<td>Other</td>
<td>103</td>
<td>15.1%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>89</td>
<td>13.0%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>49</td>
<td>7.2%</td>
</tr>
<tr>
<td>Provider wide</td>
<td>44</td>
<td>6.4%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>24</td>
<td>3.5%</td>
</tr>
<tr>
<td>Maternity</td>
<td>23</td>
<td>3.4%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>20</td>
<td>2.9%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>19</td>
<td>2.8%</td>
</tr>
<tr>
<td>Critical care</td>
<td>5</td>
<td>0.7%</td>
</tr>
</tbody>
</table>
The trust also provided the following information about themes in the compliments received:

Letters of thanks and praise were logged onto the electronic incident reporting database showing the main division, directorate, location and date received, but details of the subjects of praise was not logged onto the database. However, a high percentage of the praise related to attitude of staff, professionalism, excellent care and patient experience. It is clear from the data for this report that a high number of praise letters were received during the winter months, with over a 1/3 of the praise letters being received in the busy months of December, January and February when the Trust was under increased pressure for services (a total of 237 of the 684 praise letters were received Dec-Feb). All praise logged is shared with the staff members named and passed via the senior staff for the department (Associate Director of Nursing / Clinical Director / Matron / Head of Department etc).

(Source: Routine Provider Information Request (RPIR) – Compliments)
Accreditations

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust’s services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Details of services / areas accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Broomfield Hospital - Assessed: Criteria met. To be reassessed October 2018</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189</td>
<td>Blood Sciences and Microbiology – recommended that accreditation is offered under ISO 15189:2012 for the scope of assessment, subject to closure of mandatory improvement actions. (Assessed April 2018)</td>
</tr>
<tr>
<td>ISO 9001:2015 certification</td>
<td>Theatres and Biomedical Engineering</td>
</tr>
<tr>
<td>Emergency Care Improvement Programme (ECIP)</td>
<td>Emergency Floor, reviewed 2017</td>
</tr>
<tr>
<td>Human Tissue Authority (HTA)</td>
<td>St Andrew’s Burns Service</td>
</tr>
<tr>
<td>British Society of Echocardiography Accredited Department</td>
<td>Broomfield Cardiac Department, ongoing</td>
</tr>
<tr>
<td>SEQUOHS Accreditation (Safe Effective Quality Occupational Health Standards) 2015</td>
<td>Occupational Health Service</td>
</tr>
<tr>
<td>British Association for cardiovascular Prevention and Rehabilitation (BACPR)</td>
<td>Mid Essex Hospital Cardiac Rehab Team, certified since 2015</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Accreditations tab).

Acute services

Broomfield Hospital

Urgent and emergency care

Facts and data about this service

Details of emergency departments and other urgent and emergency care services.

- Broomfield Hospital emergency department

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

Activity and patient throughput

Total number of urgent and emergency care attendances at Mid Essex Hospital Services NHS Trust compared to all acute trusts in England, May 2017 to April 2018
From May 2017 to April 2018 there were 101,120 attendances at Broomfield Hospital emergency department as indicated in the chart above.

(Source: NHS England)
Urgent and emergency care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission increased slightly from 26.1% in 2016/17 to 26.8% in 2017/18. In both years, the proportion of attendances resulting in an admission was higher than the England average.

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from April 2017 to March 2018

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>35,502</td>
<td>20,015</td>
</tr>
<tr>
<td>Discharged*</td>
<td>10,229</td>
<td></td>
</tr>
<tr>
<td>Referred^</td>
<td></td>
<td>969</td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td></td>
<td>56</td>
</tr>
<tr>
<td>Died in department</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Left department#</td>
<td>2,025</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>890</td>
<td></td>
</tr>
<tr>
<td>Not known</td>
<td>31,429</td>
<td></td>
</tr>
</tbody>
</table>

* Discharged includes: no follow-up needed and follow-up treatment by GP  
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional  
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

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

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

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills but not everyone completed it. Staff told us that high levels of clinical demand meant that staff could not always be spared to attend training.

The trust set a target of 85% for completion of all mandatory training modules except for information governance, where the target was 95%.

Broomfield Hospital emergency department

A breakdown of compliance for mandatory training courses from June 2017 to May 2018 for qualified nursing staff in the emergency department at Broomfield Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2017 to May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Medicine management</td>
<td>73</td>
</tr>
<tr>
<td>Intermediate life support</td>
<td>59</td>
</tr>
<tr>
<td>Fire safety 1 year</td>
<td>67</td>
</tr>
<tr>
<td>Infection prevention level 1</td>
<td>67</td>
</tr>
<tr>
<td>Information governance</td>
<td>67</td>
</tr>
<tr>
<td>Manual handling people</td>
<td>57</td>
</tr>
<tr>
<td>Manual handling object</td>
<td>60</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>56</td>
</tr>
</tbody>
</table>

In the emergency department at Broomfield Hospital the trust had an overall training compliance rate of 82.4% for qualified nursing staff. The trust’s training targets were met for two of the eight mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from June 2017 to May 2018 for medical staff in the emergency department at Broomfield Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2017 to May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Infection prevention level 1</td>
<td>26</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>25</td>
</tr>
<tr>
<td>Manual handling object</td>
<td>24</td>
</tr>
<tr>
<td>Information governance</td>
<td>23</td>
</tr>
<tr>
<td>Fire safety 1 year</td>
<td>23</td>
</tr>
</tbody>
</table>
For the emergency department at Broomfield Hospital the trust had an overall training compliance rate of 75.6% for medical staff. The trust’s training targets were not met for any of the six mandatory training modules for which medical staff were eligible. In particular none of the five eligible staff had completed medicines management training.

(Source: Routine Provider Information Request (RPIR) – Training tab)

We requested up to date mandatory training figures for the department at the time of our inspection. In August 2018, the overall compliance rate for nursing staff was 88.11% and overall compliance for medical staff was 77.38%.

Nursing staff we spoke with told us they could attend training, but staffing levels sometimes affected this and their ability to have regular meetings with their manager to discuss training requirements. Medical staff we spoke with told us they had regular supervision, which included planning their access to training both in the hospital and from external sources to help them keep up-to-date with their training needs. Training was structured, well organised and consultant led. It was undertaken using varied methods of learning, for example simulation, online and face to face.

Medical staff told us they had received the necessary training in medicine management. However, data provided by the trust prior to the inspection showed that none of the eligible staff had completed the training.

The trust had employed a clinical facilitator to review the educational strategy, and consider the training and education needs of all grades of nursing staff in the department.

**Safeguarding**

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.** Staff had training on how to recognise and report abuse and they knew how to apply it. However, nursing and medical staff did not meet the trust target for safeguarding training.

The trust set a target of 90% for completion of safeguarding training.

**Broomfield Hospital emergency department**

A breakdown of compliance for safeguarding training courses from June 2017 to May 2018 for qualified nursing staff in the emergency department at Broomfield Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults level 1</td>
<td>69</td>
<td>80</td>
<td>86.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>69</td>
<td>80</td>
<td>86.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>68</td>
<td>80</td>
<td>85.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>66</td>
<td>80</td>
<td>82.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>45</td>
<td>67</td>
<td>67.2%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

For the emergency department at Broomfield Hospital the trust had an overall safeguarding training compliance rate of 81.9% for qualified nursing staff. The trust’s 90% completion target was not met for any of the five safeguarding training modules for which qualified nursing staff...
were eligible. The lowest completion rate was for safeguarding children level 3, completed by just over two thirds of qualified nursing staff. After our inspection, the trust provided us with updated data that showed that compliance had improved in all areas. For example, as of August 2018 nursing staff compliance with safeguarding level 3 training was 83.33%.

A breakdown of compliance for safeguarding training courses from June 2017 to May 2018 for medical staff in the emergency department at Broomfield Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 3</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>22</td>
<td>31</td>
<td>71.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>21</td>
<td>31</td>
<td>67.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>15</td>
<td>31</td>
<td>48.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>12</td>
<td>31</td>
<td>38.7%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

For the emergency department at Broomfield Hospital the trust had an overall safeguarding training compliance rate of 58.8% for medical staff. The trust’s 90% completion target was met for one of the five safeguarding training modules for which medical staff were eligible. Fewer than 50% of eligible medical staff had completed safeguarding children level 2 and safeguarding adults level 2.

(Source: Routine Provider Information Request (RPIR) – Training tab)

After our inspection, the trust provided us with updated data that showed that compliance had improved in some areas. However, medical staff were not compliant with any of the safeguarding modules at the time of our inspection. Medical staff compliance levels with training at the time of our inspection was: Safeguarding Adults Level 1 (67.57%), Safeguarding Adults level 2 (43.24%), Safeguarding Children Level 1 (64.86%), Safeguarding Children Level 2 (45.95%), Safeguarding Children Level 3 (83.33%).

Staff were required to complete initial safeguarding training level one during the trust induction programme, and then were required to complete level two safeguarding on a three-yearly basis. Staff working with paediatric patients in the emergency department (ED) were required to complete safeguarding children level three training every three years.

There was a dedicated executive level safeguarding lead in addition to local named safeguarding leads for children and adults at the trust.

Staff received training on how to recognise and report different forms of abuse, including domestic violence, modern slavery, and child sexual exploitation (CSE), and female genital mutilation (FGM) as part of their safeguarding training. Safeguarding leads told us that staff that completed safeguarding children level three training received further information on FGM. Staff knew and could explain to us their responsibilities in relation to FGM and CSE. Staff had access to trust wide safeguarding policies and procedures for safeguarding adults and children.

Staff gave examples of safeguarding concerns, how to make referrals to local safeguarding teams and knew how to contact the trust safeguarding leads if required. Staff told us it was sometimes difficult to complete the safeguarding training modules, because they were not given protected times during their shifts or outside their normal hours to complete online training or to get the necessary day release to complete face to face training. All staff were aware of a safeguarding incident and learning from June 2018 regarding a patient that had been at risk of domestic violence where staff had not followed the correct process for ensuring they were discharged to a place of safety. Learning from the incident had been shared and staff were aware of the correct
process to ensure that where were patients at risk of domestic violence they were escalated to the trust safeguarding leads.

The ED did not currently audit their safeguarding activity. The trust safeguarding leads told us they planned to audit safeguarding activity moving forward. All Paediatric ED attendances we viewed during our inspection were reviewed by the Paediatric Liaison Nurse and shared with community practitioners according to an agreed local protocol. Decisions were clearly recorded in patient records. All paediatric ED nurses were trained to safeguarding children level 3. For any ED attendances where there were safeguarding concerns, either historically or relating to the attendance, a copy of the concerns was forwarded to the local authority Children’s Safeguarding Team for information and any further action as necessary. Paediatric ED staff also had access to an online patient health record where they could review children’s community records while in the ED.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. The trust provided audit results of May, June and July 2018 at the time of our inspection, which showed audit results regularly did not meet trust targets. However, at the time of our inspection we observed staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

The department was visibly clean, domestic staff used ‘I am clean’ stickers that were in date at the time of inspection. Hand washing facilities, alcohol gel and hand conditioner was available throughout the department. We saw clear signage informing people to clean their hands when entering the department. The trust audited hand hygiene compliance and results were detailed on the walls in the ED for staff and patients to see. The department exceeded 95% compliance in May, June, July, and August 2018.

The trust conducted monthly infection prevention audits across all areas of the Emergency Village. The trust audit included; preventing peripheral line infection, hand hygiene, bedpan, commode, safe management of MRSA, Hospital-acquired pneumonia (HAP), personal protective equipment (PPE), and isolation of MRSA and Clostridium difficile. The trust provided audit results of May, June and July 2018 at the time of our inspection. The ED did not meet the trust target for bedpan or commode audits for the three months reported. The ED did not meet the 95% trust target for cleaning of contaminated equipment in June or July 2018. However, the trust met the target of 95% for preventing urinary catheter infection for June and July 2018.

We observed staff following hand hygiene, ‘Bare below the Elbow’ guidance, and wearing personal protective equipment such as gloves and aprons whilst delivering care in line with the trust’s policy.

Staff we spoke with could explain the protocol for patients with possible infectious disease and the department had cubicles specifically used for patients who may pose a risk of cross infection.

The trust had effective systems and processes in place for the segregation and management of clinical and non-clinical waste. Staff had access to sharps bins throughout the department and we found them labelled and dated in line with trust policy.

Domestic staff were visible in the department throughout our inspection and constantly engaged in cleaning activities. Waste bins were emptied frequently during the day.

Patient trolleys and equipment were visibly clean throughout the department. We observed staff routinely cleaning equipment, and toys in the paediatric waiting area. Staff completed daily cleaning records. Disposable curtains providing privacy were clean and in date at the time of inspection.

Environment and equipment
The service had suitable premises and equipment and looked after them well.

The department had facilities for assessment and treatment of minor and major injuries and illness with 15 major cubicles, a bay with four resuscitation spaces including dedicated space for paediatric patients, a dedicated children’s waiting area and dedicated cubicles for treatment, emergency nurse practitioner (ENP), and general practitioner (GP) led services. The emergency department included an emergency assessment unit (EAU) with 30 beds. The emergency senior assessment team (ESAT), used four cubicles adjacent to the ambulance handover point to triage patients who arrived via the ambulance bay. Patients also arrived by air ambulance where they were transferred directly into the department via the onsite helipad.

The ED had access to computerised tomography (CT) scans, magnetic resonance imaging (MRI) scanning and emergency theatres 24 hours a day, seven days a week.

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

The emergency department staff used a security swipe card system to enter various areas of the ED. This reduced the risk of unauthorised persons entering clinical areas. Office doors, medication rooms, and storerooms had combination locks to reduce access and these were secure during inspection. The paediatrics area utilised a combination of staff swipe card, intercom and closed-circuit television cameras for security. We saw staff ensuring that all visitors identified themselves on entry and departments were secure always during our inspection.

ED reception staff asked self-presenting patients for identifying information and then asked the patient to wait until called to see a nurse as part of the triage process. The triage process took place in a private room adjacent to the main ED reception area.

The emergency department had a designated room for adults and child mental health patients. The room had been risk-assessed and adapted to remove specific dangers such as ligature points (places where someone could tie a ligature to strangle themselves). The room had two entrances and exit points with panic alarms installed that summoned immediate assistance to patients and staff in the room. At the time of our inspection the room was not in use as it was awaiting new furniture. At the time of our unannounced follow up inspection the trust had fitted the new furniture and equipment, which was generally suitable for its intended use. However, the doors did not open both ways, which meant if a patient barricaded the room, staff would need to use force to enter the room. Staff told us they mitigated the risk of the non-compliant doors by ensuring there was always two members of staff in the room at any time when a patient was using the room.

Staff also used ED major cubicles for patients with mental health needs, which were in view of the main nurse's station so they could directly observe patients who may be at risk due to mental health issues. The major cubicles contained moveable equipment, and only one entry and exit point. However, staff would remove all potentially hazardous equipment from cubicles before admitting a patient with mental health needs and the trust used security staff and porters so that trust staff were not left alone with potentially aggressive patients. Staff received additional training in conflict resolution, violence and aggression breakaway, and control and restraint.

The use of majors cubicles was on the departmental risk register and included mitigating actions and an action plan for improving the care delivered to patients with mental health needs. The trust did not employ any mental health nurses at the time of our inspection. However, senior members of staff said that the trust planned to recruit to new posts that were being created and they currently utilised agency staff when required for this function.

A room within the emergency department was set aside specifically for viewing the deceased patient prior to transport to the mortuary. This was to support families in immediate need, and staff told us the room had been beneficial in supporting families.

Resuscitation equipment was readily available within the emergency department, we found staff checked equipment daily and records of checks were up to date at inspection.

Equipment trolleys within the major resuscitation bays had equipment checklists attached with regular reviews of equipment documented.
The paediatric waiting area was visibly clean and had a variety of toys and activity books for children as well as a large wall mural to create a vibrant child-friendly environment. The paediatric Emergency Department met the relevant standards for children and young people in emergency care settings set by the Royal College of Paediatrics and Child Health (RCPCH).

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

The trust scored about the same as other trusts for all five Emergency Department Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>6.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

From July 2017 to June 2018 the trust’s median time from arrival to initial assessment was better than the England average in nine out of 12 months.

Otherwise the trust’s performance was quite consistent, varying from six minutes to eight minutes, while the England average varied from seven minutes to nine minutes. In both July and November 2017, the trust’s performance was the same as the England average (seven minutes in both months). In December 2017 the trust reported a dip in performance to a median of 27 minutes. The trust explained the dip in performance in December 2017 was due to winter pressures and demands on the service.

Ambulance – Time to initial assessment from June 2017 to May 2018 at Mid Essex Hospital Services NHS Trust

(Source: Source: NHS Digital - A&E quality indicators)
Broomfield Hospital

From July 2017 to June 2018 there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Broomfield Hospital.

**Ambulance: Number of journeys with turnaround times over 30 minutes - Broomfield Hospital**

![Graph showing ambulance journeys]

**Ambulance: Percentage of journeys with turnaround times over 30 minutes - Broomfield Hospital**

![Graph showing percentage of ambulance journeys]

(Source: National Ambulance Information Group)

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From June 2017 to May 2018 the trust reported 843 “black breaches”.

More than half of these breaches, 473, occurred during the three-month period from November 2017 to January 2018. Then over the four months from February to May 2018 the number of breaches remained relatively high. There were more breaches in each of these months than in any of the four months from July to October 2017.

**Black breaches**
The department mostly identified and assessed the safety and needs of patients that attended the department.

Patients arrived at the department by either emergency ambulance, air ambulance, through healthcare professional referral or self-presentation.

Reception staff booked patients in who had self-presented, who were then called by a triage nurse located adjacent to the public waiting area.

Patients that self-presented were first seen by reception staff near the entrance to the ED. Staff entered the patients details onto the electronic system and patients then took a seat in the waiting area. If the patient was a child they were directed to the paediatric waiting area. The triage nurse saw patients in order of their time of arrival into the ED. After the triage patients were allocated to the most suitable area for treatment. Patients returned to the waiting area while waiting for treatment. Patients were next seen in order of referral or in order of seriousness of symptoms as decided by the triage nurse. Reception staff had not received training in the recognition of ‘red flag’ signs and symptoms that help to identify seriously unwell patients. Staff told us that the triage nurse regularly oversaw the waiting area to check for deteriorating patients, however this was not formally documented. We spoke with reception staff who told us any concerns were immediately escalated to the triage nurse or majors area and they said staff were responsive to concerns, providing assistance in a timely manner. In addition, staff had access to an emergency alarm, for use if a patient collapsed in the waiting area.

The Emergency Village included a GP led service that could see patients that were not suitable for ED majors or minor injuries service, but were still suitable for medical review. The triage nurse saw all patients that self-presented to the Emergency Village, conducted an initial assessment of their needs and allocated them to the correct area for further assessment or care. The GP was located next to the waiting area. Staff told us the GP service accepted certain medical conditions where others were excluded. Staff had a clear process to ensure that only clinically suitable cases were streamed to the GP service.

There was a Hospital Ambulance Liaison Officer (HALO) in the emergency department. The role of the HALO was to work with ambulance crews and hospital staff to reduce the time spent by crews in the emergency department and assist patient flow. Ambulance arrivals were seen by clinicians in a dedicated four cubicle area where an initial clinical assessment was carried out called emergency senior assessment team (ESAT). Patients were then streamed to the most appropriate clinical area.

Nursing staff used the Manchester Triage Tool (MTT) to assess patients. The MTT is used to triage patients and ascertain how critically unwell a patient may be.
Triage staff completed an early warning score (EWS) for adults and a paediatric early warning score (PEWS) for children, as part of the initial clinical assessment. An early warning score allows a clinician to identify very ill patients, prompting urgent action to review the care of the patient and call for specialist help if necessary. Staff were able to recognise deteriorating patients and we saw in records that patients were escalated appropriately.

The Royal College of Paediatrics and Child Health (RCPCH 2012) standard for the management of the sick and injured child states that all children should receive an initial triage assessment within 15 minutes of arrival. All paediatric patient records we reviewed had a documented early warning score and an initial assessment within 15 minutes of arrival. This was in line with the RCPCH standard relating to initial triage assessment times.

The ED had dedicated pathways in place for patients with sepsis. Sepsis algorithms were on display in clinical areas to prompt staff to assess for this condition. Patients with known or suspected neutropenic sepsis were flagged on the booking in system to ensure timely escalation once they had booked in to the department.

The ED audited ‘door to needle’ times which assess how quickly a patient has received intravenous antibiotics in cases of sepsis. The National Institute for Health and Care Excellence (NICE) Clinical Guidelines advises door to needle antibiotic time of less than one hour in patients with suspected neutropenic sepsis. From June 2018 to August 2018, the trust compliance results against the sepsis screening guidelines were variable as demonstrated in the table below:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ED</strong></td>
<td></td>
</tr>
<tr>
<td>June (14/16)</td>
<td>87.5%</td>
</tr>
<tr>
<td>July (43/50)</td>
<td>86%</td>
</tr>
<tr>
<td>August (35/50)</td>
<td>70%</td>
</tr>
</tbody>
</table>

Resuscitation areas contained specific guidance on paediatric advanced life support, drug calculation based on age and weight and critical care contact numbers. This allowed staff to provide evidence based treatment and care in a timely manner. The trust provided data at the time of our inspection showing that 57 members of staff had received Paediatric Immediate Life Support training across the department, including all members of nursing staff based in the paediatric ED, and 22 members of staff had received Advanced Trauma Life Support. The trust planned rotas to ensure sufficient numbers of appropriately trained medical and nursing staff were on duty on any shift.

Staff risk assessed all patients with a suspected mental health condition upon arrival at the emergency department. Staff used a mental health assessment tool that enabled staff to calculate the risk of suicide that a patient may have and if they presented a risk to others within the department. Both adult and paediatric patients had a specific risk assessment indicating risk levels and need for referral to mental health services and the psychiatric liaison team.

The trust utilised porters and security staff to support patients with mental health need in the department and assist with conflict resolution and potentially aggressive patients. The trust provided a risk assessment for the use of these staff outlining their roles, responsibilities, and provided further training for the role.

All porters and security staff that worked in the ED as first responders to patients with mental health needs had received training in conflict resolution, violence and aggression breakaway, and control and restraint. In addition, mandatory training for security and porter staff included, health and safety awareness, which included basic awareness of security safety measures, safeguarding...
adults – level one, safeguarding children – level 1, dementia awareness training - levels 1 and 2, and PREVENT- level 2.

Staff had access to clear criteria for activation of the trauma team response to the emergency department. Information was displayed in key areas to aid decision making.

The trust departmental dashboard showed that the department did not meet the trust target of 95% for venous thromboembolism (VTE) risk assessment screening in any of the months from September 2017 to July 2018. Performance ranged from 71% in February 2018 to 80.9% in October 2017. However, we observed VTE assessments were undertaken on patient’s admission to the hospital in all records we checked and we noted that where people had been identified as at-risk of developing a VTE, prophylaxis (mechanical or chemical) had been prescribed.

During our inspection, shift co-ordinators regularly checked and aided access and flow within the emergency department. Regular updates were provided to the site team throughout the day, along with the recording of patient numbers in all clinical areas.

**Nurse staffing**

The service planned to have enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment. However, there was a high reliance on temporary staff. Patients’ needs were met at the time of inspection. Plans were in place to improve staff recruitment.

The trust reported their qualified nursing staff numbers as below as of March and May 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTEs)</td>
<td>Planned staff (WTEs)</td>
</tr>
<tr>
<td>Broomfield Hospital</td>
<td>118.7</td>
<td>167.6</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staff tab)

From June 2017 to May 2018, the trust reported a vacancy rate of 30.7% for qualified nursing staff in the emergency department at Broomfield Hospital. This was higher than the trust target of 15.4%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

We requested up to date data for nursing staff vacancies for June and July 2018 at the time of our inspection. The trust reported vacancy rate across the Emergency Village in June 2018 was 23.67% and 21.33% in July 2018. The highest vacancy rates were for emergency department adults, which had vacancy rates of 32.88% in June 2018 and 33.61% in July 2018.

From June 2017 to May 2018, the trust reported a turnover rate of 5.3% for qualified nursing staff in the emergency department at Broomfield Hospital. This was lower than the trust target of 18%.

The adult emergency department used agency and bank staff frequently to provide cover for shifts. The department tried to fill shift through bank first and then utilised agency staff. Bank and agency staff were effectively inducted into the department and we saw records of agency staff induction including the induction topics covered. Safety huddles were held throughout the day.
where staffing levels were a key feature and action was taken to ensure safe staffing levels met safe levels, for example calling in bank or agency staff to cover any shortfall based on the demands within the department. The trust reported an overall fill rate for June 2018 of 104.9% and 103% in July 2018.

The children’s emergency department was open 24 hours a day seven days a week. Between 7.30am and 8pm, the department had two dedicated registered nurses (children’s branch) and between 2pm and 8.30pm, a further registered nurse (children’s branch) joined the team. Between 8pm and 12am, the department had two nurses and two health care support workers (HCSW), there was also a dedicated night shift between 9pm and 7.30am with one dedicated paediatric nurse and one HCSW.

Within the RPIR, the trust noted that there was an issue with their turnover data. The process used in the Electronic Staff Record (ESR) when staff leave and retain a staff bank contract means that they are not counted in ESR as a leaver. As a result, the turnover figures reported from ESR are lower than they are. The trust’s internal reports and the Joint Working Board report are adjusted to reflect the additional leavers, so that the correct turnover figures are reported. However, due to the manual recording of this data, and its limitations, it was not possible for the trust to analyse it to the level of detail required for the RPIR.

The trust reported that this process was changing and, in the future, all their leavers would be included in reports from ESR.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

We requested up to date data for nursing staff turnover for June and July 2018 at the time of our inspection. The trust was unable to provide this data in a usable format. The trust annual turnover target was 18.05%.

From May 2017 to April 2018, the trust reported a sickness rate of 3.1% for qualified nursing staff in the emergency department at Broomfield Hospital. This was lower than the trust target of 4.24%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

We requested up to date data for nursing staff sickness rates for June and July 2018 at the time of our inspection. The trust was unable to provide this data in a usable format.

From May 2017 to April 2018, the trust reported that 23.4% of nursing assistant staff shifts in the emergency department at Broomfield Hospital were filled by bank staff, while no shifts were filled by agency staff. In addition, 6.2% of shifts were not filled by either bank or agency staff to cover staff absence.

Over the same period, the trust reported that 11.6% of qualified nursing shifts in the emergency department at Broomfield Hospital were filled by bank staff and 20.3% of shifts were filled by agency staff. In addition, 2.8% of shifts were not filled by bank or agency staff to cover staff absence.

<table>
<thead>
<tr>
<th>Bank / agency</th>
<th>Nursing Assistant</th>
<th>Qualified nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>Bank</td>
<td>1,534</td>
<td>23.4%</td>
<td>2,081</td>
</tr>
<tr>
<td>Agency</td>
<td>0</td>
<td>0.0%</td>
<td>3,631</td>
</tr>
<tr>
<td>Not filled</td>
<td>407</td>
<td>6.2%</td>
<td>504</td>
</tr>
</tbody>
</table>
Safety huddles were held twice a day where staffing levels were a key feature and action was taken to ensure safe staffing levels, for example calling in bank or agency staff to cover any shortfall based on the demands within the department.

**Medical staffing**

The service had enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment. However, there was a high reliance on locum staff. Patients’ needs were met at the time of inspection. Plans were in place to improve medical staff recruitment.

The trust reported their medical staffing numbers as below as of March and May 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTEs)</td>
<td>Planned staff (WTEs)</td>
</tr>
<tr>
<td>Broomfield Hospital</td>
<td>32.5</td>
<td>49.5</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

From June 2017 to May 2018, the trust reported a vacancy rate of 33.7% for medical staff in the emergency department at Broomfield Hospital. This was higher than the trust target of 15.4%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

We requested up to date data for medical staff vacancies for June and July 2018 at the time of our inspection. The trust reported vacancy rate across the Emergency Village in June 2018 was 24.13% and 17.80% in July 2018. The highest vacancy rates were for the emergency department, which had vacancy rates of 33.30% in June 2018 and 39.30% in July 2018.

The trust was managing and mitigating the risk of the lack of ED consultants through ongoing recruitment, an increase in middle grade doctor cover to support consultants and the use of long term locum consultants to ensure consistent care for patients and leadership for staff.

From June 2017 to May 2018, the trust reported no turnover for medical staff at the emergency department at Broomfield Hospital. The trust target was 18.05%.

Within the RPIR, the trust noted that there was an issue with their turnover data. The process used in ESR when staff leave and retain a staff bank contract means that they are not counted in ESR as a leaver. As a result, the turnover figures reported from ESR are lower than they actually are. The trust’s internal reports and the Joint Working Board report are adjusted to reflect the additional leavers, so that the correct turnover figures are reported. However, due to the manual recording of this data, and its limitations, it was not possible for the trust to analyse it to the level of detail required for the RPIR.

The trust reported that this process was changing and, in the future, all of their leavers would be included in reports from ESR.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)
We requested up to date data for medical staff turnover for June and July 2018 at the time of our inspection. The trust was unable to provide this data in a usable format. The trust annual turnover target rate was 18.05%.

From May 2017 to April 2018, the trust reported a sickness rate of 0.1% for medical staff in the emergency department at Broomfield Hospital. This was lower than the trust target of 4.24%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

We requested up to date data for medical staff sickness rates for June and July 2018 at the time of our inspection. The Emergency Village medical staff sickness rate in June 2018 was 1.44% and the rate for July 2018 was 1.98%.

Although the trust provided the total numbers of shifts worked by medical bank and locum staff over the most recent year as requested in the Routine Provider Information Request (RPIR), they were unable to supply the total number of shifts worked by all medical staff, including permanent medical staff. This meant that the proportions of shifts worked by medical bank and locum staff could not be calculated.

However, the trust was able to supply the number of WTE medical staff budgeted for, the number of WTE permanent medical staff contracted and the number of WTE agency medical staff employed. These figures were used to calculate the proportions below.

As at May 2018, the trust reported that locum medical staff made up 36.0% of budgeted WTE medical staff in urgent and emergency care. Over the same period none of the budgeted WTE medical posts in urgent and emergency care were left unfilled; in fact, these posts were over-filled by 1.4%.

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

As of March 2018, the proportions of consultants and junior staff reported to be working in urgent and emergency care at the trust were similar to the respective England averages.

Staffing skill mix for the 25 whole time equivalent medical staff working in urgent and emergency care at Mid Essex Hospital Services NHS Trust.

![Staffing skill mix chart]

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>28%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>0%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>48%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>24%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)
Staff roles and areas of work were clearly identified and staff were aware of their roles and responsibilities in the department.

We observed “Board rounds”, which took place three times a day, where key issues in relation to patient’s needs and safety as well as the flow through the department and bed state were discussed around a white board containing pertinent patient details. This was also used as an opportunity for more senior medical staff to challenge junior staff on patient’s needs, condition management, and the department situation. This was managed professionally and effectively and staff found this helped support their professional development.

Medical staffing rosters supplied by the trust showed consultant cover was not available for more than 16 hours per day in line with the recommendations of the Royal College of Emergency Medicine. However, junior and middle grade staff told us that consultants would normally stay beyond their contracted hours to ensure medical staff had sufficient support in the department. There was consultant cover in the emergency department throughout the day from 8am to 10.30pm. Consultant medical staff were available to manage care throughout the department as needed. One person was allocated as the emergency physician in charge so that there was clear leadership at all times internally and in dealing with other departments or services. Paediatric consultant leadership was provided by the women and children’s directorate with support from the main ED consultant in charge. The medical staffing rota had a minimum of a speciality registrar in the department 24 hours a day.

Records

Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care.

Written patient records were thorough and completed to the required standards in the ED, EAU and minor injuries area. We reviewed 34 sets of patient records, which were signed and dated, with evidence of sepsis flow charts, observations, frailty assessments, and MRSA screening checks completed as routine.

Patient records were secured at all times during our inspection, either in locked cabinets or behind nursing stations to ensure the confidentiality of patient information.

Since our last inspection, the whole Emergency Village had started using personal digital assistants (PDAs) to record nursing observations and assessments electronically. PDAs were stored in locked rooms or behind nurse’s stations. Nursing staff told us that observations were often completed on paper, but then transferred onto the electronic system.

The trust completed an ‘Annual Trust-wide Audit of Clinical Record Keeping’ in March 2018. Results for the ED showed issues in the recording of observations recorded, DNACPR section completed improperly on the front sheet, allergies documented in the record, and the patient property section completion on the front sheet. Findings from the audit were reported to the trust Medical Director and shared with staff by newsletter. One of the key recommendations from the audit was for the provision of Clinical Record Keeping training to be reviewed. Each department was responsible for producing actions plans. Progress with the actions was monitored at subsequent Directorate Governance meetings.

Paper copies of patient records were transferred with patients when they admitted to a ward and the observations and assessments on the electronic system were accessible by staff throughout the trust.

Medicines

There were processes in place to ensure the service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.
However, the trust reported 65 medicine administration errors and 13 prescribing errors from September 2017 to August 2018.

At the time of our inspection we observed, staff prescribed, administered, recorded, and stored medicines appropriately. We checked the controlled drugs (CD) throughout the ED and found these accounted for and stored correctly in line with legislation and trust policy. Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs, for example morphine. Intravenous fluids were clearly labelled and stored appropriately. If patients were allergic to any medicines, this was recorded on their prescription chart.

We reviewed medication fridge temperatures within the ED and found that nursing staff routinely completed these and the fridges were within the prescribed range. At the time of our inspection, the ambient room temperature with the medication storage rooms were also monitored and recorded daily to ensure medication was safe for patient use.

In March 2018, a seven day a week (8am-8pm) clinical pharmacy service to the Emergency Village was introduced. Part of this service was to allocate a named pharmacist to the emergency department. This involved establishing a pharmacist role in the department and increasing ward staff awareness of pharmacy input to patient care.

At the time of our inspection the only medication audit carried out in the ED was the storage of medication audits, completed in August 2018. A member of the pharmacy team conducts the audits unannounced, with a senior member of ED nursing staff. The last audits conducted prior to August 2018 were in February 2018 and May 2017.

The most recent audit results from August 2018 showed that staff stored medicines at the correct temperatures and storage records were being completed correctly. The audit found evidence that the majors treatment room temperature had been recorded as out of range, but there was no evidence of action taken. The audit included a recommendation to feedback to all staff on trust policy for escalating issues with temperature recording of the treatment rooms. After the audits were completed they were collated, an action report was completed and taken to the Senior Nurses meeting.

At the time of the inspection the trust told us they planned to increase medicine audit activity in the ED for areas of activity that were not currently audited, including:

- Recording of pharmacy interventions made within ED specifically
- Medicines reconciliation monitoring
- Outpatient prescribing from ED (i.e. patients not admitted)
- Antimicrobial stewardship audit

The trust used Patient Group Directions (PGDs) in the ED. PGDs are a legal mechanism that allow certain health care professionals (for example, nurses) to supply and or administer medicines to certain patients without a prescription. Staff used PGDs in the ED to supply patients with medicines in a timely manner (for example, pain relief, and eye products). We reviewed the PGDs in the ED and found them to be correctly completed and within date for review.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
From August 2017 to July 2018, the trust reported no incidents classified as never events in urgent and emergency care.

(Source: NHS Improvement - STEIS (01/08/2017 - 31/07/2018))

In accordance with the Serious Incident Framework 2015, the trust reported 30 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from August 2017 to July 2018.

A breakdown of all incidents reported in urgent and emergency care is shown below.

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>14</td>
<td>46.7%</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>6</td>
<td>20.0%</td>
</tr>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>3</td>
<td>10.0%</td>
</tr>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>2</td>
<td>6.7%</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td>Medication incident meeting SI criteria</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td>Abuse/alleged abuse of child patient by third party</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td>Failure to obtain appropriate bed for child who needed it</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

The time taken by the trust to report these SIs to STEIS was variable:

<table>
<thead>
<tr>
<th>Time to report</th>
<th>No. of incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 14 days</td>
<td>19</td>
</tr>
<tr>
<td>15 - 30 days</td>
<td>1</td>
</tr>
<tr>
<td>31 - 60 days</td>
<td>1</td>
</tr>
<tr>
<td>61 - 90 days</td>
<td>2</td>
</tr>
<tr>
<td>90+ days</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
</tr>
</tbody>
</table>

(Source: NHS Improvement - STEIS (01/08/2017 - 31/07/2018)

Staff reported incidents using an electronic reporting system and we saw records where staff had used the system to report concerns. All staff we spoke with were aware of the reporting system and knew how to raise issues and escalate concerns.

Learning from incidents was evident, with incidents reported daily to the senior incident management group (SIMG). The SIMG was a group of senior staff that would review and make decisions on the level and impact of incidents, whether further investigation was required, or escalation to external agencies.

We reviewed the root cause analysis (RCA) of three of the reported serious incidents (SIs). The trust had thoroughly investigated each SI and detailed the incident, learning, and recommendations and actions taken to minimise events in the future. For example, one incident involved the delay in obtaining an x-ray for a patient, which resulted in the delay in the patient receiving the correct treatment. The delay was due to an agency Emergency Nurse Practitioner (ENP) not requesting an x-ray when the patient first attended the department. The key learning points from the incident were to ensure that all appropriate imaging is undertaken for patients seen...
and to ensure that all bank and agency ENPs have been fully inducted to the department. Feedback was provided to the individual ENP and their employment agency and the trust had reviewed the induction process for agency staff working in the ED to ensure they understood the process for requesting imaging in the department. The trust recognised they had a challenge regarding incidents resulting from trolley waits for mental health patients (these made up the vast majority of ‘treatment delay meeting SI criteria’, 10 in total). The trust had developed an action plan as a result of the delays for mental health patients. The ED senior leadership in the service said that they planned to improve waiting times for mental health patients through continuing staff recruitment, and the addition of registered mental health nurses (RMNs).

Staff could access the governance and learning folder at any time and staff discussed SIs at team meetings.

Safety huddles were held twice per day (this is where staff meet at the start and end of shifts to discuss various issues in relation to the safe operation of the department, for example, patient flow, staffing levels, current themes, or safety concerns).

Safety huddle discussions used information from the quality and safety information board to encourage staff discussion of the latest data in relation to issues like falls, sepsis, incidents, patient’s feedback, and general safety performance.

Team meeting records showed where learning from incidents had been recorded, along with agreed actions. Staff were briefed on incident content, reasons, and how learning was fed back to the wider staff team. Learning from incidents was shared with staff via email and newsletters.

Mortality and morbidity meetings were held to share learning from patient deaths, covering general, paediatric, mental health, and trauma cases. Medical staff said they were able to attend the meetings.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. All staff we spoke with in majors, minors, paediatrics, and emergency admissions unit knew about duty of candour and its relationship to being open and honest in dealing with significant events. We saw evidence of duty of candour being exercised with patients and their families in serious incident reports that the trust shared at the time of the inspection.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. However, we saw evidence that not all policies were accessible or complete.

The emergency department (ED) provided care and treatment based on national guidance including National Institute for Health and Care Excellence (NICE) and the Royal College of Emergency Medicine (RCEM) standards.

On arrival to the department, staff assessed patient’s physical, mental health and social care needs and referred patients for further professional assessment where necessary by other specialist services, for example surgery.

Trust policies and procedures were available to view and print off if required from the trust intranet pages, staff could access this from a variety of computers in the ED. However, not all policies were accessible or were in the incorrect folder. For example, the safe restraint policy was last due for review in 2016, but had not been completed, there was no adult diabetic ketoacidosis (DKA) pathway protocol available on the intranet, and the antibiotic policy file only contained a neonatal policy, but no adult’s policy. Two members of medical staff said they had received copies of the relevant policies by email, but could not locate them at the time of the inspection. The policies and patient pathways we reviewed referred to national guidelines such as NICE and RCEM. We reviewed ten policies and procedures on the trust intranet.
Nursing and medical staff used the sepsis six screening tool, which is best practice for the early identification of sepsis. The trust took part in the annual Royal College of Emergency Medicine (RCEM) Severe sepsis and septic shock in adult’s audits.

Local audits were also taking place in the ED, for example, hand hygiene, venous thromboembolism (VTE) and national early warning scores (NEWS).

We requested VTE audit data covering the Emergency Village at the time of our inspection. The trust did not provide data regarding the ED. The trust conducted VTE audits in the Emergency Short Stay (ESS) ward and Acute Medical Unit (AMU). Both areas are high turnover wards, where patients’ stay is expected to be short and they are either discharged or transferred to other clinical areas in the hospital. Staff conducted VTE assessments in the AMU on 78.33% of occasions audited in quarter one (April to June 2018) and 100% in quarter two (July to September 2018).

The results for the ESS for quarter one was 80.92% and 60% for quarter two. The trust had a Quality Improvement Plan in place, which included improving documentation of risk assessment and prevention of VTEs.

The standard risk assessment and observation tools included dementia screening, which was regularly undertaken by staff in the frailty unit. The frailty unit also had access to distraction items for patients with a cognitive impairment. For example, textured twiddle muffs to support patients with dementia. Twiddle muffs help provide stimulation for patients with additional needs.

Nutrition and hydration

In the CQC Emergency Department Survey, the trust scored 6.7 for the question “were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Staff gave patients enough food and drink to meet their needs and improve their health.

Fresh free water was available within the ED from a water cooler, patients in the main ED waiting area accessed food and drink from a vending machine. Staff used a red jug and red tray system that enabled staff to identify patients who may need additional support with eating and drinking whilst in the department.

Staff offered patients drinks if clinically safe to do so and they had been in the department for some time. Drinking water was available to patients in bed and within reach.

There was provision for food out of hours. Support staff ensured a selection of sandwiches were available for patients should this be required. Drinks were offered at set times of the day in addition to being available on a drinks trolley in the department when being required.

The emergency assessment unit offered hot meals to patients with choice from a menu. This included healthy choice options and was available at lunch and supper times.

Pain relief

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

In the CQC Emergency Department Survey, the trust scored 6.7 for the question “how many minutes after you requested pain relief medication did it take before you got it?” This was about the same as other trusts.
The trust scored 7.7 for the question “do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

We observed staff assessing patient’s pain levels early in the patient’s pathway by different methods in line with the Faculty of Pain Medicine’s Core Standards for Pain Management (2015). For adult’s staff used a pain score, ten being the worst discomfort and one being very mild discomfort. Staff used other pain assessment tools for children dependent upon age and those with a cognitive impairment, for example using smiley or sad faces. Staff reacted promptly by administering pain relief medication when patients required it. We noted that staff reviewed patient levels of pain and documented for both adults and children as part of that assessment process during our inspection.

Where appropriate staff checked patient pain levels throughout patients stay in the emergency department and we noted this was also recorded in the nursing notes, along with any additional analgesia administered if necessary.

The ED staff used Patient Group Directions (PGDs) to enable nursing staff to provide timely pain relief. PGDs provide a legal framework, which allows some registered health professionals to supply and or administer specified medicines, such as painkillers, to a predefined group of patients without them having to see a doctor. Nursing staff also had access to a senior doctor for prescribing analgesia for severe pain.

We reviewed nine sets of paediatric notes, which demonstrated staff offered children pain relief within 20 minutes, if clinically required. We also observed that children were offered pain relief before interventions. This demonstrated compliance with the RCEM management of pain in children (July 2013).

Patient outcomes

Managers monitored the effectiveness of care and treatment. However, there was limited evidence the trust use used the findings to improve care and treatment.

In the 2016/17 Moderate and acute severe asthma report, Broomfield Hospital emergency department failed to meet any of the standards (all 100%).

The department was in the upper UK quartile for two standards:

- Standard 5: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV

  - Standard 5b (fundamental): within 4 hours (moderate). This department: 61.2%; UK: 28%.

- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
  - Adults 16 years and over: 40-50mg prednisolone for 5 days
  - Children 6-15 years: 30-40mg prednisolone for 3 days
  - Children 2-5 years: 20mg prednisolone for 3 days

This department: 76.2%; UK: 52%.
The department’s results for the remaining five standards were all within the middle 50% of results.

(Source: Royal College of Emergency Medicine)

In the 2016/17 Consultant sign-off audit, Broomfield Hospital emergency department failed to meet any of the standards (all 100%).

The department was in the lower UK quartile for two standards:

Standard 1 (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 4.9%; UK: 11%.

Standard 2 (developmental): Consultant reviewed: fever in children under 1 year of age. This department: 0.0%; UK: 8% (note that 50% of the patients in this group audited were seen by an ST4 or above).

The department’s results for the remaining two standards were both within the middle 50% of results.

(Source: Royal College of Emergency Medicine)

In the 2016/17 Severe sepsis and septic shock audit, Broomfield Hospital emergency department failed to meet any of the standards (all 100%).

The department was in the upper UK quartile for two standards:

- Standard 5: Blood cultures obtained within one hour of arrival. This department: 68.0%; UK: 44.9%.
- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 38.8%; UK: 18.4%.

The department’s results for the remaining six standards were all within the middle 50% of results.

(Source: Royal College of Emergency Medicine)

We requested a copy of the action plans for the 2016/17 RCEM audits for Moderate and acute severe asthma, Consultant sign off, and Sepsis and septic shock at the time of our inspection. However, the trust was unable to locate a copy of the relevant action plans, because the audit lead at the time of the audits left the trust earlier in 2018. This meant we could not be assured the trust was using audits to plan and make improvements. The trust informed us that the current consultant lead for audit had prioritised review and action in response to RCEM audits for the period 2017/18, which were published in 2018. These include fractured neck of femur (NOF), pain in children and procedural sedation. In future Emergency care audit activity will be available corporately. The trust shared the action plans for the 2017/18 RCEM audits.

The trust sepsis team had recently developed a specific ED improvement plan to ensure all improvement activity is captured and delivers increased compliance with the key quality standards. The trust has planned that asthma and consultant sign off are audited locally in 2018/19 to establish a current baseline and develop any required improvement activity.
From July 2017 to November 2017, the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5%, from January 2018 to June 2018 performance was slightly better than the standard. The trust did not provide data for December 2017. Throughout the period, performance at the trust was better than the England average.

Unplanned re-attendance rate within seven days - Mid Essex Hospital Services NHS Trust

(Source: NHS Digital - A&E quality)

After our inspection we requested the most recent RCEM pain in children audit and action plan. In the 2017/18 RCEM pain in children audit, Broomfield Hospital emergency department failed to meet any of the eight standards. However, the trust finished above the national average in five of the eight standards, including patients in severe pain (pain score 7 to 10) should receive appropriate analgesia, according to local guidelines and patients with moderate pain (pain score 4 to 6) should receive appropriate analgesia in accordance with local guidelines. The trust action plan for children in pain included actions including sharing the results of the audit with frontline staff to increase awareness, creating a hot topic notice for staff to be displayed on staff areas, which outlined the key areas for improvement and the proposals for the re-audit.

The trust participated in the Trauma Audit and Research Network (TARN). However, the Trust recognised that data completeness was an issue that was impacting on the ability to use this benchmarking data to drive improvement and to give assurance to patients and regulators. The trust had taken a number of actions to improve TARN reporting and data completeness, including; presenting a business case to employ a full time TARN co-ordinator to ensure effective and complete data entry, a new trauma lead had been appointed and the trauma group now reports regularly to the trust Patient Safety Group. The trauma lead had established a repository for guidance on managing trauma on the trust intranet and an ongoing audit to highlight trauma activity including metrics such as attending staff, pre-alerts, and primary survey times. They had also developed links with the informatics team to determine what metrics were available and how these could be used to drive improvement. Training provision had been made available as an induction session for relevant new starters.

The trust completed the 2017/18 RCEM Fracture Neck of Femur (NOF) Audit. The trust did not meet the national standard in any of the six standards and was also below the national average in all standards. The trust had an action plan to improve performance in how they treated patients with a fractured NOF, which included sharing the audit findings with staff, greater nurse use of Patient Group Directions (PGD) for analgesia (PGD is a written instruction for the administration of medicines to groups of patients who may not be individually identified before presentation for...
treatment), and introduce radiology department priority system for hip X-rays. However, there was no evidence of progress or completion of the action plan at the time of our inspection. All actions were due to be completed between September 2018 and January 2019.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

From June 2017 to May 2018, 79.1% of staff in the emergency department at Broomfield Hospital received an appraisal compared to a trust target of 79%. The 79% appraisal target was met for three out of six staff groups, including medical staff. However, the appraisal target was not met for the remaining three staff groups, including qualified nursing staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>June 2017 to May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Completed</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic, technician staff</td>
<td>1</td>
</tr>
<tr>
<td>Medical staff</td>
<td>22</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>11</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>25</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>54</td>
</tr>
<tr>
<td>NHS infrastructure support staff</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>121</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

At the time of our inspection we requested updated data for appraisal compliance in the ED. In August 2018, 94% of medical staff and 85% of nursing staff had received an appraisal against a trust target of 79%. All the medical and nursing staff we spoke with confirmed they had received an annual appraisal or had one scheduled. However, nursing staff said it was often difficult to arrange appraisals and supervisions with senior staff due to demand in the department. Staff told us that as part of their appraisal, they discussed their development and any training needed for their revalidation.

There were systems and processes in place to ensure newly appointed staff, bank and agency staff completed local inductions. We spoke with agency nurses and health care assistants (HCAs) who told us they received an ED specific induction. Local inductions took place in the ED and records were kept in a folder either in the matrons’ office or at the nurse’s station.

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Throughout our inspection, we routinely observed positive multidisciplinary working throughout the ED. Staff showed a mutual respect for each of their specialisms and worked together as a team towards supporting patients’ needs and outcomes. Medical staff said it was sometimes a challenge to get prompt input from inpatient speciality colleagues, but that the trust had plans to improve communication between teams. We saw that physiotherapists and occupational therapists working effectively as part of a team enabling patients to be discharged safely and efficiently.
The ED had a number of link nurses who specifically aimed to support staff knowledge and understanding of specialist interests, for example dementia, and safeguarding across the ED.

We observed positive interaction between ED staff and ambulance staff attending the department. Ambulance handovers in the main were well communicated, caring, calm, and friendly.

The emergency department had access to mental health workers who provided support to adults, seven days per week, either by direct contact with patients or via advice on the phone or email, this enabled access to early intervention to support patients’ mental health. However, ED staff told us they did not always get a timely response, which resulted in delays to those patients receiving the necessary treatment or onward referral. Staff told us delays were recorded as incidents so issues could be escalated and reviewed appropriately.

The emergency department had access to mental health workers who liaised with psychiatrists and consultants to support patients with mental health conditions. The mental health team implemented a mental health action plan. This encouraged multidisciplinary working as staff now had a clear pathway to follow for completion of risk assessing patients with dementia and other mental health conditions.

The emergency department had access to a specialist alcohol advice worker who liaised with the mental health team and emergency department staff to support patients with alcohol dependency issues.

There was a Hospital Ambulance Liaison Officer (HALO) in the emergency department. The role of the HALO was to work with ambulance crews and hospital staff to reduce the time spent by crews in the emergency department. The HALO was in place between the hours of 10am to 10pm. Nursing staff and the ambulance crews felt the presence of this role aided communication and flow through the department in a positive way.

**Seven-day services**

The ED department was available 24 hours a day, seven days a week.

The emergency department had consultant cover between the hours of 8am-10.30pm. There was an out of hour’s on-call system in place with patients and staff also having face to face access to junior and registrar grade staff 24 hours a day, seven days a week. The paediatric ED service was also available 24 hours a day, seven days a week.

The occupational therapy team were available seven days per week 8am to 6pm. Physiotherapists were also available within the department seven days a week 8am to 6pm and an on call available out of hours for specific conditions, for example respiratory needs.

The ED team had access to a dedicated psychiatric liaison service seven days per week, from 9am to 7pm and a mental health lead within the ED department. Outside of these hours, the staff contacted the local out of hour’s mental health crisis team on a dedicated phone line. Staff told us this had a positive impact on patients, as they would be able to see a professional for guidance on their wellbeing or condition that may enable them to return home more quickly or avoid admission.

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

The trust was meeting the NHS seven days a week priority clinical standards, because patients normally didn’t wait longer than 14 hours to initial consultant review, they got access to diagnostic tests within the required turnaround time, had access to specialist, consultant-directed interventions, and patients with high-dependency care needs received twice-daily specialist consultant review. The trust acknowledged that some mental health patients did end up waiting beyond the 14 hours for initial consultant review. Ten serious incidents that were attributed to ED in the 12 months before our inspection were recorded as exceeding 12-hour waits and all were related to patients waiting for mental health provisions.

**Health promotion**
Staff within the ED supported national priorities to improve the population’s health, for example, smoking cessation, alcohol dependency, dementia, and cancer. Patients’ accessed specific advice on health and condition management from a wide range of health-related leaflets and posters throughout the ED and on the trust’s website.

Staff gave advice to patients on discharge to enable them to manage their condition at home and specific advice on where to seek further advice if necessary.

Staff identified patients who may require additional support through alerts on the electronic patient record system. For example, alerts were available to identify patients who had a learning disability or dementia. Staff said that these alerts would prompt them to provide additional support, usually in liaison with link nurses or specialist teams. Staff could also refer patients to external agencies or organisations for additional further support.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They understood how and when to assess whether a patient had the capacity to make decisions about their care.

Broomfield Hospital emergency department

The trust identified some anomalies in their Mental Capacity Act (MCA) level 2 training in the process of compiling the data to send to us. The trust supplied their action plan to address these anomalies to us at the time of our inspection. The action plan included an action to ensure accurate training compliance data was recorded, which had a planned completion date of the end of October 2018.

The trust reported that from June 2017 to May 2018 MCA level 1 training was completed by 86.0% of staff in the emergency department at Broomfield Hospital compared to the trust target of 90%

The breakdown by staff group for qualified nursing staff and medical staff for MCA level 1 training is shown in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>June 2017 to May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>71</td>
</tr>
<tr>
<td>Medical staff</td>
<td>21</td>
</tr>
</tbody>
</table>

The trust reported that from June 2017 to May 2018 MCA level 2 training was completed by 39.7% of staff in the emergency department at Broomfield Hospital compared to the trust target of 90%.

The breakdown by staff group for qualified nursing staff and medical staff for MCA level 2 training is shown in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>June 2017 to May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td></td>
<td>31</td>
</tr>
<tr>
<td>Staff group</td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>50</td>
</tr>
<tr>
<td>Medical staff</td>
<td>5</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Training tab)

We observed staff interacting with patients and routinely obtaining verbal consent for all care and treatment. This included for example having their blood pressure or temperature taken.

Staff we spoke with knew about the Mental Capacity Act (2005) and ensuring people had the capacity to make informed decisions or consent to care and treatment. From our observations, we evidenced staff understood the Mental Capacity Act and how it aims to protect vulnerable people who were not able to make their own decisions. We reviewed patient’s records and saw that consent had been documented as obtained where this was applicable.

Staff knew their responsibilities in relation to supporting patients with mental health needs including adults, children, and young people. Paediatric staff we spoke with knew how to apply the Gillick competency when supporting children and young people. The Gillick competency is to determine that children under 16 can consent if they have sufficient understanding and intelligence to fully understand what is involved in a proposed treatment, including its purpose, nature, likely effects and risks, chances of success and the availability of other options. If a child does not pass the Gillick test, staff must get the consent of a person with parental responsibility (or sometimes the courts) prior to commencing treatment.
Is the service caring?

Compassionate care

The trust's urgent and emergency care friends and family test performance (% recommended) was similar to or better than the England average each month from July 2017 to June 2018. Performance was relatively stable with performance of around 88% in most months over the period.

A&E Friends and Family Test performance - Mid Essex Hospital Services NHS Trust

(Source: NHS England Friends and Family Test)

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

We spoke to nine patients (eight adults, one child, and a mother with baby that was unwell) and six relatives during our inspection of the emergency department (ED). Feedback was positive, describing staff as kind, caring and compassionate, though some did comment about the length of their wait.

Patients reported that staff introduced themselves when first meeting patients or relatives. We observed staff speaking to patients politely and with a smile, introducing themselves and their role within the ED.

Throughout our inspection, we observed staff being polite and courteous to patients and respond compassionately to patients’ needs. Staff displayed non-judgemental behaviours towards all attendees we observed in the department.

Nursing and medical staff preserved patient privacy and dignity by closing curtains or cubicle doors before carrying out care to protect a patient’s privacy and dignity. Where appropriate, staff also asked for permission before entering cubicles and curtained off areas.
All the patients we spoke with described staff as friendly and caring, including a patient who said, ‘staff have been comforting’ and another who said, ‘the kind and caring staff explained everything and were extremely reassuring at all times’.

**Emotional support**

**Staff provided emotional support to patients to minimise their distress.**

We observed staff demonstrating a caring attitude towards patients. Staff offered emotional support to patients to reduce their anxiety and distress as much as possible.

The paediatric nurses used distraction techniques such as using books or cuddly toys when supporting children who were anxious or distressed and had a range of equipment, for example toys, TV to support patients and help to keep them calm.

Staff described how they utilised bereavement areas to allow people to have a quiet area to understand and take on board news they had received. Wherever possible staff said they would take time to sit with relatives to provide emotional support.

There was a trust wide chaplaincy service, which was advertised on notice boards within the ED. Throughout our inspection, the chaplaincy service was visible within the ED.

**Understanding and involvement of patients and those close to them**

**Staff involved patients and those close to them in decisions about their care and treatment.**

Relatives of patients told us staff kept them fully informed of what was happening and that staff had asked for their input into the care and treatment of their relative.

All the patients and relatives we spoke with in the ED told us they had felt involved in the care delivered and had been given sufficient time to ask staff questions if they did not understand something.
The trust scored about the same as other trusts for all 24 Emergency Department Survey questions relevant to the caring domain. **Question**

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>6.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>5.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>5.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>5.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>5.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>6.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall score</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)
Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

During our inspection, we noted sufficient seating was available in all areas for patients and relatives. The reception areas were well equipped to provide food and drink as well as a dedicated phone to enable patients to request a taxi service.

The trust had decorated the paediatric area in the emergency department (ED) with children in mind. For example, there was colourful wall art and images to attract children’s attention. The area contained a range of appropriate toys for children, a television, and age appropriate books.

Meeting people’s individual needs

The service took account of patients’ individual needs, but was not always successful in meeting them especially for mental health patients.

The trust scored about the same as other trusts for all three Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

The ED took account of patient’s individual needs. Where possible staff made reasonable adjustments within the ED for patients, for example those living with dementia, autism or learning disability. For example, providing appropriate sensory equipment, such as soft toys and twiddle muffs.

Patients with particular needs, for example those with a learning disability, were ‘flagged’ on the trusts electronic system used for booking patients into ED and a nurse specialist was accessible for patients with learning disabilities. The trust’s learning disability nurse provided support to patients, their families, and carers and provided advice to staff. The specialist nurse received referrals from staff as well as families and carers. They undertook an assessment of need and then advised staff about any reasonable adjustments required. Staff encouraged relatives and carers to stay in the department with patients who had learning difficulties.

The trust used the ‘This is me’ document for patients living with dementia so that staff knew how a patient normally achieved their activities of daily living and the strategies that staff may need to employ to assist the patient in the hospital environment.

The needs of patients with mental health problems were not always met within the ED. The neighbouring mental health trust did not always have beds available for patients who needed to be admitted. As a result, mental health patients had to be accommodated in the ED. There were regularly patients in the ED waiting for mental health beds throughout our inspection and staff
told us that patients had waited for up to 14 hours in recent months. The emergency department and village did not provide the therapeutic environment required by patients with mental health problems. Nursing staff told us that they did not have the skills necessary to respond to the challenging behaviour that was sometimes exhibited by patients with serious mental health problems. The ED department risk register indicated that there were risks for mental health patients spending extended periods of time in the ED. Senior staff were aware of this and were working with local mental health providers to improve the situation and had an action plan in place to improve the care for mental health patients in the trust.

The ED team had access to a dedicated psychiatric liaison service seven days per week, from 9am to 7pm and a mental health lead within the ED department. Outside of these hours, the staff contacted the local out of hour’s mental health crisis team on a dedicated phone line. ED staff knew how to make a referral to this service. However, staff told us they did not always get a timely response, which resulted in delays to those patients receiving the necessary treatment or onward referral. Staff told us delays were recorded as incidents so issues could be escalated and reviewed appropriately.

The trust employed a lead nurse responsible for dementia in September 2018, who provided support and guidance within the ED to help staff understand and support the needs of patients and their families living with dementia. The trust did not provide data regarding dementia screening of patients in the ED.

Staff had access to interpretation services for patients and families whose first language was not English and the department was fitted with a hearing loop to aid people with hearing impairments.

The ED had equipment specifically for accommodating bariatric (clinically obese) patients, including beds, trolleys, and wheelchairs.

A chapel and prayer room was available twenty-four hours a day and the trust provided a chaplaincy team for patients with an on-call rota, for relatives and staff of all faiths, or none. This enabled staff to contact members of the team when required. The team provided or facilitated spiritual and religious care.

Patients had access to leaflets in the waiting area providing information on a variety of health conditions. Further leaflets in alternative languages were also available as well as advice on the chaperone process. Patients and staff could access a named dementia nurse, learning disabilities nurse and specialist children’s nurses.

The department encouraged public volunteers to work in the department to assist with the nutrition and hydration needs of patients and relatives.

There was wheelchair access to all parts of the department and the reception desk had a hearing loop for those who had hearing impairments.

**Access and flow**

**Patients could not always access services when they needed them.**

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard for any of the months over the 12 month period from June 2017 to May 2018.

The trust submitted no data for this metric from December 2017 to June 2018.

From July to November 2017 the trust’s performance for this metric was consistently worse than
both the 60 minute standard and the England median.

**Median time from arrival to treatment from July 2017 to May 2018 at Mid Essex Hospital Services NHS Trust**

The trust was not able to provide data for December 2017 to June 2018 for this metric due to data accuracy issues. We requested the data for July 2018 for this metric at the time of our inspection. The trust told us the median time from arrival to treatment in July 2018 was 80 minutes.

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From August 2017 to July 2018 the trust consistently failed to meet the 95% standard, and also performed worse than the England average in all but two months. Performance across the time period fluctuated, between 92.9% (October 2017) and 74.2% (December 2017).

**Four hour target performance - Mid Essex Hospital Services NHS Trust**

(Source: NHS England - A&E Waiting times)
From August 2017 to July 2018 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was better than the England average in eight out of 12 months. There were three short periods of improved performance, none of which were sustained.

In both August 2017 and April 2018, the trust’s performance was within one percentage point of the England average, and in July 2018 it performed the same as the England average (10.5%). May 2018 was the only month when the trust performed worse than the England average.

**Percentage of patients waiting more than four hours from the decision to admit until being admitted - Mid Essex Hospital Services NHS Trust**

(Source: NHS England - A&E Waiting times)

The table below shows the numbers of patients from August 2017 to July 2018 waiting more than four hours and more than 12 hours, from decision to admit until admission by month.

In total, eight patients waited for more than 12 hours until admission over the period.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
<th>Number of patients waiting more than 12 hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2017</td>
<td>229</td>
<td>0</td>
</tr>
<tr>
<td>September 2017</td>
<td>71</td>
<td>1</td>
</tr>
<tr>
<td>October 2017</td>
<td>55</td>
<td>2</td>
</tr>
<tr>
<td>November 2017</td>
<td>122</td>
<td>0</td>
</tr>
<tr>
<td>December 2017</td>
<td>231</td>
<td>1</td>
</tr>
<tr>
<td>January 2018</td>
<td>191</td>
<td>0</td>
</tr>
<tr>
<td>February 2018</td>
<td>151</td>
<td>2</td>
</tr>
<tr>
<td>March 2018</td>
<td>219</td>
<td>0</td>
</tr>
<tr>
<td>April 2018</td>
<td>272</td>
<td>1</td>
</tr>
<tr>
<td>May 2018</td>
<td>269</td>
<td>1</td>
</tr>
<tr>
<td>June 2018</td>
<td>139</td>
<td>0</td>
</tr>
<tr>
<td>July 2018</td>
<td>239</td>
<td>0</td>
</tr>
</tbody>
</table>
Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment

From July 2017 to October 2017 the percentage of patients who left before being seen for treatment was slightly lower than the England average, before rising above the England average in November 2017.

We requested data regarding the percentage of patients who left before being seen for treatment. The data provided by the trust is detailed in the table below:

<table>
<thead>
<tr>
<th>YYYY MM</th>
<th>walked out</th>
<th>Total</th>
<th>% walked out</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017 12</td>
<td>149</td>
<td>8421</td>
<td>1.8%</td>
<td>3.5%</td>
</tr>
<tr>
<td>2018 01</td>
<td>168</td>
<td>8290</td>
<td>2.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>2018 02</td>
<td>130</td>
<td>7512</td>
<td>1.7%</td>
<td>3.1%</td>
</tr>
<tr>
<td>2018 03</td>
<td>125</td>
<td>8720</td>
<td>1.4%</td>
<td>3.3%</td>
</tr>
<tr>
<td>2018 04</td>
<td>177</td>
<td>8670</td>
<td>2.0%</td>
<td>2.6%</td>
</tr>
<tr>
<td>2018 05</td>
<td>144</td>
<td>9326</td>
<td>1.5%</td>
<td>2.4%</td>
</tr>
<tr>
<td>2018 06</td>
<td>167</td>
<td>8876</td>
<td>1.9%</td>
<td>2.4%</td>
</tr>
<tr>
<td>2018 07</td>
<td>179</td>
<td>9237</td>
<td>1.9%</td>
<td>2.2%</td>
</tr>
<tr>
<td>2018 08</td>
<td>152</td>
<td>8639</td>
<td>1.8%</td>
<td>Not yet available</td>
</tr>
<tr>
<td>Total</td>
<td>1391</td>
<td>77691</td>
<td>1.8%</td>
<td>2.8%</td>
</tr>
</tbody>
</table>

Note: Patients leaving department has been calculated on diagnosis of "walked out". Disposal is not currently available in the data warehouse feed.

From July 2017 to June 2018 the trust’s monthly median total time in A&E for all patients was consistently higher than the England average, with a spike in December 2017 when the trust’s monthly median total time in A&E for all patients was 232 minutes compared to the England average of 159 minutes.

Median total time in A&E per patient - Mid Essex Hospital Services NHS Trust
The ED senior leadership in the service said that they planned to improve waiting times for patients through continuing staff recruitment, the addition of registered mental health nurses (RMNs) to improve the flow for mental health patients, and the recent addition of the new HALO to improve ambulance turnaround times. The trust recorded data regarding the number of patient admissions that had been avoided by streaming them through the Ambulatory Care Unit (ACU), which was over 200 patients every month from September 2017 to August 2018. The trust also supplied data showing the number of patients discharged home from the ED following input from occupational therapy of physiotherapy staff from September 2017 to August 2018. The best performing months were September and October 2017 when the trust discharged 33 patients home after therapy input and the worst performing month was December 2017 when nine patients were discharged home after therapy input.

At the time of our inspection we requested recent data regarding the performance of the ED in treating patients with mental health needs. The ED had 331 mental health patient attendances that received an initial assessment in July and August 2018, of which 70.4% were assessed within 15 minutes. Of the 308 patients attending that required mental health services in July and August 2018 that had a reported treatment time, 31.2% were treated within 60 minutes. Of the 331 patients attending requiring mental health input in July and August 2018, 63.3% were treated within four hours.

The trust expectation is that all patients will have an Expected Discharge Date (EDD) set at board rounds within 48 hours of admission to the hospital. The trust provided data showing that 100% of patients in the trust had received an EDD within 48 hours between March and September 2018.

The ED held regular huddles during each shift between the medical, nursing, and site teams. This enabled the teams to consider the range and needs of the patients against the flow through the department and the wider bed capacity across the hospital. We observed positive interactions amongst the staff team to promote flow through the department, identifying bed availability and considering which patients’ staff were likely to admit to the wider hospital from the ED.

The department had a ‘fit to sit’ area for patients who were not critically unwell and could sit in a chair when appropriate. This approach was designed to assist the use of ambulatory care pathways and reduce the demand on trolley/cubicle spaces.

There was a trust escalation plan and a full capacity policy, which described the actions to be taken if the ED was full and ambulances were no longer able to handover patients as soon as they arrived. In the event of the department being at full capacity the trust would draw on staff from other areas of the hospital to assist with demand and postpone any non-urgent activity within the hospital. This degree of crowding did not occur during our inspection.
Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

From June 2017 to May 2018 there were 90 complaints about urgent and emergency care services. For the 77 complaints that had been closed, the trust took an average of 44.3 working days to investigate and close complaints. This was in line with the trust’s complaints policy, which states complaints should be closed within 25 working days, or 60 working days for more complex complaints.

For the 13 complaints that had not been closed, the average time these complaints had been open for was 54.5 working days. This was also in line with the trust’s complaints policy, however six complaints had exceeded the target of 60 working days at the time of reporting. The breakdown by subject is shown in the table below.

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>79</td>
<td>87.8%</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>4</td>
<td>4.4%</td>
</tr>
<tr>
<td>Communications</td>
<td>3</td>
<td>3.3%</td>
</tr>
<tr>
<td>Appointments</td>
<td>2</td>
<td>2.2%</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>1</td>
<td>1.1%</td>
</tr>
<tr>
<td>Restraint</td>
<td>1</td>
<td>1.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>90</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

From June 2017 to May 2018 the trust received 89 compliments about urgent and emergency care at Broomfield Hospital.

The breakdown for wards and reporting units is shown in the table below.

<table>
<thead>
<tr>
<th>Ward/unit/team that the compliments related to</th>
<th>No. of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident and emergency</td>
<td>85</td>
<td>95.5%</td>
</tr>
<tr>
<td>ED Paediatrics</td>
<td>4</td>
<td>4.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>89</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

In their RPIR the trust did not provide a breakdown by subject or theme for compliments in each core service.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

There was a trust wide policy for the management of complaints, which staff could access through the intranet. The patient advice and liaison service (PALS) or complaints team supported patients, their families, and carers in making complaints or giving feedback to the hospital about the ED.

Information on how to make a complaint was displayed at regular intervals throughout the department. Patients and relatives were encouraged to complete feedback forms located in prominent areas.
Staff we spoke with could tell us about recent complaints that had been received in their areas, but could not recall any specific learning which had taken place. Staff told us that learning was cascaded by email, at team meeting and at huddles at the beginning and end of shifts.
Is the service well led?

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service.

The trust was divided into five divisions. The emergency department (ED) was part of Division 1, Medicine and Emergency Care which was led by the interim clinical director, supported by the associate director of operations, associate director of nursing, and matrons within the department.

There was visible leadership of the ED at local level and staff thought highly of the senior clinician, matrons, and sisters in charge. Staff felt the previous constant changes in leadership had affected staff morale, but believed the consistent nurse leadership that was now in place had helped staff to feel more valued and improve morale. Staff particularly recognised the matrons for their ongoing support during a difficult period.

Ward leadership roles were clearly identified within the ED. Staff knew who was in charge and staff were effectively deployed to various work areas. All staff were aware of the respective roles and responsibilities within the department.

Staff told us they felt valued by colleagues and there was a whole team ethos towards meeting patient needs. Senior staff deployed staff based on their competencies and experience within the department. The team were looking at ways to improve the skills mix and link nurse knowledge, but said this was affected by staff recruitment.

The matrons and lead nurse were aware of the challenges the department faced, including the four-hour target, staffing and crowding within the emergency department. The trust had identified actions to attempt to improve performance of the department, including admission avoidance strategies and the planned recruitment of a registered mental health nurse.

Locally, the lead nurse supported the matrons who reported to the senior management team on a regular basis.

Nurses we spoke with told us the local leadership team were approachable, supportive and visible throughout the department. During our inspection, we saw leaders were visible in clinical areas.

Consultants and doctors described the senior management team as supportive and approachable. Nursing staff felt the lead nurse and matrons maintained a regular presence within the department.

The senior team reported they felt well supported by the trust-wide executive team. Regular communication took place between local emergency department staff and the executive team.

Senior staff were passionate about delivering high quality care and supporting staff within the department.

Vision and strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community. However, staff were not clear on the vision or long-term strategy for the Emergency Department.

There was no formal vision or strategy for the emergency department. However, staff were aware of the proposed merger with other local NHS trusts and the business case and preparations that were taking place to facilitate it. Staff were aware and had been involved in admission avoidance.
strategies, for example the implementation of the Emergency Village and frailty unit. Staff were not aware of a long-term strategy for the service.

The trust values were that “At our best we are a kind, professional, positive, team.” The trust had four strategic priorities; Achieving clinical and service excellence, Quality Leadership, Effective Relationships, Business Excellence. Part of the trust strategy was to maintain the emergency department (ED) at Broomfield hospital while meeting the commitment in the merger business case, the Sustainability and Transformation Partnerships (STP), and Essex Success Regime. The strategy considered local healthcare needs and demographic factors moving forward. The strategy includes meeting the rising demand for emergency (non-elective) care and making the “front door” the best it can be for patients – responding to patients’ urgent care needs more quickly and appropriately.

All senior staff and the majority of frontline staff were aware of the trust vision and values. Posters outlining the trust vision or values were displayed in the waiting area and on the walls of the department. However, the majority of staff were not aware of the long-term strategy for the trust apart from the planned merger.

The senior emergency department staff had been involved in planning future service configuration. This had included discussion and planning about short, medium, and long-term plans for the future in the context of the Essex Success Regime and planned merger with other local NHS providers with a specific reference to the trust’s own vision. However, operational staff we spoke with were unclear of the strategy for the trust going forward.

**Culture**

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Nursing staff told us they felt it was a supportive department to work in, and said staff worked well together across the professional disciplines. Staff interacted in a supportive way to ensure they were meeting the needs of patients. Staff particularly noted the leadership of the consultants and senior nurses, and described them as ‘extremely approachable and supportive’.

Junior doctors told us it was ‘a good place to work’, in particular, the attitude of all staff with each other was supportive, and they felt the department was a positive place for them to develop skills and experience.

Domestic staff reported that the ED was a good place to work; they added that they were part of the department team and felt pride in maintaining clean areas for patient care, but it could be very demanding at times when the department got busy.

Ambulance crews visiting the emergency department had generally positive views on the department and believed the addition of the Hospital Ambulance Liaison Officer (HALO) in the emergency department would help ambulance and hospital staff feel more supported and aid communication.

**Governance**

The department used a systematic approach to continually improve the quality of its services and to safeguard high standards of care.

There were established systems to ensure governance and monitor performance led by a divisional triumvirate; an interim clinical director, supported by the associate director of operations and deputy chief nurse.

The directorate had a monthly ED directorate governance meeting attended by triumvirate, medical and nursing leads, which included a review of incidents, risks, clinical effectiveness, mortality reviews, and patient experience. The directorate governance monthly meetings reported up to the divisional board, divisional performance and accountability meetings and to the trust patient safety group. The purpose of the directorate governance group was to provide a forum to
review performance in all areas of patient safety and quality of care so that appropriate actions could be developed and implemented to address any deficiencies. The group oversaw the development and implementation of the trust’s risk management strategy and safety and quality strategy.

Concerns from ward staff and managers within the ED could be escalated to the directorate governance group for action. The trust patient safety group received quarterly reports from various subgroups including clinical effectiveness, IP&C, Medicines Optimisation and Safety, Thrombosis, Mortality Review, Safeguarding, Tissue Viability, Falls. Senior ED staff told us information from the patient safety group and quarterly divisional reports were fed back to department team meetings.

An example of the risks identified was the safety of mental health patients in the department, which was mitigated by the use of extra security staff in the department and the use of agency registered mental health nurses when required.

The emergency department continued to use the serious incident learning initiative (SILI) where staff were encouraged to attend meetings on an ad hoc basis dependent on need, to discuss incidents and learning from incidents. Staff would be given the opportunity to present their own incident findings and share this with the team and we saw a central record of incidents that contained feedback and lessons learnt. The SILI could also refer incidents directly to the serious incident management group (SIMG), to establish if further actions or escalation of the issues identified in the incident were required.

**Management of risk, issues and performance**

**The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.**

The ED had a risk register that identified current risks and the mitigating actions taken to minimise risks to patients and the staff team. These were reviewed at appropriate clinical governance forums and staff we spoke with were aware of the risks identified. Staff and managers described the principal risks in the department as nursing and medical staffing levels and recruitment, treatment of mental health patients, and patient flow.

Our review of the ED local risk register confirmed that staffing, various quality indicators (including time to treatment) and access and flow for patients with mental health needs were documented as on-going risks.

Risks were overseen from a divisional level. The trust was managing and mitigating the risk of the lack of ED consultants through ongoing recruitment, an increase in middle grade doctor cover to support consultants and the use of long term locum consultants to ensure consistent care for patients and leadership for staff. The risk register acknowledged that actions taken to mitigate the risk to mental health patients not receiving timely intervention or treatment in the department had so far not been effective. For example, the use of extra security staff in the department and the use of agency registered mental health nurses when required. At the time of the inspection, the divisional leadership team informed us that they were planning to recruit a registered mental health nurse into the department to help to mitigate the risk to patients and save money on agency fees. However, funding for this post had not been agreed.

The ED clinical lead was passionate about developing staff within the department. Doctor recruitment and retention was recognised as a key challenge. The high use of locum medical staff was on the divisional risk register. Use of locum staffing could compromise patient safety and quality of service delivery, increase costs for the service and limit the amount of supervision and support for junior doctors.

Monthly mortality meetings allowed medical staff to review care and share learning. However, staff told us that attendance was a challenge due to departmental demand.
The trust had arrangements in place to respond to emergencies and major incidents including, major incident and business continuity plans, and actions in the event of a utilities failure or major incident.

Staff had access to major incident equipment storage. Equipment included signage, decontamination tents, and radios. Within the ED itself, staff used a white board to record and coordinate roles in a major incident, and had access to high visibility jackets, hand held communication devices, flash and action cards to identify roles and responsibilities should an incident or emergency occur.

**Information management**

The trust collected, analysed, managed and used information to support all its activities, using secure electronic systems with security safeguards. However, the trust had problems providing accurate data on its performance for the period December 2017 to June 2018.

Staff had access to a range of policies and guidance through the trust’s intranet. Computers were regularly located throughout the department to enable staff timely access to information and guidance. However, not all policies were accessible or were in the incorrect folder.

Clinical staff had access to information technology systems to track patients through the department. In addition, medical records contained a flag indicating any additional or complex needs a patient may have.

Diagnostic test results were available electronically meaning staff could access this information in a timely manner.

Patient confidentiality was maintained through use of computers which were protected from the public. This meant staff had oversight of patients within all clinical areas. At all times during our inspection, we saw that computer terminals were locked and secure when not in use. Paper based records were stored securely.

The use of both paper and electronic records in the emergency department for patient observations meant it was not immediately clear when and if patients had received the necessary observations at the appropriate time. Staff told us they had been told to complete both the paper and electronic versions, but that they would usually only use the electronic version. However, all patient records we checked had correctly completed observations on either paper or the electronic records system.

The trust had problems with the reporting of some data starting in December 2017 including; reporting the median time from arrival to treatment between December 2017 and June 2018, and the trust’s unplanned re-attendance rate to A&E within seven days in December 2017, because they were unable to verify the accuracy of the data. The data submitted by the trust to NHS Digital for the percentage of patients who left the ED before being seen for treatment between December 2017 and June 2018 was also not accurate. At the time of our inspection, the trust was now confident it was reporting all national metrics accurately.

**Engagement**

The trust engaged well with patients, relatives and staff to plan and manage appropriate services, but there was limited evidence the trust collaborated with partner organisations effectively.

The department sought patient feedback at regular intervals throughout the department through the use of comments boxes. In addition, the matron had a feedback box to enable all staff and patients to provide feedback.
The department engaged with staff through a variety of methods including daily huddles, use of social media, newsletters and emails.

Posters were displayed in public areas encouraging people to complete the Friends and family test. Results were also on display in public and staff areas.

**Learning, continuous improvement and innovation**

The department was committed to improving services by learning from when things went well and when they went wrong, promoting training, research, and innovation.

The ED had recently implemented a short de-brief session for nurses at the end of their shifts as an opportunity for them to discuss things that had gone well or that needed to improve, share best practice, and an opportunity for the nurse in charge of the shift to feedback to staff and thank them for their efforts. The de-brief session was designed to help the department learn from staff feedback and to ensure that staff felt valued.

The trust continued to use serious incident learning initiative (SILI) where staff were encouraged to attend meetings to specifically discuss incidents and learning from incidents. The SILI could also refer incidents directly to the serious incident management group (SIMG) to establish if further actions or escalation of the issues identified in the incident were required.

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**Medical care**

**Facts and data about this service**

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

All inpatient care is based at Broomfield Hospital site. Acute medicine is undertaken in the Emergency Village which comprises of an Acute Medical Unit (AMU), which is the primary route of admission and assessment for GP referred medical patients, and Emergency Short Stay (ESS) ward.

Other specialities include gastroenterology, cardiology, outpatient dermatology and neurology, care of the elderly, stroke, endocrinology; and renal. Each service manages general medical cases in addition to the specific medical specialities.

The hospital has 295 medical inpatient beds located across 17 wards and units:

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>Speciality or description</th>
<th>Inpatient beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute medical unit</td>
<td>20 beds, including eight monitored beds</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>There are also two ambulance triage rooms, 10 assessment trolleys and six couches in ambulatory care and the waiting room. There are 12 slots for ambulatory review each day</td>
<td></td>
</tr>
<tr>
<td></td>
<td>It is intended that length of stay should be less than 24 hours</td>
<td></td>
</tr>
<tr>
<td>Angiography suite</td>
<td>Eight trolley spaces and two chair spaces</td>
<td></td>
</tr>
<tr>
<td>Baddow ward</td>
<td>Care of the older person</td>
<td>26</td>
</tr>
<tr>
<td>Braxted ward</td>
<td>Care of the older person</td>
<td>26</td>
</tr>
<tr>
<td>Danbury ward</td>
<td>Medical - primarily gastroenterology</td>
<td>32</td>
</tr>
<tr>
<td>Medical Care Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Day therapies</strong></td>
<td>Day therapies unit with 12 chairs</td>
<td></td>
</tr>
<tr>
<td><strong>Discharge lounge</strong></td>
<td>Capacity for four beds plus eight chairs</td>
<td></td>
</tr>
<tr>
<td><strong>Endoscopy unit</strong></td>
<td>-</td>
<td></td>
</tr>
<tr>
<td><strong>Felsted ward</strong></td>
<td>Medical - primarily respiratory ward 20</td>
<td></td>
</tr>
<tr>
<td><strong>Goldhanger ward</strong></td>
<td>Medical with step down stroke rehabilitation beds 27</td>
<td></td>
</tr>
<tr>
<td><strong>Heybridge ward</strong></td>
<td>Medical oncology 12</td>
<td></td>
</tr>
<tr>
<td><strong>Rayne ward</strong></td>
<td>Haematology inpatient 6</td>
<td></td>
</tr>
<tr>
<td><strong>Renal unit</strong></td>
<td>Renal dialysis unit - 17 chairs and six beds</td>
<td></td>
</tr>
<tr>
<td><strong>Stroke unit</strong></td>
<td>- 25</td>
<td></td>
</tr>
<tr>
<td><strong>Short stay medical emergency and frailty unit</strong></td>
<td>14 acute physicians; six emergency observation beds, 12 frailty beds and 14 beds set up for maximum 48 hour stay under acute medicine 32</td>
<td></td>
</tr>
<tr>
<td><strong>Terling ward</strong></td>
<td>Medical - primarily for cardiac and renal patients 31</td>
<td></td>
</tr>
<tr>
<td><strong>Writtle ward</strong></td>
<td>Winter contingency ward 26</td>
<td></td>
</tr>
</tbody>
</table>

Medical care services provided at Broomfield Hospital include cardiology, gastroenterology, respiratory medicine and stroke services. Each service manages general medical cases within its wards in addition to the specific medical specialities.

*(Sources: Routine Provider Information Request (RPIR) Sites tab and acute RPIR context acute tab)*

The trust had 37,216 medical admissions from April 2017 to March 2018. Emergency admissions accounted for 17,549 (47.2%), 275 (0.7%) were elective, and the remaining 19,392 (52.1%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 16,900
- Medical oncology: 5,739
- Clinical haematology: 3,725

*(Source: Hospital Episode Statistics)*
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Compliance with mandatory training was mixed among substantive staff in medicine. The trust set a target of 85% for completion of all mandatory training modules except for information governance, where the target was 95%.

There were systems in place to deliver training via e-learning and face-to-face sessions, however senior staff told us that it could be challenging to release staff for training at times due to the demands on the service.

A breakdown of compliance for mandatory training courses from June 2017 to May 2018 for qualified nursing staff in medical care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2017 to May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Medicine management</td>
<td>261</td>
</tr>
<tr>
<td>Infection prevention level 1</td>
<td>265</td>
</tr>
<tr>
<td>Intermediate life support</td>
<td>213</td>
</tr>
<tr>
<td>Information governance</td>
<td>250</td>
</tr>
<tr>
<td>Manual handling object</td>
<td>246</td>
</tr>
<tr>
<td>Manual handling people</td>
<td>234</td>
</tr>
<tr>
<td>Fire safety 1 year</td>
<td>243</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>229</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>27</td>
</tr>
</tbody>
</table>

In medical care the trust had an overall training compliance rate of 88.2% for qualified nursing staff. The trust’s training targets were met for six of the nine mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from June 2017 to May 2018 for medical staff in medical care is shown below:
In medical care the trust had an overall training compliance rate of 86% for medical staff. The trust’s training targets were met for four of the eight mandatory training modules for which medical staff were eligible. Fewer than 70% of medical staff had completed resuscitation and intermediate life support training.

(Source: Routine Provider Information Request (RPIR) – Training tab)

We requested training compliance rates for sepsis training for staff on medical wards. Training for medical staff as of September 2018 was as follows:

<table>
<thead>
<tr>
<th>Org L4</th>
<th>Organisation</th>
<th>Sepsis 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>288 Medicine Directorate</td>
<td>288 Medical Staff - Cardiology</td>
<td>30.00%</td>
</tr>
<tr>
<td>288 Medicine Directorate</td>
<td>288 Medical Staff - Diabetes &amp; Endocrinology</td>
<td>50.00%</td>
</tr>
<tr>
<td>288 Medicine Directorate</td>
<td>288 Medical Staff - Elderly</td>
<td>57.14%</td>
</tr>
<tr>
<td>288 Medicine Directorate</td>
<td>288 Medical Staff - Gastroenterology</td>
<td>55.56%</td>
</tr>
<tr>
<td>288 Medicine Directorate</td>
<td>288 Medical Staff - Renal</td>
<td>33.33%</td>
</tr>
<tr>
<td>288 Medicine Directorate</td>
<td>288 Medical Staff - Respiratory</td>
<td>30.00%</td>
</tr>
<tr>
<td>288 Medicine Directorate</td>
<td>288 Medical Staff - Stroke</td>
<td>57.14%</td>
</tr>
</tbody>
</table>

Training for nursing staff as of September 2018 was as follows:

<table>
<thead>
<tr>
<th>Org L4</th>
<th>Organisation</th>
<th>Sepsis 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>288 Medicine Directorate</td>
<td>288 Renal - Haemodialysis Unit</td>
<td>100.00%</td>
</tr>
<tr>
<td>288 Medicine Directorate</td>
<td>288 Ward A205 Felsted</td>
<td>71.43%</td>
</tr>
<tr>
<td>288 Medicine Directorate</td>
<td>288 Ward A302 Danbury</td>
<td>63.64%</td>
</tr>
<tr>
<td>288 Medicine Directorate</td>
<td>288 Ward A305 Terling</td>
<td>100.00%</td>
</tr>
<tr>
<td>288 Medicine Directorate</td>
<td>288 Ward C250 Baddow</td>
<td>92.31%</td>
</tr>
<tr>
<td>288 Medicine Directorate</td>
<td>288 Ward C251 Braxted</td>
<td>100.00%</td>
</tr>
<tr>
<td>288 Medicine Directorate</td>
<td>288 Ward C450 - Writtle (Contingency)</td>
<td>100.00%</td>
</tr>
<tr>
<td>288 Medicine Directorate</td>
<td>288 Ward E125 Stroke Unit</td>
<td>76.92%</td>
</tr>
<tr>
<td>288 Medicine Directorate</td>
<td>288 Ward E222 - Goldhanger (Med)</td>
<td>75.00%</td>
</tr>
</tbody>
</table>

Safeguarding
We had concerns about the effectiveness of safeguarding training in equipping staff with the knowledge required to consistently recognise and escalate all types of safeguarding concerns.

Staff told us the trust had a safeguarding team that comprised of a named nurse, doctor and midwife for safeguarding children, a safeguarding adult lead and an adult safeguarding specialist. Staff we spoke with knew who the safeguarding leads for the trust were and could give examples of when they had personally raised a safeguarding concern.

Staff told us that safeguarding training did not include female genital mutilation (FGM) which meant there was a risk that staff may not recognise and escalate potential signs of FGM. Some staff told us that PREVENT was part of safeguarding training but others said it was not. (PREVENT aims to stop individuals from getting involved or supporting terrorism or extremist activity, and is designed to safeguard people in a similar way to safeguarding processes to protect people from gang activity, drug abuse, and physical and sexual abuse). Not all staff could recall what level of safeguarding training they had received. Therefore, we had concerns about the effectiveness of the training in equipping staff with the knowledge required to consistently recognise and escalate safeguarding concerns.

**Safeguarding training completion rates**

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses from June 2017 to May 2018 for qualified nursing staff in medical care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2017 to May 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>263</td>
<td>283</td>
<td>92.9%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>261</td>
<td>283</td>
<td>92.2%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>252</td>
<td>283</td>
<td>89.0%</td>
<td>90%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>251</td>
<td>283</td>
<td>88.7%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

In medical care the trust had an overall safeguarding training compliance rate of 90.7% for qualified nursing staff. The trust's 90% completion target was met for two of the four safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from June 2017 to May 2018 for medical staff in medical care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2017 to May 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion rates (%)</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>94</td>
<td>128</td>
<td>73.4%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>87</td>
<td>128</td>
<td>68.0%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>67</td>
<td>117</td>
<td>57.3%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>62</td>
<td>119</td>
<td>52.1%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

In medical care the trust had an overall safeguarding training compliance rate of 63.0% for medical staff. The trust's 90% completion target was not met for any of the four safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)
Cleanliness, infection control and hygiene

Systems and processes were not effective to ensure consistent good practice regarding cleanliness and infection prevention and control (IPC) processes.

Across medical wards we inspected, there was varied compliance with good practice regarding cleanliness and infection prevention and control (IPC) processes. On Writtle ward we found a 24-hour urine sample in the sluice room dated 31 May 2018 meaning it had been left there over three months. We were therefore concerned about the infection prevention and cleaning processes in the ward as this had not been noticed. We were also concerned that IPC audits were not thorough enough to have identified this issue until we saw it. We raised it to the nurse in charge who disposed of it. We have included further details about this under the ‘incidents’ subheading.

There was a policy in place for guidance in trust IPC processes called the ‘Decontamination and Disinfection of Equipment and Environment Policy’ which was, as of September 2018, under review. This was due to recent changes in the IPC team and the appointment, across three local NHS trusts in the sustainability and transformation plan, of a head of decontamination services. However, we had concerns that staff did not always have enough time to review updated policies due to workload pressures, and there was a lack of robust induction process for temporary staff (reported on more fully under ‘Staffing’), which meant we were not assured all staff would be familiar with the policy to ensure they were following it.

There had been eight incidences of *Clostridium difficile* (*C. Diff*) from June to August 2018, three of which had occurred on Danbury ward. This high prevalence was a concern and the trust advised us that on investigation all cases were found to be unavoidable. In some cases, root cause analysis identified areas for learning which has been incorporated into the trust wide IPC action plan. This was not on the local risk assurance framework.

The screening rates upon admission onto medical wards for MRSA from April to July 2018 were as follows:

<table>
<thead>
<tr>
<th>MRSA Screening Compliance (%)</th>
<th>Apr-18</th>
<th>May-18</th>
<th>Jun-18</th>
<th>Jul-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective</td>
<td>89</td>
<td>93</td>
<td>91</td>
<td>93</td>
</tr>
<tr>
<td>Emergency</td>
<td>89</td>
<td>88</td>
<td>88</td>
<td>100</td>
</tr>
<tr>
<td>Average Overall</td>
<td>89</td>
<td>89</td>
<td>89</td>
<td>95</td>
</tr>
</tbody>
</table>

In the Goldhanger ward risk summit in August 2018 (reported on more fully in ‘Well-led’) there was discussion that there was a concern around IPC with five cases of MRSA and two cases of *C. Diff*, but the minutes did not state the timeframe for these occurring. The minutes also noted that the air conditioning system and inconsistent legionella flushing practices contributed to the IPC risk. However, the only actions documented in the risk summit in relation to this concern was “need to review infection control on risk register” rather than any specific action plan with clear steps for improvement. This was a concern because there were insufficient assurances that it would be addressed. The service had carried out a deep clean of the ward when it was emptied following an unrelated serious incident at the end of August 2018.

There had been an assessment by NHS Improvement in May 2018 following seven cases of MRSAb in 2017-18 and 55 cases of *C. Diff* against an objective of 13. Following this visit the trust was assessed as NHSI Infection Prevention internal escalation level ‘red’. There were plans for a subsequent NHS Improvement visit in September 2018, but due to the assigned escalation level (although this applied trust wide rather than specifically medical services), it was a concern that it had not been identified on the local risk assurance framework.
On Baddow and Braxted wards we had concerns about insufficient processes to isolate patients who may pose a risk of infection. The service had identified that a lack of doors on these wards minimised the ability to isolate patients who were infectious. This was included on the risk assurance framework as there was no capacity to isolate whole bays in the event of a norovirus outbreak. This made managing infection control challenging when trying to minimise infection risks to other patients.

We observed appropriate use of personal protective equipment (PPE) and hand washing by staff in wards we inspected. A member of cleaning staff we spoke with on the Emergency Short Stay ward (ESS) explained some of their cleaning and IPC processes, including the use of separate buckets and mops for side rooms and bathrooms.

The endoscopy ward was following national guidance outlined in Health Technical Memorandum 01-06: Decontamination of flexible endoscopes. Used endoscopes would be taken to a dedicated room where the endoscope washers were built into the wall. Once clean, the endoscopes were removed from the other side of the washers, which was in the adjacent clean endoscopes room, where they were then logged as clean and stored appropriately. We spoke with the decontamination lead for endoscopy, who showed us that a ‘receipt’ following cleaning of the endoscope was automatically issued through the washer. This was then transferred to the relevant patient notes for whom it was next to be used. The receipts had an endoscope ID number with the date and time of cleaning.

As part of their Joint Advisory Group (JAG) accredited status, the unit also undertook an annual review of their decontamination processes. The most recent review had rated one area as amber/red as the washers were nearing their expiry. This was reflected on the service risk register and there was a business case in progress to replace the washers.

The unit also carried out weekly water sample checks, scope protein tests and sink level checks, among other checks, to ensure good IPC practices were being maintained. We reviewed these for the last month at the time of our inspection and saw these had been consistently carried out and signed off with no issues raised.

There had been an incident in August 2018 with a spillage in the endoscopy unit. The unit had to close for the day due to the IPC risk. The nurse in charge explained the other actions that were taken including occupational health assessment for staff present on the unit. They rebooked all the patients who all had new appointments within the space of a few weeks. Under a contract with an external specialist decontamination company they were able to address the issue within 12 hours.

Environment and equipment

The service generally had suitable premises and systems were in place to ensure equipment was maintained, although we identified some environmental and equipment concerns on Goldhanger ward.

Most medical wards we visited were well laid out and their environment fit for purpose with clear segregation of different areas where required; for example, the stroke ward was split into two areas for acute patients (10 beds) and step-down patients (eight beds) with nine additional side rooms.

However, there were some environmental and equipment related risks on Goldhanger ward. The risk summit minutes from August 2018 showed the concern that the ward was not “fit for purpose and is shabby in its appearance” and that “staff have little pride in the environment”, which was reflected as a concern by nurse leads on the ward. There were also equipment risks in relation to call bells, which we have reported on below.

On Baddow, Braxted, Goldhanger and the stroke wards, there was a key code access to leave the ward for security purposes, because there were patients on deprivation of liberty safeguards (DoLS) residing there.

Prior to inspection, we had received concerns that medical wards did not have sufficient access
to equipment, notably pressure relieving equipment such as cushions and mattresses. However, when we asked staff about this on inspection, we found there had been improvement in access to equipment as a protocol had been established for prompt ordering and receipt of equipment.

We found a high-level disinfectant (2.1% sodium chlorite) left in an unlocked cupboard on Writtle ward which would have been accessible to patients or visitors walking past. We raised this with a nurse who put it away securely. There was no dedicated Control of Substances Hazardous to Health equipment (COSHH) cupboard on Writtle ward. We were told this had been raised as an issue and we were told there would be one installed within the next month. However, it was not on the service’s risk assurance framework so it was not clear how the service was assuring itself this was being addressed and monitored.

We inspected resuscitation trolleys on medical wards. They were all sealed with a security tag and contents matched the checklist. However, checks were not being consistently completed across all wards. For example, on Writtle ward there was one missed check in August 2018, two in July, four in June and three in May. However, on Baddow, for example, all checks had been completed from June to September 2018.

Equipment such as blood pressure machines and electrocardiogram (ECG) machines were within servicing dates in all areas we inspected. Oxygen cylinders were stored appropriately in secured cages and were within date. However, curtains around beds on ESS did not have a date for replacement.

There were three dedicated non-invasive ventilation (NIV) patient beds on Felsted (respiratory) ward. Service leads stated this was insufficient to meet patient needs. The plan for patients needing NIV was that they would be admitted to the high dependency unit (HDU) or Felsted, depending on severity and level of care required. However, we were told by staff on the ward and service leads that they were often not accepted by HDU, and if there was no bed available on Felsted they may spend hours waiting in the ED, the emergency assessment unit or outlying ward, which were not the most appropriate environments for their needs. This was on the risk register for the service, rated as a major risk. There were proposed actions in place, including a revised NIV protocol to be shared, and developing a business case for increased nursing complement to allow level one respiratory beds on Felsted. However, it did not state how or when the protocol would be shared, or when the business case would be developed and by whom. At the time of our inspection it was a concern from service leads that the protocol introduction had not led to any reduction in the risk, and that there had been no progression with the business case.

The discharge lounge was not designed to board patients overnight, but this was frequently being done due to discharge and capacity issues. There were eight chairs and three beds, and only one unisex toilet and no shower facilities. There was no dedicated resuscitation equipment for the discharge lounge, with the nearest being in AMU (please see below). We have provided further details in the ‘responsive’ domain. However, there was access to a water fountain and kitchen facilities.

Assessing and responding to patient risk

There was a lack of systems and assurances in place to ensure staff could always assess and respond to patient risk promptly and appropriately.

We had concerns that the high nurse vacancies, high use of agency staff and significant level of moving staff to cover different wards, meant there was a risk that staff may not be able to respond to patient deterioration, aggression or crisis as promptly and appropriately as they would like to. For example, on ESS during our inspection, there were three patients who required one-to-one care due to severe mental health difficulties. These three patients were assessed as lacking capacity. However, their staffing levels on the day did not allow the ward to meet this one-to-one level of care (on the day they had three band six nurses, one band five nurse and two agency nurses to cover a total of 32 beds).

There was no resuscitation equipment in the discharge lounge and we were not assured that staff in the discharge lounge would be able to respond to a deteriorating patient in a timely manner. We were told they had no space to accommodate a resuscitation trolley. A substantive member of
staff was not able to show us where the resuscitation equipment was located (it was at the end of the adjoining corridor connected to the medical assessment unit). We raised concerns about the risk that staff may not be able to respond to patient deterioration or risk appropriately, although staff did say that in the event of a patient deteriorating, they would call the trust resuscitation team. When we returned for the unannounced visit, staff in the discharge lounge were able to tell us where the resus equipment was located, however there was still no dedicated resuscitation equipment or grab bag in place. Our concerns about potential risk to patients was heightened because the discharge lounge were frequently boarding patients overnight, although management told us there was a plan to introduce a substantive band seven post to improve oversight.

We had concerns that the inconsistent completion of care plans for prevention of falls, pressure ulcers, infection or other risks meant there was increased safety risks to patients. For example, we saw that a patient on Felsted ward had been assessed as at high risk of pressure ulcers on the Waterlow scoring system (a skin integrity assessment tool). The notes documented that the patient’s sacrum was red and the tops of their ears were ‘blanching’ but the prevention of pressure damage care plan had not been completed. We have included further details about the concerns about poor completion of care plans under the ‘records’ subheading below.

There had been a recent drive to attempt to improve rates of patient falls in the service and the response to falls. On ESS a junior sister told us about an incident that had occurred in 2017 where an assessment had not been properly carried out after the patient had a fall. As part of the learning and changes in practice from this, the ward staff had received additional training from the moving and handling team focusing on ensuring patients were assessed properly after a fall. However, it did not appear that this learning and additional training had been shared to other wards (please see further details under the ‘incidents’ subheading).

We had concerns about call bells. The service’s risk assurance framework highlighted that the call bell system on the ward was dated and broke down frequently and that there was a lack of emergency call bells in bathrooms on the ward. This was a concern because there was a risk that patients may not be able to alert staff to their need for assistance and there may be a delay in responding to risk to patients. This was reflected in conversations we had with staff on the ward. However, as the risk assurance framework did not include dates when risks had been added, it was not clear how long this had been an issue. This was reflected as an issue in the Goldhanger ward risk summit in August 2018, where it was reported that the call bell system was “currently being reported for malfunction at least five times a week”. We were concerned that there were insufficient mitigating actions for this risk, as the only action on the framework was “New system to be implemented on the ward but financially not viable during current economic climate”.

The service was not routinely auditing call bell response times so there was no clear monitoring of how long patients were waiting for staff to attend to their needs and any associated risk. We requested audits of this and the service was unable to provide this specifically, although they did provide information from a patient satisfaction survey. As part of this, they asked patients about the responsiveness of its staff in responding to call bells. The results stated that, out of 135 patients and relatives surveyed between April and September 2018 as part of the survey, “The majority…were generally satisfied with the responsiveness of trust staff when they pressed the call bell button”, but there was no exact number given.

The survey results showed that patients had commented that any delays in responding to call bells were “usually because staff were busy with other patients or the ward appeared short of staff”. However, due to the lack of specific call bell audits or spot checks it was not possible to quantify how promptly staff were responding to call bells and patients potentially at risk of deterioration.

The service used the National Early Warning Score (NEWS) system to assess patients at risk. However, the service was not auditing their NEWS to ensure scores were consistently being correctly calculated. This concern was escalated further because of the concerns raised to us by staff about the high rates of agency nurses and the process of competency checks for temporary staff.

We requested to see any audit results around compliance with national guidance on sepsis assessment and treatment; for example, whether the patient received antibiotics within one hour in
accordance with guidance from the National Institute for Health and care Excellence (NG51: Sepsis: recognition, diagnosis and early management). The service told us there was a backlog of data from April 2018 to September 2018 due to issues with previous IT Systems, identifying data and resources, so could only provide the following data for the first two weeks of September 2018. We had concerns about the effectiveness of sepsis management, for example not all the ‘sepsis six’ assessments being completed, due to poor record keeping, which we have outlined under the ‘records’ subheading below.

<table>
<thead>
<tr>
<th>Inpatients</th>
<th>Antibiotics in on hour</th>
<th>Red flag to antibiotics</th>
</tr>
</thead>
<tbody>
<tr>
<td>39/43</td>
<td>90.6%</td>
<td>28/36</td>
</tr>
<tr>
<td></td>
<td></td>
<td>77.77%</td>
</tr>
<tr>
<td>29/34</td>
<td></td>
<td>85.2%</td>
</tr>
</tbody>
</table>

However, as the data was not broken down by ward or speciality we could not identify specific areas of concern and the data was from too short a period to draw reliable conclusions.

There was discrepancy in access to mental health support for patients at risk. For example, on ESS, there was a patient at risk of self-harm. The junior sister told us this risk was managed by nursing the patient in a side room which was a calmer environment for them and that they had the support from a mental health nurse overnight as well as during the day. However, on the stroke ward we were told that patients at risk of mental health crises were not always assessed promptly; a substantive nurse told us they often waited up to a week for this, which they felt increased the risk to patients.

Our concerns about access to mental health support were heightened because in August 2018 there had been a serious incident in Goldhanger ward where a patient experiencing acute mental illness had presented a significant risk to themselves and other patients. Although the incident was well managed and there was no harm, a senior sister told us that one of the learning points from the serious incident was that mental health assessments were not completed promptly enough to assess and respond to patient risk before it escalated.

Staff we spoke with across wards knew how to contact the trust resuscitation team in the event of deterioration. On Writtle ward, a senior nurse gave us an example of when this had happened the previous night because of a patient having a reaction to diazepam and triggering on the NEWS.

During our inspection, all 17 records we reviewed documented that medical reviews had been carried out with the appropriate frequency according to the care plan to assess the patient’s condition.

Nurses also said they would escalate deteriorations for prompt medical review by a doctor, and a HCA on the stroke ward gave a recent example of where they had escalated directly to a doctor because of the level of concern.

On the stroke ward there was a dedicated thrombolysis nurse bleep holder who was available 24 hours a day. There was also a contingency plan, for example in case the nurse was off work with sickness, whereby a junior doctor would carry the bleep so there was always cover to respond promptly to patients requiring thrombolysis.

**Nurse staffing**

Vacancy rates and agency use were high and there was evidence that low staffing was impacting on safe patient care.

We had concerns about low nurse staffing levels across medicine, and in all wards we visited, staff confirmed this was their main risk. Our concerns were heightened because staff told us it was not always incident reported when staffing numbers dropped below planned levels as that was considered usual. This was not in accordance with the trust's nursing staffing shortfall policy, which stated there was a responsibility “to ensure that if inadequate staffing/skill mix is not resolved, it is identified via incident reporting and red flag events are identified and recorded within the incident report” (NICE, 2014). On Goldhanger ward there were five incidents reported due to
low staffing from June to September 2018. The reports included an occasion where the nurse stated most of the 27 patients had been confused, they felt the patients suffered due to ‘not being seen for several hours’, for example patient washes at 5pm being the first patient contact, and that patients ‘skin began to break down’ and the staff member felt very unsafe. On another occasion the incident report stated the ward had high acuity, high risk of falls and several patients requiring one to one care, and the nurse felt patients ‘requiring assistance in washing, feeding etc were not getting the level of care that they required’ and ‘nothing could have been done’ due to the low staffing levels.

The service covered gaps in rota\s as far as possible by transferring staff from other wards. However, this meant that staff were often not familiar with the ward on which they were placed and staff confirmed this was a challenge. The matron recognised staff were not always happy to do this but said they tried to mitigate the risk by only moving between other medical wards. Band seven nurses who were planned to be supernumerary frequently had to work clinically meaning they could not carry out their support and managerial responsibilities.

Staffing reviews were carried out twice daily with the support of the site management and the matrons also had their own divisional daily huddle to assess the most pressing areas for staffing and reallocate staff if needed.

The trust reported their qualified nursing staff numbers as below as of March and May 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTEs)</td>
<td>Planned staff (WTEs)</td>
</tr>
<tr>
<td>Broomfield Hospital</td>
<td>198.2</td>
<td>271.7</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staff tab)

**Vacancy rates**

From June 2017 to May 2018, the trust reported a vacancy rate of 23.7% for qualified nursing staff in medical care. This was higher than the trust target of 15.4%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

However, when we inspected, we found vacancy rates on some wards to be significantly higher than this. For example, we were told the vacancy rate on Goldhanger was around 65%, although minutes from the Goldhanger ward risk summit in August 2018 stated there were nine whole time equivalent (WTE) nurses recruited to start over the next five months (from September 2018 to February 2019).

During inspection, nursing staff at every level highlighted the pressures caused by high vacancies. For example, on the stroke ward they had 12 band five vacancies. They had just recruited to three of these 12 posts. On the day of our inspection they were meeting planned staffing levels of five nurses and four HCAs on the early and late shifts, and four nurses and two HCAs on the night shift. However, a nurse told us staffing levels usually did not meet this and an HCA said that earlier in the same week, a registered nurse was covering eight patients and the HCA was covering 12 patients, which they said impacted on both their workload and patient safety.

Similarly, on Braxted ward there were 10 nurse vacancies at the time of our inspection and staff acknowledged this impacted on patient care. On ESS there were eight nurse vacancies at the time of our inspection, and during our inspection we observed that staff were very pressured due to the acuity of the patients and staffing levels.

**Turnover rates**

From June 2017 to May 2018, the trust reported a turnover rate of 5.9% for qualified nursing staff
in medical care. This was lower than the trust target of 18.05%.

Within the RPIR, the trust noted that there was an issue with their turnover data. The process used in ESR when staff leave and retain a staff bank contract means that they are not counted in ESR as a leaver. As a result, the turnover figures reported from ESR are lower than they actually are. The trust’s internal reports and the Joint Working Board report are adjusted to reflect the additional leavers, so that the correct turnover figures are reported. However, due to the manual recording of this data, and its limitations, it was not possible for the trust to analyse it to the level of detail required for the RPIR.

The trust reported that this process was changing and, in the future, all of their leavers would be included in reports from ESR.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From May 2017 to April 2018, the trust reported a sickness rate of 4.2% for qualified nursing staff in medical care. This was in line with the trust target of 4.24%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

From May 2017 to April 2018, the trust reported that 14.9% of nursing assistant staff shifts in medicine at Broomfield Hospital were filled by bank staff, while 0.03% of shifts were filled by agency staff. In addition, 2.8% of shifts were not filled by either bank or agency staff to cover staff absence.

Over the same period, the trust reported that 7.6% of qualified nursing shifts in medicine at Broomfield Hospital were filled by bank staff and 9.9% of shifts were filled by agency staff. In addition, 3.1% of shifts were not filled by bank or agency staff to cover staff absence.

<table>
<thead>
<tr>
<th>Bank / agency</th>
<th>Nursing assistants</th>
<th>Qualified nurses</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>Bank</td>
<td>7,792</td>
<td>14.9%</td>
<td>5,618</td>
</tr>
<tr>
<td>Agency</td>
<td>16</td>
<td>0.03%</td>
<td>7,347</td>
</tr>
<tr>
<td>Not filled</td>
<td>1,467</td>
<td>2.8%</td>
<td>2,316</td>
</tr>
<tr>
<td><strong>Total shifts available</strong></td>
<td>52,399</td>
<td></td>
<td>74,269</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

However, this data did not match what we found at the time of inspection in September 2018 where there were agency nurses in every ward and matrons reported it as a more significant challenge than the data from previous months above.

Some medical wards, notably Writtle ward, Goldhanger (stroke step down) and the discharge lounge, were frequently staffed by agency nurses only. For example, on one of the days of our inspection, Writtle ward only had agency nurses planned for the night shift and the matron told us they were reviewing where they could swap a trust nurse onto this ward. We were told by senior nurses on wards and the ADON that they relied on the competency and registration checks from the agency rather than carrying out their own. In the discharge lounge there were two HCAs and one agency nurse. An HCA told us the level of agency nurses was a challenge because they could not always provide strong ward leadership as they were unfamiliar with the ward and with the other staff. Another HCA felt that there was gradual improvement as agency staff became more regular but was concerned that the ward also experienced shortages in HCA staffing on occasion, which was a challenge.

Agency staff did not have access to the electronic patient record system so if something needed putting onto it they would have to ask the nurse in charge. At times when the ward was staffed only by agency, this would then rely on the information being passed on at handover.
On Goldhanger, the risk was partly mitigated by the use of lines of agency so the agency nurses had been working long-term in their wards. For example, one agency nurse had worked on Goldhanger regularly for 18 months so the ward manager felt comfortable putting them in charge of a night shift.

Medical staffing

Medical staffing was not always meeting planned levels in some areas of the service.

The trust reported their medical staffing numbers as below as of March and May 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTEs)</td>
<td>Planned staff (WTEs)</td>
</tr>
<tr>
<td>Broomfield Hospital</td>
<td>156.5</td>
<td>188.2</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From June 2017 to May 2018, the trust reported a vacancy rate of 15.7% for medical staff in medical care. This was similar to the trust target of 15.4%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Service leads highlighted they had concerns about medical vacancies in certain wards. For example, on Felsted ward (respiratory) there were meant to be five full-time respiratory consultants but they only had two. However, they had recently recruited for a consultant to start in September 2018 and another in November 2018. Two doctors we spoke with on the ward felt this had made things busier for registrars but that it had not impacted on patient safety due to the sufficient junior and mid-level medical staff. On ESS, there was one junior doctor to cover 18 patients instead of the planned two. There was a high acuity of patients on this ward which was a concern in terms of sufficient medical oversight.

However, doctors said they could access speciality medical reviews promptly as required.

Turnover rates

From June 2017 to May 2018, the trust reported a turnover rate of 6.6% for medical staff in medical care. This was lower than the trust target of 18.05%.

Within the RPIR, the trust noted that there was an issue with their turnover data. The process used in ESR when staff leave and retain a staff bank contract means that they are not counted in ESR as a leaver. As a result, the turnover figures reported from ESR are lower than they actually are. The trust’s internal reports and the Joint Working Board report are adjusted to reflect the additional leavers, so that the correct turnover figures are reported. However, due to the manual recording of this data, and its limitations, it was not possible for the trust to analyse it to the level of detail required for the RPIR.

The trust reported that this process was changing and, in the future, all of their leavers would be included in reports from ESR.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From May 2017 to April 2018, the trust reported a sickness rate of 1.5% for medical staff in medical care. This was lower than the trust target of 4.24%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage
Although the trust provided the total numbers of shifts worked by medical bank and locum staff over the most recent year as requested in the Routine Provider Information Request (RPIR), they were unable to supply the total number of shifts worked by all medical staff, including permanent medical staff. This meant that the proportions of shifts worked by medical bank and locum staff could not be calculated.

However, the trust were able to supply the number of WTE medical staff budgeted for, the number of WTE permanent medical staff contracted and the number of WTE locum medical staff employed. These figures were used to calculate the proportions below.

In May 2018 the trust reported that medical locum staff made up 11.6% of budgeted WTE medical staff in medical care. Over the same period 7.4% of budget WTE medical posts in medical care were left unfilled.

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

**Staffing skill mix**

As of March 2018, the proportion of consultant staff reported to be working at the trust was similar to the England average. The proportion of junior (foundation year 1-2) staff was higher than the England average.
### Staffing skill mix for the 116 whole time equivalent medical staff working in medicine at Mid Essex Hospital Services NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>44%</td>
<td>43%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>3%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>26%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>27%</td>
<td>22%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2
(Source: NHS Digital Workforce Statistics)

### Records

**Patients’ individualised care records were not completed or managed in a way that kept patients safe. Records were poor in their completion and clarity, including care plans not being completed, sepsis assessments incomplete and falls assessments not completed.**

Records were paper-based and stored in locked trolleys on each ward. In May 2017, the trust implemented a new electronic patient record system. Following this, various teething problems had emerged including inaccurate patient tracking and referral to treatment data. Therefore, at the time of our inspection, staff were still using paper records to document patient care and treatment.

We had concerns in relation to patient records. We reviewed 17 sets of records overall. Patients’ individualised care records were not completed or managed in a way that kept patients safe. Records were poor in their completion and clarity, including care plans not being completed, sepsis assessments incomplete and falls assessments not completed. Records did not follow a consistent or clear order.

We opened one patient record on Goldhanger ward and found a different patient’s notes in there. On the same ward, we found a set of patient notes that had fallen through to the bottom of the records storage trolley. When we raised this to the nurse in charge, it turned out this patient had already been discharged. The care plan of another patient on Goldhanger ward showed they were meant to be turned two hourly. The last one was documented around four hours previously. We asked an HCA about this and they said first that “the nurse would fill it in later”. When we asked how they were assured the patient had in fact been turned they said the gap in notes might be because the patient refused, but this was not documented so it was not possible to tell.

The sepsis assessments were also not documented in a consistent way. In some notes the assessment was in the paper records, on others the notes directed you to the mobile online clinical care system, where the assessment was. Staff were not clear on where the correct place was for it to be. On Baddow ward, a patient’s notes showed they had triggered on NEWS for sepsis risk but then the pathway (on the second part of the same risk assessment) was not completed. The nurse told us it was on the mobile online clinical care system and showed us, however four of the six assessments, including blood cultures and urine output, had not been marked as complete. It was not clear from the paper records that the patient was on the sepsis six pathway; it was necessary to go into the online system to ascertain this information.
In another set of notes for a patient on Felsted ward, the patient had a NEWS of 3 and triggered for the sepsis pathway. However, the next part of the notes, similarly to above, was not completed. We raised this with a nurse on the ward, who said it could be in the nursing sepsis screening record but when we checked this, it was also blank. On the drug chart we saw the patient was prescribed antibiotics in response to the sepsis risk but it did not document how quickly they received the antibiotics and there was no documentation of the additional sepsis six pathway steps. This meant it was not clear whether the pathway was being followed. It also meant there was a risk that if a member of staff was caring for the patient and was unfamiliar with the patient (which was likely in view of the high use of agency staff) they would not be fully aware of the patient’s condition and care plan.

There was discrepancy in the documentation of escalating patients triggering on NEWS where necessary. On some wards, it was done on the mobile online clinical care system and on others it was in paper records. This meant that record keeping procedures were inconsistent and it was not always clear where a certain part of the record was located. This was a concern because the high reliance on agency staff meant that if a member of staff was new to the ward, it was not clear where to look to find each part of the patient record, and staff may have to spend a lot of time going through different parts of the patient record (the medical notes, nursing notes and online clinical care notes) to obtain the information they needed. Staff we spoke with including nursing leads confirmed the records system was time consuming.

It was also evident that not all staff were recording in the same way. On the stroke ward, an HCA changed a patient’s dressings but then it was the registered nurse who subsequently recorded it. The HCA did not see what was being written at the time. Therefore, we were concerned that things would not always be accurately recorded if staff relied on other staff to document what they had done. However, when we asked two other HCAs on the same ward, they said they would always document in the notes themselves where they had been the ones giving care. The lack of consistency was a concern and was not in accordance with record keeping guidelines from the Nursing and Midwifery Council (NMC, 2015) which state “Record keeping can be delegated to health care assistants (HCAs), assistant practitioners (APs) and nursing students so that they can document their care”; and “the nurse needs to ensure that the HCA, AP or student is competent to undertake the activity and that it is in the patient’s best interests for record keeping to be delegated”; and “registered nurses should only countersign if they have witnessed the activity or can validate that it took place”. Due to our concerns around staff being familiar with local policies (under the ‘effective’ domain, below) we were not assured that staff would be confident in their knowledge and use of the trust policy on record keeping and documentation.

The three matrons responsible for medical wards recognised that record keeping was a high risk for the service, however this was not documented on the service’s risk assurance framework (reported on in the well-led section). We were told there was a feeling that “unless staff have written it themselves, they are not sure if the documentation is reliable”. They said that there was often duplication of notes as a result. They also told us they felt the quality of the records was a hindrance “rather than enhancing care”. We asked whether there were any plans to improve this and were told that the long-term goal was to be completely paperless. The trust told us that in the interim measures were being taken to ensure records were documented and managed in a way that kept patients safe through the establishment of a task and finish group across all three trusts. Staff felt the high use of agency nurses contributed to poor record keeping.

Our concerns about record keeping were heightened because we requested record keeping audit results from March to August 2018. The service provided their annual trust-wide documentation audit report. However, there were only two sets of notes reviewed on each medical ward as part of this audit, which was not a sufficient sample to represent record-keeping in the service. We were also concerned they were not carrying out these audits more frequently to monitor more closely the areas for improvement in record keeping, particularly as the matrons for the service reported it was a concern.

The annual audit report showed poor results in record keeping. Overall 51% of papers were secure, only 10% had an NHS number and 71% had a legible name. However, the results were not broken down by ward or speciality so we could not identify any areas of particular concern
from the audit. Due to the poor audit results our concerns were heightened that these checks were not being done more frequently, with actions shared to drive improvement.

**Medicines**

**We had concerns about medicines management and medicines-related incidents in the service and there was a lack of effective processes in place for the safe and consistent management of medicines.**

The domain scorecards used by the service to monitor aspects of patient safety showed there had been medicines incidents on medical wards every month from June 2017 to May 2018. The numbers ranged between six administration or prescribing errors (in February 2018) and 20 (in March 2018).

We found that the reporting of and learning from medicines incidents were not consistent. From our discussions with ward staff and pharmacists, we were concerned that there was a lack of certainty around what constituted a medicines incident and staff spoke with could not give examples of recent improvement or changes in medicines practices. Therefore, there was a risk of medicines incidents reoccurring. For example, a staff nurse told us that if a prescribed medicine was unavailable for two or more doses despite requests, they would follow it up directly with pharmacy staff but it would normally not be documented as an incident. This was not in line with best practice and meant that learning or changes from such incidences would not be shared in order to improve medicines management processes.

Staff including ward managers felt that the lack of permanent staff familiar with trust policies and practice had increased the risk of medicines incidents. To address this, we were told on Goldhanger ward that the regular agency staff were starting to undertake competency assessments usually given to full time nurses which included medicines management. However, there were no formal plans for this to be rolled out on other wards.

We had particular concerns in Goldhanger ward, where two serious incidents in relation to medicine were currently undergoing investigation. We discussed these with the pharmacist. In June 2018, a patient was incorrectly prescribed an anticoagulant 20mg four times a day for prophylaxis, instead of once a day. The chart was rewritten by a doctor and verified by a pharmacist; however, the patient already had received five days of doses before the error was identified. In August 2018, a patient was admitted to Goldhanger ward from the acute medical unit (AMU), where methylprednisolone (a corticosteroid used to reduce inflammation) was already prescribed three days earlier and none received. A further two days were missed on Goldhanger ward (totalling five days of missed medication). The patient deteriorated and was transferred to a tertiary centre. However, as the incidents were still in the investigation stage there had not been root causes and recommendations identified at the time of inspection.

We had concerns that the service did not consistently use National Patient Safety Agency (NPSA) alerts to ensure and improve safety in their management and administration of medicines. For example, we saw prescriptions for low molecular weight heparin (LMWH), without information on the drug chart or notes whether the patients’ weight and renal function were taken into consideration with regards to dose and adjustments. The prescribed dose of LMWH should be dependent on patients’ weight and renal function as recommended by the NPSA alert: ‘Reducing treatment dose errors of low molecular weight heparin’. Under dosing increases the risk of thromboembolic event and overdosing increases the risk of bleeding. Similarly, there was evidence the service was not always compliant with the British Thoracic Society guidelines for oxygen use in adults in healthcare and emergency settings (2017). On Felsted ward, we saw that a patient was on oxygen and the pharmacist confirmed this was part of their care plan. However, when we checked the medicines chart with the pharmacist, oxygen was not documented as being prescribed on there. We raised this at the time with the pharmacist and nurse in charge. The patient was supposed to be on oxygen but this had not been documented and the nurse was going to request a doctor to confirm. It was a concern that it was not clear to us or staff whether
that patient should have been on oxygen. We then checked two other patients’ medicines charts who were on oxygen. One had full documentation of the prescription of oxygen; the other had it prescribed on the chart but there was no signature and there was no specification as to how many litres on the chart.

There was no evidence of specific clinical audits to monitor compliance with medicines policies and patient safety alerts, despite documented medicine related errors such as those discussed above in clinical areas in relation to patient safety alerts.

Controlled drugs (CDs) were not always appropriately checked. For example, on Goldhanger ward the CD book was untidy with any errors crossed out, which was not in line with trust policy. A pharmacy entry for medicines returned from ward had no quantity entered, although we were able to track these back to the CD register in the pharmacy department.

We had concerns about the process for ensuring safe temperatures in medicines storage rooms. The maximum temperature for the safe storage of medicines was 25 degrees Celsius. On Baddow ward, there was no record of room temperature monitoring prior to 29 June 2018. Then on the temperature checking records for the 29 and 30 June, the temperature was recorded as 30 degrees Celsius. The temperature had been recorded as out of range for the whole of July and August 2018 except for one date in July. There was a note in the temperature checking log to say this had been escalated to the matron and to estates management but it was not clear what actions were subsequently taken. There was an air conditioning unit in the storage room however, the nurse in charge told us this had only been installed in August 2018. The trust policy stated that if medicines storage room temperatures were recorded as above 25 degrees Celsius for longer than seven days out of 30 days, it should be reported to pharmacy. However, a pharmacy alert from May 2018 stated that staff were required to report any instance of temperatures being recorded as out of range. We were concerned this message had not been shared with all staff including agency staff so temperature issues may not have always been reported or recognised as a concern.

Pharmacists conducted quarterly CD audits and the results of these audits were sent to the ward managers. However, due to our concerns outlined above, we were not assured these were sufficiently effective to ensure the safe management of CDs.

Staff we spoke with on Goldhanger ward and the AMU, specifically about medicines, were not aware of the critical medicines list. Critical medicines are those which must be given immediately or within two hours of the prescribed time. All hospitals were directed by the National Patient Safety Agency (NPSA) rapid response alert: ‘Reducing harm from omitted and delayed medicines in hospital’ to identify a list of critical medicines where timeliness of administration is crucial.

Staff in the discharge lounge raised concerns that patients often came to the discharge lounge without their medicines to take out (TTOs) already in place, meaning there would be delays while staff chased up doctors to do this so the patient could go home. On the stroke ward, we were told about change in practice following an incident where a patient had been discharged with TTOs on their medicines chart which did not match what was stated on their discharge letter. As a result, there was an emphasis on staff to check the discharge letter against the medicines chart for TTOs before the patient left the ward. However, it was not clear that this practice had been shared with other wards and the discharge lounge to improve medicines management across the service. Also, due to the high use of agency staff, substantive nurses were not always assured that agency nurses would know to follow this practice.

The service had carried out medicines storage audits in August 2018. This was the responsibility of the pharmacy team. The audits identified concerns, such as pharmacy medicines orders not always received in a timely manner; orders not consistently being checked against a pharmacy delivery note upon receipt; and staff not being trained on how to use the CD electronic ordering system.
There were recommendations in place such as implementing training on the use of the CD electronic ordering system. However, there was no named lead for implementing these recommendations or timeframe specified as to when they should be achieved. Also, there was a recommendation to ‘ensure medicines are received in a timely manner’ but no indication of how this was going to be achieved. Our concerns about this specific issue were heightened due to the fact staff told us during inspection about issues with prompt receipt of medicines ordered and patients being transferred to the discharge lounge without TTOs. Therefore, we were not assured that, although this had been identified as a concern, there was sufficient oversight and clear steps to implement the recommendation and to act on the concern. We were also concerned that the temperature issues we had identified in Baddow ward, above, had not been picked up by the audit.

Positive feedback from the medicines storage audits in August 2018 included staff awareness of how to access medicines policies and the segregation of IV fluids containing potassium, in accordance with best practice.

The introduction of a dedicated pharmacy team in the ‘emergency village’ had led to improvements in medicines optimisation for patients in these areas (acute medical unit and emergency short stay), although this was not reflected in other medical wards.

Allergy statuses were documented clearly in the eight patient drug charts we looked at during the inspection. We saw evidence of good antimicrobial stewardship with regular multidisciplinary ward rounds and appropriate endorsements on drug charts.

Medicines we checked randomly were in date across medical wards.

**Incidents**

We had concerns about reporting and learning from incidents.

There was an online incident reporting system and all staff we spoke with knew how to report an incident but nursing staff could not give examples of where learning from a recent incident had been shared, except where that staff member had been involved in the incident themselves. There were forums in place for learning from incidents, including a weekly pressure ulcer panel and fortnightly restraint panels attended by the matrons, who then shared information with ward sisters at weekly sisters’ meetings. The sisters were then responsible for sharing learning with staff, through ward huddles or meetings.

However, it was unclear how learning was effectively and consistently shared to all staff. Staff including service leads felt this was in part due to the high use of agency nurses who did not have the same familiarity with the ward and incidents. Similarly, because there was so much movement of staff between wards that were not familiar to them, they may not have been made aware of recent incidents that had happened on the ward to which they were moved. Staff on medical wards felt that the high reliance on agency nurses had contributed to incidents due to learning and improvement not being consistently shared.

There were information folders in staff rooms which had updates about recent incidents and staff knew about these but due to the staffing and capacity issues, rarely had time to check these.

We found a urine sample in the sluice of Writtle ward from May 2018 and brought this to the attention of the sister. We returned two days later to check it had been incident reported and it had not been; the sister made a note to report it. Following inspection, we requested the incident report to show this had been done. This was a concern as the ward was not aware of, or consistently monitoring, their own incidents. The actions stated in the incident report were to include a sluice check for samples in the daily assurance document; and for the associate directors of nursing to ensure that this incident was shared in all clinical areas via team safety huddles. However, it raised concerns about the proactivity of reporting incidents.
Clinical leads told us there was a trust wide mortality review group to review deaths and share learning, which fed into the trust patient safety group. However, junior doctors we spoke with were not aware of these mortality reviews so we were not assured that the sharing of learning ‘from board to ward’ in relation to deaths was consistent and effective.

We reviewed the mortality review group (MRG) meetings from July and August 2018. We had been told there was a two-month lag between deaths occurring and discussion at the MRG but the August minutes discussed deaths from three months previously (April 2018). It was a concern that deaths were not being escalated to the MRG in a timely manner to ensure initial factors could be identified and initial learning could be implemented promptly. It was also a concern that there were issues with completion of reviews. The July report was partially completed as reviews received were from Care of the Elderly, Frailty and the Stroke Unit only for May 2018. Out of the 10 deaths requested for review from care of the elderly and frailty, only six were available for the reviews. Two of these six were identified to have problems in care, namely no VTE assessment on admission and missed dose of therapeutic clexane for a patient who subsequently died from a pulmonary embolus; and a delay in best interest decision for palliation whilst waiting for an Independent Mental Capacity Advocate (IMCA).

The August minutes showed that 12 out of 25 deaths reported in April 2018 in care of the elderly and frailty unit were requested for mortality reviews, and only four sets of case notes included the care episode documentation for the patient’s death. This reflected the concerns we had about records, explained above. There was an action identified to escalate widespread issues with missing notes to the site directors meeting. Three of the 12 deaths reviewed in this speciality identified problems in care, including lack of documentation on weight bearing status; missed opportunity to discuss the ceiling of care with the next of kin; and a clear MDT plan for palliation in the event of deterioration for a patient with learning disabilities not being followed, and inappropriate interventions undertaken.

The mortality review group report from August 2018 highlighted that workloads, difficulties with information management systems and poor record keeping were barriers to full and timely mortality report completion. There were 84 retrospective mortality reviews completed and uploaded to the electronic mortality monitoring system from April 2017 to July 2018. We requested the mortality and morbidity meeting minutes for the service from March to August 2018 but only received meeting minutes from the cardiology, respiratory, renal and stroke wards. Some of these were not formal mortality meetings but rather departmental meetings where a recent mortality was included as an item on the agenda. This was a concern as these departmental meetings were taking place every other month but there was limited discussion and learning around mortality. Although there was more in-depth discussion at the mortality review groups as outlined above, due to our concerns about the lack of junior doctor presence at these mortality review groups and our concerns about consistent reliable processes for sharing learning from incidents in general, we were not assured this type of information would always be filtered down to ward staff.

For example, the respiratory department meeting minutes from August 2018 stated that in April, four deaths were reviewed, all found to be not preventable. In June, three deaths were reviewed, one of which was potentially preventable and the patient had not been seen before passing. The only additional comments were to “emphasise that ACEI (angiotensin-converting-enzyme inhibitor, a medicine used primarily for the treatment of hypertension and congestive heart failure) should be stopped in patients with severe infection and that the service was “doing well to get patients onto [the end of life (EOL) pathway], however reminder to staff for back sheet of EOL booklet to be completed”. We did not see discussion of this death in the mortality review group meetings provided by the trust.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From August 2017 to July 2018, the trust reported no incidents classified as never events in
medical care.
(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 57 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from August 2017 to July 2018.

The breakdown by incident type was as follows:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>No. of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcer</td>
<td>29</td>
<td>50.9%</td>
</tr>
<tr>
<td>Slips/trips/falls</td>
<td>10</td>
<td>17.5%</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient</td>
<td>6</td>
<td>10.5%</td>
</tr>
<tr>
<td>Treatment delay</td>
<td>4</td>
<td>7.0%</td>
</tr>
<tr>
<td>Venous thrombo-embolism</td>
<td>2</td>
<td>3.5%</td>
</tr>
<tr>
<td>Abuse/alleged abuse of adult patient by staff</td>
<td>2</td>
<td>3.5%</td>
</tr>
<tr>
<td>Medication incident</td>
<td>1</td>
<td>1.8%</td>
</tr>
<tr>
<td>Healthcare associated infection/Infection control incident</td>
<td>1</td>
<td>1.8%</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident</td>
<td>1</td>
<td>1.8%</td>
</tr>
<tr>
<td>Screening issues</td>
<td>1</td>
<td>1.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>57</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

The time taken by the trust to report these SIs to STEIS was variable:

<table>
<thead>
<tr>
<th>Time to respond</th>
<th>No. of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 14 days</td>
<td>17</td>
<td>29.8%</td>
</tr>
<tr>
<td>15 to 30 days</td>
<td>5</td>
<td>8.8%</td>
</tr>
<tr>
<td>31 to 60 days</td>
<td>13</td>
<td>22.8%</td>
</tr>
<tr>
<td>61 to 90 days</td>
<td>8</td>
<td>14.0%</td>
</tr>
<tr>
<td>90 days or more</td>
<td>14</td>
<td>24.6%</td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

We reviewed the SI reports for six SIs in the service. The ‘ward learning’ section for these incidents stated learning was to be shared via ward meetings. However, due to our concerns above about the consistency of shared learning, we were not assured this always took place, particularly among agency staff who might be working on the ward on an infrequent basis.

On Goldhanger ward, there had been seven serious incidents from June to September 2018.

We had concerns that the low staffing numbers, high agency use and frequent moving of staff between wards had an impact on these serious incidents.

**Safety Thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 36 new pressure
ulcers, 19 falls with harm and 20 new urinary tract infections in patients with a catheter from June 2017 to June 2018 in medical care.
Prevalence rate (number of patients per 100 surveyed) of harms at Mid Essex Hospital Services NHS Trust

1 Total Pressure ulcers (36)
2 Total Falls (19)
3 Total CUTIs (20)

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Urinary tract infections in patients with a catheter

(Source: NHS Digital)
Is the service effective?

Evidence-based care and treatment

Care and treatment was not always in line with best practice and national guidance and local policy.

There was a local audit schedule for 2017-18 for the service but we were concerned it was not comprehensive, and there was a lack of identified actions to implement the audits and drive improvements. For example, the service was not auditing their response times to patient call bells or NEWS recording (which we have reported on in the ‘safe’ domain above). This meant the service may not have been able to promptly identify any areas of concern to ensure the consistent effective running of services. The audit schedule did not state how frequently each audit was to be carried out.

Local audits included on the schedule included (not limited to) ward cover bleep audit; consultant ward round handover sheet audit; and audit of the ambulatory care and acute medicine unit with severe hypertension.

Six of the audits were marked as ‘overdue’, although it was not clear by how long. The overdue audits included Stroke readmission audit and Quality improvement in Stroke Prevention with Oral Anticoagulation Therapy. A further five of the audits were marked as ‘abandoned’ but no reason was given within the audit plan.

Participation in national audit included National Diabetes Adult Audit: National Inpatient Audit; National Asthma and COPD Audit programme: Pulmonary Rehabilitation; National Asthma and COPD Audit programme: Secondary Care; and Falls & Fragility Fractures Audit Programme: Inpatient Falls, among others. However, the service did not participate in the National Audit for Inflammatory Bowel Disease, which was recognised on the risk assurance framework as a risk for the service. This was because staff did not have the capacity to complete this and because of issues with the trust’s electronic information management system. The trust told us they were developing a business case to address this.

The service had a programme to monitor compliance with relevant national guidelines from the National Institute for Health and Care Excellence (NICE). There were 13 completed project plans with outstanding actions identified as a result of this programme, including in relation to Mechanical clot retrieval for the treatment of acute ischaemic stroke, Acute Upper Gastrointestinal bleeding, and drug allergy diagnosis and management. There were a further five completed project plans with ongoing actions, six awaiting project plan implementations to address recommendations, and five national guidance documents where the service was in the process of assessing their relevance to the service. However, the information provided by the service did not show details as to the levels of compliance with the NICE guidelines identified.

Nutrition and hydration

Staff understood the importance of nutrition and hydration for effective care and treatment.

Patient’s nutritional needs were assessed using the Malnutrition Universal Screening Tool (MUST) as recommended by the British Association for Parenteral and Enteral Nutrition.

On Goldhanger ward we observed a meal time, which was well managed. They had a kitchen adjacent to the ward where hot meals were prepared and there was a board in the kitchen with patients’ dietary requirements.

We saw that MUST scores in most of the records we inspected were completed appropriately and there was dietician input where required, except for one of the patient records we reviewed on Emergency Short Stay (ESS) ward where MUST had not been completed. However, we were
concerned that the poor record keeping, which we have detailed in the 'safe' domain, meant there was a risk that patient's specific nutritional needs may not always be recorded properly.

**Pain relief**

**Pain was well managed from our observations during inspection, although consistent completion of pain scoring was a self-reported risk for the service.**

Pain was well managed and documented in patients’ notes. In one set of notes for a patient living with dementia, we saw appropriate use of the Abbey pain scale. The Abbey pain scale is a tool to help assess pain in patients who are unable to clearly articulate their needs.

All patients we spoke with reported their pain was well managed. We observed good communication from staff to patients when administering analgesia.

However, it was documented on the service’s risk assurance framework that on some occasions, Abbey pain scores were being poorly completed on elderly care wards due to lack of understanding and variance in interpretation of the Abbey pain tool. There were appropriate actions for improvement in place, including ward-based training to ensure and improve staff awareness and competence in using the tool and we did not identify any examples of poor completion on inspection.

**Patient outcomes**

**Information about the outcomes of patient care and treatment was routinely collected and monitored; however, there were mixed results in different outcomes and performance.**

**Relative risk of readmission**

**Broomfield Hospital – elective admissions**

From February 2017 to January 2018, patients at Broomfield Hospital had a lower than expected risk of readmission for elective medical admissions compared to the England average.

Over this period patients in all of the top three elective specialties by count of admissions had lower than expected risks of readmission.

**Elective Admissions - Broomfield Hospital**

![Graph showing relative risk of readmission for elective admissions](image)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.*

**Broomfield Hospital – non-elective admissions**

Over the same period, patients at Broomfield Hospital had a similar to expected risk of readmission for non-elective medical admissions compared to the England average.

- Patients in general medicine and respiratory medicine had similar to expected risks of readmission for non-elective admissions
- Patients in geriatric medicine had a higher than expected risk of readmission for non-elective admissions

**Non-Elective Admissions - Broomfield Hospital**
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics (HES) - Readmissions (01/02/2017 - 31/01/2018))

**Sentinel Stroke National Audit Programme (SSNAP)**

Mid Essex Hospital NHS Trust takes part in the Sentinel Stroke National Audit programme.

On a scale of A-E, where A is best, the hospital’s overall SSNAP level was consistently A over the five most recent audit periods, from April 2016 to November 2017. The trust’s overall SSNAP level was grade B for the earlier audit period from January to March 2016.

The hospital’s patient- and team-centred total key indicator levels were likewise consistently grade A over the five most recent audit periods, from April 2016 to November 2017, and grade B for the period from January to March 2016.

The hospital’s score for patient-centred stroke unit indicator was grade B for the most recent time period from August to November 2017. This was consistent with the five earlier audit periods from January 2016 to July 2017.

The hospital’s performance for team-centred stroke unit indicator was consistently B over the six audit periods from January 2016 until November 2017.

The trust’s performance is shown in the tables below.

<table>
<thead>
<tr>
<th>Overall Scores</th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 16 - Mar 17</th>
<th>Apr 17 - Jul 17</th>
<th>Aug 17 - Nov 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>B</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Combined total key indicator level</td>
<td>B</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
</tbody>
</table>
Lung Cancer Audit

The trust participated in the 2017 Lung Cancer Audit.

The crude proportion of patients seen by a cancer nurse specialist was 76.2%, which did not meet the audit aspirational standard of 90%. The 2016 figure was 80.7%.

The case-mix adjusted proportion of patients with Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 15.6%. This was within the expected range compared to other hospitals. In 2016 the trust’s performance for this metric was not significantly different from the national level.

The proportion of fit patients with advanced NSCLC receiving systemic anti-cancer treatment was 25.7%. This performance was much worse than expected and made the trust a negative outlier. The national average was 62%. It should be noted that the sample size for this metric was relatively small at 26 cases. The trust’s performance in the equivalent measure from the 2016 audit was not significantly different from the national level.

The proportion of patients with Small Cell Lung Cancer receiving chemotherapy was 46.0%. This was within the expected range compared to other hospitals. In 2016 the trust’s performance for this metric was significantly worse than the national level, therefore this indicated improvement.
The case-mix adjusted one year relative survival rate for the trust in 2017 was 33.7%. This was within the expected range compared to other hospitals. In 2016 the trust’s performance for this metric was not significantly different from the national level.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017

At Broomfield Hospital the crude proportion of patients who had a vision assessment (if applicable) was 48%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 37%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 27%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a call bell in reach (if applicable) was 100%. This met the national aspirational standard of 100%.

(Source: Royal College of Physicians)

Competent staff

We were not assured that processes were in place, such as robust induction and competency assessments, to ensure that temporary staff were competent to carry out roles and responsibilities.

Appraisal rates

From June 2017 to May 2018, 81.3% of staff in medical care at the trust received an appraisal compared to a trust target of 79%. The 79% appraisal target was met for four out of seven staff groups, including qualified nursing staff and medical staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>June 2017 to May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Completed</td>
</tr>
<tr>
<td>Medical staff</td>
<td>113</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic</td>
<td>31</td>
</tr>
<tr>
<td>and technical staff</td>
<td></td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>254</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>208</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>23</td>
</tr>
<tr>
<td>NHS infrastructure support staff</td>
<td>88</td>
</tr>
<tr>
<td>Qualified healthcare scientists</td>
<td>39</td>
</tr>
<tr>
<td>Total</td>
<td>756</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Staff raised concerns about the competencies of nursing staff due to the frequency of staff moving to unfamiliar wards to cover rota gaps and high reliance on non-substantive nurses. On ESS, we were told that band six and seven nurses had requested certain agency nurses were not booked again because they did not provide the expected duty of care, did not complete notes appropriately, and did not provide an appropriate handover. However, we were told there had been improvement to the standards and work of agency nurses since they had done this, over the last few months. Staff felt that the lack of robust induction processes, the pressurised and overstretched working environment, and the lack of sufficient internal competency checks for agency nurses, had contributed to incidents including medicines incidents; poor documentation in patient records; and insufficient nursing handover. On the stroke ward, a HCA told us they had concerns about the effectiveness of assurances and checks that temporary staff were competent in basic nursing tasks such as cannulation and using equipment properly.
However, substantive nurses told us there were opportunities to maintain and develop their competencies. For example, an occupational therapist on ESS had recently undergone social services training to develop their understanding of wider patient needs. Similarly, there were examples of where HCAs had started their nurse training in the service to progress and develop. The matrons for the service were hoping to use these staff as examples to encourage other HCAs to do the same. There was also an HCA on Goldhanger ward currently undergoing their associate practitioner pathway.

Junior doctors said they felt well supported by consultants and FY1s were required to do an audit themselves by the end of 2018 to develop competencies.

Multidisciplinary working

There was effective internal multidisciplinary working across the service although staff felt communication with external partners was a challenge.

There were weekly multidisciplinary team (MDT) meetings for people with complex needs to provide a comprehensive assessment or update about the patient’s condition and care plan. Social services generally had good input; we saw them contributing to a board round on ESS, and we were told on Baddow and Braxted wards that if social services could not be present at the round they would always make contact afterwards to help support the needs of individual patients. We saw effective MDT working between nursing and medical staff, particularly during daily board rounds. Ward clerks and housekeeping staff were also considered central to the team and we saw they provided strong support to their respective wards.

We saw sufficient input from physiotherapy, occupational therapy and speech and language therapy (SALT) where relevant, in patient notes, and staff confirmed they had good access to these teams. An occupational therapist we spoke with on ESS said they felt part of the team and that they were a key part of board rounds.

We had some concerns about the effectiveness of external MDT communication with relevant bodies; for example, care homes and community services had raised concerns about communication around discharge, on which we have reported in the ‘responsive’ domain under ‘access and flow’. Ward and service leads reported it was a frequent challenge liaising with external services such as community care services and mental health services which meant there was a risk that patients’ needs were not met in a timely manner.

Seven-day services

Staff were working towards a seven-day service, although there was no weekend access to occupational therapy and speech and language therapy (SALT).

Out of hours, there was an on-call consultant on site from 5pm to 10pm and then off site but contactable by phone and bleep. They were then on site the next day from 8-9am for post take reviews. There was a stroke consultant on call seven days a week for out of hours thrombolysis; a consultant gastroenterologist on call seven days a week for emergency GI bleed cover; and a renal consultant on call from 5pm to midnight for the Renal Dialysis Unit (the unit was closed on Sundays).

On Felsted respiratory ward, consultant cover at weekends had recently improved so that there was a consultant-led ward round on both Saturday and Sunday (following the ward round they would then be on call for the rest of the weekend).

Medical wards had access to a full clinical pharmacy service including medicines reconciliation, clinical advice, patient counselling and preparation for discharge from Monday to Friday, 9am to 5.15pm. In April 2018 extra pharmacy services were introduced to provide additional support to the ‘emergency village’ (AMU, ESS/frailty as well as the emergency department) from 8am to 8pm, seven days a week. There was an on-call pharmacist for advice and for urgent medicines. However, due to our concerns about medicines management and the reports from staff that patients did not always have their medicines to take out (TTOs) ready upon being transferred to the discharge lounge, we were not assured that pharmacy support was sufficient to contribute to
the smooth and effective running of services.

There was access to physiotherapy services from 8am to 5pm daily, including at the weekend. However, the service did not provide seven-day access to occupational therapy and speech and language therapy (SALT). This was on the service’s risk assurance framework due to possible delays to ongoing treatment as a result of patient needs not being met in a timely manner. However, there were local controls in place such as SALT service staffed to Royal College of Physicians (RCP) recommended levels for Monday to Friday, and a Dysphagia Trained Nurses scheme in operation for dysphagia screening out of hours, although there was no plan to extend the SALT services to fully mitigate the risk.

Health Promotion

Staffing and capacity issues meant staff were not always able to dedicate the time they would like to maximise patients’ long-term health and independence.

Due to the pressures caused by staffing and capacity, we saw that ward staff did not always have capacity to focus on longer-term health promotion with their patients, particularly on Writtle ward and ESS. This was reflected as a frustration for staff when we spoke with them and impacted on patient experience. For example, relatives of a patient who was on Baddow ward at the time of inspection (who had initially been admitted through ED following a fall) told us the patient was always either in bed or in a chair, whereas previously they had been able to walk with a frame. They also said the patient had lost weight and felt their needs were not being met and there was a lack of focus on promoting the patient’s general wellbeing (for example, by encouraging him to walk using his frame), due to staff not having the time and capacity to do this.

However, on the stroke ward there was a clearer focus on helping people manage and improve their own health. One patient showed us the writing and stretching exercises they had been doing with the support of their occupational therapist and physiotherapist. They said they had noticed improvement already and were looking forward to continuing this at home.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Consent to care and treatment was sought in line with legislation and guidance, however not all staff had completed Mental Capacity Act training.

Mental Capacity Act and Deprivation of Liberty training completion.

The trust reported that from June 2017 to May 2018 MCA level 1 training was completed by 90.4% of staff in medical care compared to the trust target of 90%.

The breakdown by staff group for qualified nursing staff and medical staff for MCA level 1 training is shown in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>June 2017 to May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>265</td>
</tr>
<tr>
<td>Medical staff</td>
<td>88</td>
</tr>
</tbody>
</table>

The trust reported that from June 2017 to May 2018 MCA level 2 training was completed by 29.7% of staff in medical care compared to the trust target of 90%.

The breakdown by staff group for qualified nursing staff and medical staff for MCA level 2 training is shown in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>June 2017 to May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td></td>
</tr>
</tbody>
</table>
### Deprivation of Liberty Safeguards training

Deprivation of Liberty Safeguards training is covered under the MCA levels 1 and 2 training modules.

(Source: Routine Provider Information Request (RPIR) – Training tab)

An audit of MCA assessments was carried out from December 2017 to April 2018, and a meeting held in September 2018 (this took place after our inspection) to discuss the results and decide on recommendations. The findings showed that almost a quarter of patients admitted into the trust had doubtful capacity; and of these, 58% were not identified as potentially lacking capacity and hence had not been assessed accordingly. Only three out of 21 wards had achieved 100% compliance, while seven wards were zero per cent compliant. This audit was done across a range of medical and surgical wards but the majority of patients lacking capacity were on the medical wards. This raised a concern as it meant patients were not having capacity assessments consistently.

The actions identified for improvement were ‘every patient whose mental capacity in doubt should be assessed’; ‘education and awareness’; ‘mandatory training for doctors’; and re-audit’ but there was no further detail as to timescales for these actions, named leads responsible for ensuring these were done, and steps to achieve them, for example, how they were going to ensure education and awareness was implemented and shared at ward level. The actions had been recommended at a meeting after our inspection so we could not assess whether the audit results had been effectively shared with ward staff.

Of the 17 records we reviewed, all had mental capacity assessments documented where applicable, except three in the acute medical unit where it appeared they had not yet been assessed for capacity, if an assessment was required. Knowledge and awareness of mental capacity among medical and nursing staff was good.

Where there was a DNACPR order in place, there was documentation of this being discussed and reasons given. However, on one we reviewed on Braxted ward, it had been signed and dated by a junior clinician but not additionally by a senior clinician as the form stated should be done.

### Is the service caring?

#### Compassionate care

Staff were patient-focused and compassionate, but the staffing and capacity issues meant they could not always provide the level of holistic care they would have liked, and we saw evidence of privacy and dignity not being maintained.

From July 2017 to June 2018 the Friends and Family Test (FFT) response rate for medical care at the trust was 27%. This was based on 2,582 responses. This was similar to the England average of 25%.

A breakdown of FFT performance by ward for medical wards at this hospital with total responses over 100 for the period from July 2017 to June 2018 is shown below.

Baddow ward and Danbury ward scored under 80% for the 12-month period overall. Overall 11 out of 128 respondents on Baddow ward (8.6%) said they were unlikely or extremely unlikely to recommend the ward. Overall 30 out of 236 (12.7%) respondents on Danbury ward said they were unlikely or extremely unlikely to recommend the ward. In both cases there were some respondents who said that they would neither recommend or not recommend or who answered,
“don’t know”.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp. Rate</th>
<th>Percentage recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Medical Unit and ambulatory care unit</td>
<td>166</td>
<td>29%</td>
<td>89%</td>
</tr>
<tr>
<td>Baddow ward</td>
<td>128</td>
<td>16%</td>
<td>93%</td>
</tr>
<tr>
<td>Braxted ward</td>
<td>257</td>
<td>40%</td>
<td>88%</td>
</tr>
<tr>
<td>Danbury ward</td>
<td>236</td>
<td>21%</td>
<td>86%</td>
</tr>
<tr>
<td>Felsted ward</td>
<td>184</td>
<td>31%</td>
<td>94%</td>
</tr>
<tr>
<td>Short stay medical emergency and frailty unit</td>
<td>390</td>
<td>22%</td>
<td>83%</td>
</tr>
<tr>
<td>Stroke ward</td>
<td>284</td>
<td>46%</td>
<td>96%</td>
</tr>
<tr>
<td>Writtle ward</td>
<td>106</td>
<td>13%</td>
<td>43%</td>
</tr>
</tbody>
</table>

Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

During our inspection, we saw examples of patients’ dignity not being respected and a lack of compassionate approach from staff. Staff including service leads said they found it difficult that they were not able to spend as much time with patients providing holistic support and care because they were under pressure just to meet basic care needs. Although this appeared to be due to factors such as lack of clear support and leadership for staff, low staffing and capacity issues, as opposed to staff not wanting to care for patients, we were concerned about the impact on patients’ experience of care.

On Braxted ward, a patient told us they had been in the same clothes for five days (since they had been admitted) and had not been asked about a change of clothes. On the same ward, we saw a female patient had her chest exposed and was using her arm to cover herself. We saw a HCA walk straight past without acknowledging this. After a few minutes we raised it to a member of staff at the nurses’ station who addressed this.

On Writtle ward, we heard a member of staff loudly stating, ‘Is she crying or is she just making noises?’ to another member of staff in the middle of a bay, which could be heard at the nurses’ station and by patients in the bay. This was while the member of staff was assessing a different patient.

On Baddow ward, a patient’s family were very upset because staff had got the patient’s name wrong on the ‘This is Me’ dementia information pack, which had only been completed over a month after admission to the ward. When the family mentioned it to a nurse, they were told “we can just cross it out”. The family were upset by this response and by the approach of staff. The same family said they felt the high use of agency staff impacted on care and patient experience because they were less familiar with individual patients. For example, a relative had called up on one occasion to find out how the patient was that day and the response from an agency nurse was “I don’t know, I just started my shift”.

However, we saw some examples of compassionate care. For example, on Goldhanger ward, the son of a patient had severe learning disabilities and the patient had previously been the primary carer. The son came onto the ward every day and we saw the staff talking warmly to him. The son regularly had meals on the ward so that he could spend more time with his mother who was receiving end of life care. Two patients on the stroke ward said they were happy with the care they
had received despite feeling that staff on the ward were very busy and pressured, with one 
describing it as “eye opening”.

Staff as individuals displayed a caring approach; for example, one nurse on Felsted ward said the 
best thing about their work was “making patients happy and seeing them smile”. However, it was a 
frustration that they did not have the capacity to provide the holistic level of care they would have 
liked. An HCA on the stroke ward said it “can be hard” because they were so conscious of 
maintaining patients’ dignity and caring for them in a compassionate way.

**Emotional support**

*Staff felt frustrated that capacity and demand meant they could not always provide sufficient emotional support.*

Similarly to the findings above, staff felt frustrated and upset that they could not provide the level 
of emotional support to patients and families that they would have liked.

There was a multi-faith trust chaplaincy service which could be accessed 24 hours a day to 
provide support to patients and relatives via requested bedside visits and weekly ward visits by 
chaplaincy volunteers.

The occupational health department offered a counselling service for staff but this service could 
also be accessed by patients and relatives. On Felsted (respiratory) ward, we were told that 
bereaved relatives were given the opportunity to come back to the ward and discuss their 
experience with the staff.

**Understanding and involvement of patients and those close to them**

Patients and families were not always involved in care planning and communication was not 
always sufficient to ensure they understood.

We had concerns that staff did not always take the time to ensure patients and families 
understood and felt involved in their care. Again, this appeared to be due to capacity and staffing 
pressures. For example, the same family we spoke with on Baddow ward (see above) told us they 
had received limited information about the patient’s progress and care plan and did not feel that 
medical staff involved them in discussions about care. A patient in the discharge lounge told us 
they didn’t know when they were due their medicines.

However, there were examples of patient understanding and involvement on the stroke ward. We 
spoke with two patients there, both of whom reported they had been given the information they 
needed and both nursing and medical staff had taken the time to help them understand their care 
plans, including after discharge. One said their consultant “explains everything” and “talks to me in 
an ordinary way”. On Goldhanger ward, we observed a nurse doing the medicines round 
explaining to a patient when they would next receive their medicines and the process of 
administering them. The patient appeared concerned that it might be painful and we saw the nurse 
reassuring them.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

*We had concerns that medical services did not consistently meet the needs of the population served in terms of ensuring flexibility, choice and continuity of care; and that the service was not tailored to the patient experience and the local population to ensure appropriate service delivery.*

We had some concerns that particular wards were not being managed to provide the purpose for 
which they were intended due to lack of capacity and delays with flow through the service. 
Patients were frequently staying overnight in the discharge lounge which was not in accordance 
with the discharge lounge policy, which stated it was open from 8am to 8pm. This was not on the 
risk assurance framework for the service.
On the emergency short stay (ESS) ward, patients were often staying over a week or two weeks on occasions, and it is intended to be for 24 to 48-hour stays according to the trust’s ESS flow and admission criteria, before being discharged or transferred onto the appropriate ward for longer-term care (although there were 12 dedicated frailty beds on the ward as well). However, sometimes this was the most appropriate to meet patient needs; for example, one patient who had been on the ward for 14 days was a patient receiving end of life care and staff felt it would be more distressing to move them to another ward than to continue to treat them there.

We were told by staff that end of life care patients were frequently treated on Writtle ward even though it was meant to be a contingency ward. At the time of inspection, there was one end of life care patient on the ward. We were told the family had requested that they remain on the ward for their last days and we saw that this had been documented in the patient records. Service leads acknowledged they were seeing more patients being transferred to Writtle ward who did not have a “clear exit plan”. Patients at the end of life or awaiting fast track discharge were excluded from the admission criteria; however, we were told that occasionally due to deterioration, patients would subsequently become end of life during their stay on Writtle and the service would not move those patients to a different ward. They had had nine fast track referrals from March 2018 to September 2018 on the ward.

In the discharge lounge, there was a lack of magazines, books or other things for patients to occupy themselves with while waiting for transport. There was a television on but some chairs were facing away from it. As patients were often here for extended periods of time, it was a concern that the service was not set up or delivered in a way to maximise patient experience.

From April 2017 to March 2018 the average length of stay for medical elective patients at Broomfield Hospital was four days, which was shorter than the England average of six days.

Average lengths of stay for elective specialties:

- Average lengths of stay for elective patients in general medicine and pain management were shorter than the England averages
- Average length of stay for elective patients in gastroenterology was similar to the England average

**Elective Average Length of Stay - Broomfield Hospital**

![Elective Average Length of Stay Chart](image)

*Note: Top three specialties for specific site based on count of activity.*

Over the same period, for medical non-elective patients, the average length of stay was 4.9 days, which was shorter than the England average of 6.4 days.

Average lengths of stay were shorter than the respective England averages for all three of the top non-elective specialties by count of activity.

**Non-Elective Average Length of Stay - Broomfield Hospital**

![Non-Elective Average Length of Stay Chart](image)
Meeting people’s individual needs

Services were not consistently delivered in a way that met the individual needs of patients.

The service reported they were proud of their initiatives to improve the service for patients living with dementia, primarily on Braxted and Baddow wards. Braxted had recently won a care award for the results in the national dementia survey. There was a ‘memory garden’ for the adjacent care of the elderly wards (Baddow and Braxted) and we were told patients were encouraged to take part in activities there to improve their dexterity and balance. Patients were also encouraged to eat in the garden if they wished. These wards also had an activities trolley with board games and books and they had a therapy dog who visited weekly. On Goldhanger ward, a dedicated support worker helped with distraction and communication techniques for patients living with dementia.

However, during our inspection, we saw examples of where the service was not responsive to the needs of patients living with dementia. On Baddow ward (care of the elderly), we spoke with the relatives of a patient who had been on the ward for over a month and had only just had the ‘This is Me’ dementia assessment completed. The tool was not explained to the family, and the family told us that it stated the patient had a catheter in “at the moment”, whereas the patient had had this in place for years, so the family did not think it was an accurate reflection of the patient’s needs. We have included further details about this in the ‘caring’ section of this evidence appendix. ‘This is Me’ is a tool that provides professionals with information about a person with dementia to help enhance the care and support they receive whilst in an unfamiliar environment.

The trust provided the audit results for Find, Assess/Investigate, Refer (FAIR) assessments in July and August 2018 at the time of our inspection. This data collection reports on the number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours in England who have been identified as potentially having dementia, who are appropriately assessed and who are referred on to specialist services. The trust reported that 58% of patients that should have had an assessment in the Emergency Short Stay (ESS) ward in July received an assessment and 63% received an assessment in August 2018. In the acute medical unit (AMU) 58% received an assessment in July 2018 and 44% received one in August 2018. The director of nursing (DoN) was aware of the need to address the FAIR standard and dementia assessment features in the trust Safeguarding Improvement Plan. As a consequence of these results, the DoN had been reviewing the process in the organisation for data collection and was linking in with a neighbouring NHS hospital to review their practices.

There was an end of life care facilitator who worked with staff on Baddow and Braxted wards to help meet the needs of these patients.

Ward staff could refer to the diabetes specialist nurse team for support in meeting the needs of patients with diabetes.

There was a flagging system on the online mobile clinical care system for patients with learning disabilities. At the time of inspection there was only one learning disabilities specialist nurse working trust-wide so sometimes there was delay in assessment and support; however, the trust had a vacancy advertised to recruit another.

Staff told us they had access to interpreting services for patients who did not speak English. Patient leaflets and surveys were available in various languages and formats upon request.
The service had a ‘discharge pack’ used for patients who lived alone or needed additional support. This included milk, bread, and teabags among other food and drink items so that patients being discharged would have something to eat if it would be difficult for them to get provisions immediately after discharge.

**Access and flow**

Access and flow was a significant issue for the service, and discharges were not always done in a timely or appropriate way.

We had concerns about access and flow through the hospital. Writtle ward, which had initially been opened for contingency to help with winter pressures in 2017, had never been able to close afterwards as the pressures had continued. Although there was a set of criteria for patients to be admitted to Writtle ward, staff said this was not always adhered to due to capacity pressures. The criteria included that the patients must not require intravenous (IV) treatment and must not require mental health input. A senior nurse on the ward said that other wards did not always comply with this when transferring a patient to Writtle ward. However, this was not always incident reported and there was no other monitoring system for this issue so we could not ascertain how often this was an issue.

Patients were meant to be clerked by the medical team in AMU after being moved from the emergency department (ED); however, staff in AMU said that due to delays with flow, medical staff would usually review the patient in ED.

Staff said there were difficulties in ensuring the appropriate community services or home care packages were in place which meant that patients requiring this often ended up staying longer even when they were medically fit for discharge. The matron was concerned that this in turn sometimes led to even more challenges with patients as their independence was reduced for even longer while waiting to be discharged. They gave the example of care home staff coming to assess patients and then declining to take them because their needs were considered too complex for the care home to manage.

We were told by staff in all areas there was a feeling of pressure to get patients discharged as quickly as possible, sometimes with insufficient regard given to the potential for readmission or the overall care of the patient.

This was reflected in intelligence we received prior to inspection. The CQC had received around 15 concerns from care homes or other organisations about inappropriate or unsafe discharges of patients from the trust, from April 2017 to March 2018. We raised our concerns with the trust and they conducted a thematic analysis in May 2018 of all incidents relating to discharge, from November 2017 to April 2018, in response to our raising concerns. There had been 58 (not limited to the medical core service). Twenty of these were categorised as ‘failure or delay in follow-up arrangements’, such as the discharge summary not matching the drug chart, or no district nurse referral where required. Thirteen were categorised as ‘inappropriate discharge’, and 19 were due to the patient being discharged with incomplete or no medication. It was a concern that this theme of suboptimal discharges was not highlighted as a risk on the risk assurance framework. Due to the concerns raised by staff including nursing leads about rushing discharges and patients transferred to the discharge lounge without everything in place, we were concerned that this thematic review had not led to any practical improvement in discharges.

This was also reflected in our observations during inspection. For example, on Baddow ward, a patient had been admitted through ED following a fall. They were transferred to the acute medical unit (AMU) and then to Danbury ward, then to Writtle ward as they were considered medically fit for discharge, but the family raised concerns to the medical staff that the patient looked unwell and had a persistent cough. When the doctor assessed the patient, they diagnosed pneumonia. After further treatment, the patient was discharged home; however, this was a failed discharge and due to the patient’s condition upon being home for four hours an ambulance had to be called and the patient was re-admitted. The family were concerned at the pressure to discharge the patient; for example, they said that it had taken three people to assist the patient moving from their bed to their chair and yet the family were still being told by staff that it was safe to discharge...
the patient home. The family were also concerned with the number of ward moves the patient had experienced.

Patients were admitted to the discharge lounge sometimes before they were ready. An HCA in the discharge lounge told us that wards did not always provide them with enough information about the patient in the handover or through the notes meaning they would often need to contact the ward to find out. We were given the example of being told the DNACPR details were in the notes and then discharge lounge staff would not find it there. This was despite the fact there was a checklist to cover at handover to the discharge lounge.

Nursing staff said that they usually found doctors quite accessible when patients required a discharge summary. However, the service did not have any nurse-led discharges in place. Staff felt that low nurse staffing numbers contributed to the issues with timely discharge and flow through the service; nurses could not be pulled away from clinical responsibilities, meaning there was generally no nurse free to take responsibility for discharge planning. For example, the nurse in charge on the stroke ward told us delayed discharges were an issue and the lack of external stroke assessors (to which patients were referred post-treatment) as well as difficulties establishing care packages and transport often meant delays of one to two weeks for medically fit patients. A doctor on Braxted ward also said discharges were a significant problem and that the high use of agency staff impacted on this because they did not have access to the electronic system to keep the discharge planning process moving smoothly.

The concerns around smooth discharge processes were reflected in the service’s internal audits on admitted discharge summaries. The service did not achieve the 95% target in any month from September 2017 to July 2018, with the highest month achieving 75% and the lowest month achieving only 55.9%.

There was a patient flow co-ordinator, which nursing and medical staff felt was valuable in improving flow, but they had to cover all medical wards which was a challenge.

The three matrons for the medical division said that patient flow had become such a priority that it had caused the actual care on the ward and patient experience of the service to become “neglected”. ‘Demand and capacity’ was included on the service risk assurance framework but there was a lack of clear action plan or strategy to improve discharge processes.

Each ward had a discharge planning board which was used in board rounds to discuss the patients approaching discharge and what was needed before they could be safely discharged. This helped with discharge planning and we saw it being used effectively but due to complex patients and lack of support in the community there were still significant issues with timely and appropriate discharge; for example, when we visited Baddow ward on one of the days, 18 out of 26 patients were medically fit for discharge but had not been able to be discharged because of other reasons. The matron highlighted that the neurology rehabilitation pathway in the community was a particular challenge for prompt access for patients, with patients often waiting three or four months. They said these patients were cared for on Goldhanger ward during this time. The sister on Goldhanger ward shared these concerns about slow discharges, saying there had been examples of patients waiting up to six months to be given an appropriate neurology bed.

The trust provided data to show the number of medical outliers (medical patients residing on non-medical wards due to capacity issues) from May to August 2018:

<table>
<thead>
<tr>
<th>Month</th>
<th>Medical Spells</th>
<th>Medical Outliers</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018-05</td>
<td>2539</td>
<td>93</td>
<td>3.66%</td>
</tr>
<tr>
<td>2018-06</td>
<td>2588</td>
<td>93</td>
<td>3.59%</td>
</tr>
<tr>
<td>2018-07</td>
<td>2598</td>
<td>62</td>
<td>2.39%</td>
</tr>
<tr>
<td>2018-08</td>
<td>2624</td>
<td>99</td>
<td>3.77%</td>
</tr>
</tbody>
</table>

(Data Source: Clinicom PAS/Lorenzo)

On the stroke ward, the nurse in charge told us they did frequently take outliers but they always
kept two dedicated beds available for stroke patients. On other medical wards staff did not report medical outliers to be a particular concern.

Access and flow within endoscopy was smoother and more effective. There was a morning list and afternoon list. The unit received referrals via outpatient clinics, multidisciplinary referral and straight to treatment for emergency referrals. The lack of dedicated pre-assessment nurse meant that sometimes there were same-day cancellations which could have been pre-empted with a stronger pre-assessment team. The service acknowledged this but due to financial constraints it was unlikely to be implemented.

The unit co-ordinator explained how patients were then prioritised for surveillance, planned procedures and emergency procedures. If there were cancellations it tended to be if the service already knew the patient would require an inpatient stay (rather than being able to be discharged straight from the endoscopy unity recovery area) and there was no bed available for them. There was a clinical nurse specialist to help manage discharges from endoscopy which we saw helped timeliness and communication.

Referral to treatment (percentage within 18 weeks) - admitted performance

The trust reported no referral to treatment (RTT) data for admitted patient pathways to NHS England for November 2017 or for January to June 2018. In their RPIR the trust stated that, following the implementation of their electronic patient record system in May 2017, management of access for patients on RTT pathways “lost visibility”. In response the trust requested and received approval from NHS Improvement to pause reporting. The trust developed a recovery plan to return to reporting through data validation for every patient on a RTT pathway. The trust reported that this plan was due to complete in July 2018. However, by the time of our inspection in September 2018, the recovery plan for RTT monitoring had still not been completed. It was a concern that the service was therefore unable to demonstrate how compliant they were with targets for RTT for several months.

From June to October 2017 and in December 2017, the trust’s RTT time for admitted pathways for medical care was consistently worse than the England average. In both September and December 2017, the trust’s performance was below 80% (77.8% and 77% respectively).

(Sources: NHS England; Routine Provider Information Request (RPIR) – Quality statement tab)

Referral to treatment (percentage within 18 weeks) – by speciality

Based on data for the period from June to October 2017 and December 2017, one specialty was above the England average for admitted RTT (percentage within 18 weeks):

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
</table>

20171116 900885 Post-inspection Evidence appendix template v3
Thoracic medicine | 95.8% | 92.8%

Over the same period seven specialties were below the England average for admitted RTT (percentage within 18 weeks). In cardiology and dermatology fewer than 70% of patients were admitted within 18 weeks of referral over these six months.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General medicine</td>
<td>94.4%</td>
<td>96.3%</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>85.7%</td>
<td>97.5%</td>
</tr>
<tr>
<td>Neurology</td>
<td>81.8%</td>
<td>91.3%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>73.3%</td>
<td>93.8%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>70.0%</td>
<td>94.4%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>66.7%</td>
<td>82.4%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>63.0%</td>
<td>82.4%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

However, we were able to review the oncology RTT data as this was submitted via a different system. There had been improvement in this; for example, in February 2018 the average wait for patients’ first appointment was 22 days and it was 8.9 days as of September 2018. The service were aiming to reduce it further to seven days. We spoke with the lead for elective and cancer services, who demonstrated a clear focus on the consistent improvement of referral to treatment times for oncology patients. There was a cancer performance recovery plan in place with a clear trajectory for improvement from July 2018 until March 2019, and a backlog trajectory to set out how the service was going to work on clearing backlogs and improving timeliness for patients. The recovery plan was separated into performance targets for each cancer type and there was a risk log to keep aware of the potential obstacles to achieving this intended improvement. They told us that lung cancer was the biggest risk in terms of prompt access to services.

Patients moving wards per admission

The trust were unable to provide data on ward moves for solely non-clinical reasons as this is not recorded in their patient administration system. However, they provided the total number of moves which included both clinical and non-clinical reasons, but it was not possible to determine the proportion which were non-clinical. From July 2017 to June 2018 for patients admitted via the acute medical unit (AMU), 43.2% had no moves, and 3.3% had three or more moves. The Trust's AMU pathway is designed for a high patient throughput with fast turnaround or admission to hospital and therefore we might expect high levels of patients with ward moves.

(Source: Trust Routine Provider Information Request P51)

Patients moving wards at night

From June 2017 to May 2018, there were 3,065 patient moves at night on medical wards and units. The highest numbers of ward moves were reported in October and November 2017 and January 2018 (299, 280 and 314 respectively).

When the acute medical unit and emergency short stay units are excluded, the highest numbers of ward moves at night over this period were reported for the frailty unit (105), the stroke unit (50) and Goldhanger ward (39). However, as above, this includes both clinical and non-clinical moves as the trust was not able to record this level of detail on their patient administration system.

(Source: Trust Routine Provider Information Request P52)

Learning from complaints and concerns

There was a lack of robust systems and support to ensure learning from complaints was consistently shared between wards.

We were concerned that learning from complaints was not always shared effectively. There was evidence that where a staff member was directly involved in a complaint, they would receive feedback, but staff on wards were unable to give examples of shared learning from other wards.
There was a feeling from staff that wards worked in isolation from one another, mainly due to the lack of capacity and time to dedicate to sharing learning from complaints.

However, on Felsted respiratory ward, staff were encouraged to resolve complaints locally and be involved in the process to encourage learning. The matron explained some of their recent themes in the complaints they had received, including communication. They had recently introduced a clinical educator working across Danbury, Telford and Felsted wards, who led a ‘topic of the month’ ward-based session. The topic in October 2018 was going to be communication and the work around this had planned to involve working with the band six and seven nurses, for example to encourage escalating any verbal feedback or concerns from patients and relatives to the nurse in charge as early as possible, to avoid concerns potentially escalating.

Patients or relatives who had raised a formal complaint were invited to have a face-to-face discussion with the relevant ward sister, matron and medical director.

The matron also told us another theme in complaints was staff attitude. When this happened, they would speak to the member of staff directly, and if this related to an agency member of staff who no longer worked for the trust this would be relayed to the agency. However, it was clear from observations and from speaking to staff that the high demand on staff and lack of processes to ensure staff had sufficient capacity, were contributing to complaints concerns around abruptness and this was a frustration for staff as well, which we have reflected in the ‘caring’ domain.

There was a directorate-wide ‘in your shoes’ initiative where patients or relatives who had recent experience of the service would share their experience with staff to help their understanding of the patient experience.

Complaints were discussed at both the directorate sisters’ meeting and at the trust level sisters’ meeting. Debriefs for complaints also took place at monthly ward meetings, however, nursing staff including the matrons acknowledged that it was often difficult to capture all staff in the debrief as they could not always be pulled away from their clinical responsibilities, and that the information may not always be passed on to agency staff.

**Summary of complaints**

From June 2017 to May 2018 the trust received 169 complaints about medical care. For the 141 complaints that had been closed, the trust took an average of 38.6 working days to investigate and close these complaints. The trust policy stated that complaints should be responded to within 25 working days, or 60 working days for more complex complaints. As we could not determine the proportion of complaints that were deemed ‘more complex’, it was not possible to conclude whether this was in line with their complaints policy.

For the 28 complaints that had not been closed, the average time these complaints had been open for was 59.0 working days. This was in line with the trust’s complaints policy; however, 11 complaints had exceeded the target of 60 working days at the time of reporting.

The breakdown by subject is shown in the table below.

<table>
<thead>
<tr>
<th>Subject</th>
<th>No. of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>122</td>
<td>72.2%</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>16</td>
<td>9.5%</td>
</tr>
<tr>
<td>Communications</td>
<td>12</td>
<td>7.1%</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>10</td>
<td>5.9%</td>
</tr>
<tr>
<td>Appointments</td>
<td>4</td>
<td>2.4%</td>
</tr>
<tr>
<td>Transport (ambulances)</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>1</td>
<td>0.6%</td>
</tr>
</tbody>
</table>
Admin/policies/procedures (inc patient record) | 1 | 0.6%
Privacy, dignity & well being | 1 | 0.6%
Total | 169 | 100.0%

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From June 2017 to May 2018 the trust received 142 compliments about medical care. The breakdown for wards or clinical areas with five or more compliments is shown in the table below.

<table>
<thead>
<tr>
<th>Ward or area</th>
<th>No. of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac care</td>
<td>14</td>
<td>9.9%</td>
</tr>
<tr>
<td>Baddow ward</td>
<td>12</td>
<td>8.5%</td>
</tr>
<tr>
<td>Stroke unit</td>
<td>12</td>
<td>8.5%</td>
</tr>
<tr>
<td>Felsted ward</td>
<td>10</td>
<td>7.0%</td>
</tr>
<tr>
<td>Peripheral inserted central catheter (PICC) service</td>
<td>10</td>
<td>7.0%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>9</td>
<td>6.3%</td>
</tr>
<tr>
<td>Acute medical unit</td>
<td>9</td>
<td>6.3%</td>
</tr>
<tr>
<td>Terling ward</td>
<td>7</td>
<td>4.9%</td>
</tr>
<tr>
<td>Goldhanger ward</td>
<td>7</td>
<td>4.9%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>7</td>
<td>4.9%</td>
</tr>
<tr>
<td>Oncology</td>
<td>6</td>
<td>4.2%</td>
</tr>
<tr>
<td>Emergency short stay</td>
<td>6</td>
<td>4.2%</td>
</tr>
<tr>
<td>Danbury ward</td>
<td>5</td>
<td>3.5%</td>
</tr>
</tbody>
</table>

In their RPIR the trust did not provide a breakdown by subject or theme for compliments in each core service.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

We had concerns that staff were not sufficiently supported by leadership in the service.

Medical services were led by a clinical director, three matrons working cross-divisionally and consultant leads.

We had concerns about the strength of leadership within medicine. Staff did not always feel supported or feel there was clear leadership and support. Due to capacity and demand issues, local leads could not always provide the level of support to staff that they would like to and this was impacting on ward staff.

There was mixed feedback about the visibility and support of the trust executive team. Matrons reported they were very supportive and appreciative, with one of them saying they worked very well together and the executive team was “the best it has been”. Consultants and middle grade doctors also felt there was sufficient presence from the executive team. However, ward nursing
staff felt that due to many recent changes in the executive team, they did not feel there was a strong presence on the ward at this level and felt ‘removed’ from the decisions of senior management. For example, one member of staff said there had been so many changes that they did not know who the executive team were.

There were concerns raised about the lack of effective communication by divisional and senior leads about decisions that affected staff. Earlier in 2018 there had been a decision to create a ‘twilight shift’ following a recommendation by an independent body. This led to the reduction of medical staff on both early and night shifts. Medical staff and local leads were not clear on the reasoning behind this decision and who had implemented it. There was frustration among medical staff that this decision had been taken without the consultation and involvement of the staff who would be affected. For example, one consultant said the change was “a surprise” to both senior and junior medical staff and that “no one knew who commissioned the change”. The divisional lead said they were now having to do a lot of work to essentially reverse this measure to revert to the position they were in before this decision, with regard to medical shift patterns.

However, matrons were visible on the wards and were trying to boost and maintain morale despite the challenges in the service. Ward managers said they were well supported by matrons.

Vision and strategy

There was a lack of clear vision and strategy to ensure the development, improvement and sustainability of the service.

There was a lack of clear vision or strategy for medicine. Although this was largely due to staffing and capacity pressures being the main priorities, we were concerned that there was no evident long-term plan to develop services in a sustainable way. Matrons told us they saw the overall vision as being safe and well-led and providing “a good experience for patients” but it was not clear what the steps were towards achieving this. They acknowledged that staffing challenges meant it was difficult to see past the “day to day” priorities and work of the service and it was a frustration that they had no capacity to focus on the development of both staff and the service.

We asked the matrons what the service’s focus would be for the next six to twelve months. They said their goals were to continue improvements in morale, work on recruitment and retention, and refocus the priority of patient-centred care rather than achieving flow and discharge promptly.

We had concerns that there was no clear plan shared with staff about how the service was going to manage the ‘winter pressures’ period considering that they had experienced severe capacity issues over the summer and that Writtle ward which had originally opened for contingency over the last winter, had never been able to close afterwards.

We had particular concerns about the lack of clear purpose or plan for Writtle ward. It had been kept open for contingency but used a mixture of staff pulled from other areas so lacked a ward ‘identity’. A senior nurse on the ward told us they might be expanded to be essentially another care of the elderly ward, but there was nothing documented to set out clearer plans for the ward or what the arrangements would be for ‘winter pressures’.

There were trust-wide strategic priorities, focused on achieving clinical and service excellence, providing quality leadership, building effective relationships and maintaining business excellence. However, ward staff in the medical division were not aware of these strategic priorities. Staff were aware of the plans for a merger with two other local trusts in the future but there was no evidence of involvement or consultation with staff in this, or awareness from staff about what impact the merger would have on the medical service. We were not assured that service leads had ensured they felt included and involved in the future and strategy of the service.

Due to the sustainability and transformation plan, it was anticipated that the stroke service would be combined and streamlined to provide one service across three sites in Essex.

Culture

Staff were supportive of one another despite high vacancies but pressure due to staffing and capacity meant morale was often poor.
Many nurses displayed stress and emotion when we spoke with them due to the pressures they were experiencing in relation to capacity and lack of sufficient staff numbers. This was impacting on staff morale. However, it was clear that staff were supportive of each other and pulled together as a team despite high vacancies impacting on them. This included an agency nurse stating they felt well-supported and included as part of the team. Staff in endoscopy felt more positive about the culture within their service and morale was higher.

We were concerned about the lack of learning culture in relation to incidents because, although there were forums in place to discuss incidents and share learning, it did not appear to be effective. Staff also shared the feeling that medical wards tended to work in isolation, so there sharing of information from incidents in other wards did not consistently take place. We have detailed this further in the safe domain.

Service leads including matrons said they were proud of their staff particularly because they felt there was growing pressure on staff yet they still pulled together to work as a team. We saw this during our inspection and staff said this helped them to stay motivated. For example, a member of staff described the stroke ward as a ‘close-knit’ team, which matched the interactions between staff on the stroke ward that we observed. Staff, both nursing and medical, were dedicated to their work and their patients despite the challenges.

Service leads and staff on Goldhanger ward said the ward had a long standing negative ‘reputation’ that meant it was a challenge to recruit to the ward. A sister on the ward told us that morale had also been left low following a spate of staff leaving. However, there had been recent improvement in relation to this, in part due to a ‘Wonder ward’ initiative whereby an external body had come in to identify factors of poor morale that could be improved. One of the initiatives implemented was a ‘star board’ on the ward, where staff could write down an appreciation or recognition of something another member of staff had done or for support they had given them. We saw this was actively being used by staff to commend and recognise each other.

The sister said this had led to a noticeable boost in morale and there was more support through team meetings and staff were arranging social activities together. However, in the Goldhanger ward risk summit in August 2018, it was discussed that the ‘Wonder ward’ initiative was “now impossible to do”. It was not clear why this would be the case.

During our inspection of Braxted ward, the chaplain was visiting to speak with staff about how they were coping with the recent death of a colleague and provide them with support.

**Governance**

**Governance processes were not sufficiently strong to provide oversight of the service.**

The divisional governance structure was as follows: each medical ward or department had weekly meetings which fed into directorate governance meetings, which in turn fed into the divisional board. Due to the widespread concerns across medicine, for example in relation to staffing, agency competencies, incident reporting and inappropriate discharges, we were not assured that the governance arrangements in practice provided sufficient oversight, accountability and risk management of the service.

The strength of governance processes was impacted by the lack of sufficient audit processes (as reported under effective), the staffing issues and the concerns around capacity and demand, meaning ward leads who were intended to have accountability for different responsibilities such as audits and dissemination of information, did not always have the capacity to ensure these were carried out.

An example of this can be seen in our evidence on medicines management where there was a lack of clear accountability and governance processes to monitor issues and drive improvement.

The service highlighted as a risk on its risk assurance framework that there were “delays in completing governance tasks in a timely manner leading to an increased risk that potential incidents could be repeated before actions are put in place to mitigate”. This was due to staffing levels impacting on nurse leads being able to complete their non-clinical work. An update of the risk in June 2018 stated that delays were improving but there remained a backlog of incidents.
requiring escalation and a significant backlog of actions. Due to our concerns about incident reporting and learning from incidents (explained in the safe domain), we were not assured this was being addressed sufficiently.

The medical directorate reported quality concerns to the trust monthly clinical governance group who in turn reported to the patient safety and quality committee. The structure for feedback was then via matrons’ meetings, ward sisters’ meetings and then delivered to ward staff at daily huddles. Therefore, in theory there was a ‘ward to board’ governance reporting structure in place and vice versa for feedback and communications but in practice this did not appear to be effective as ward staff did not feel involved in or aware of governance processes. This was at least in part due to the high levels of agency staff and staff frequently being moved from their own wards to cover other areas as it meant staff did not always feel a sense of ownership and familiarity with a particular ward.

Ward managers produced a ward governance report which included information on incidents, falls, pressure ulcers and infection rates to discuss and share learning across the service through the forum of the weekly sisters’ meetings. Matrons attended a daily executive review group, where serious incidents were discussed. There was also a daily divisional huddle where any incidents in the last 24 hours were discussed. However, due to our concerns about reporting and learning from incidents, as explained in the ‘safe’ domain, we were not assured that there was consistent and sufficient oversight of incidents at these meetings, even though matrons felt there was a “positive incident reporting culture”.

**Management of risk, issues and performance**

**There was a lack of effective measures in place for the management and oversight of risk, issues and performance in the service.**

We had concerns about the effective management of risk in the service. Due to the concerns we identified, for example in relation to records, documentation of sepsis pathways, reporting and learning from incidents, medicines management, and the competencies and induction processes for agency staff. Leads did not always have oversight or ownership of risk, issues and performance in their speciality. Although service leads acknowledged some of the issues, for example record keeping, when we asked them, they were not aware of an action plan to ensure continuous mitigation and improvement of these risks. However, during our inspection, the executive leadership team informed us that a task and finish group was revising the nursing documentation across all three trusts.

There was a ‘risk assurance framework’ for the service which was a log of the risks self-reported by the service. However, we were concerned that a number of risks we had identified were not included on the framework. For example, record keeping, medicines management, and patients being boarded overnight in the discharge lounge, were not specified as risks on the framework. This meant they were not being regularly overseen or assessed formally as risks; no staff member was named as accountable for managing and reviewing the risks; and no clear action plans were documented to work towards mitigation and improvement of these risks.

It was also a concern that there was no indication of the dates that individual risks had been added to the risk register so it was not possible to see how long the risks had been present and the timescale of any actions or mitigating factors. Similarly, there were not always dates and steps specified for actions proposed. For example, for the risk in relation to lack of NIV beds, outlined in the ‘safe’ domain of this report, the actions to develop a business case and share a revised protocol with staff were unclear as to their timeframes, methods for ensuring this, and persons responsible for each stage.

Our concerns about risk management were heightened because many of the areas where we had concerns, for example in relation to records, agency nurse competencies, and sepsis documentation and assessment, were not being audited by the service. This meant that service leads may not be identifying and acting on particular areas of risk.

The matrons felt there was a significant risk caused by the level of agency staff, which we have detailed in the ‘safe’ domain of this report. This was a concern shared by both nursing and medical
staff on the wards. We had concerns that there was no clear recovery plan or recruitment and retention strategy to improve this.

This concern about risk management over nurse staffing levels was heightened further because matrons acknowledged, and we saw during our inspection, that this risk impacted on a number of other risks for the service. They gave the example of a nurse in charge not taking breaks during their night shift because of concerns about leaving the ward only staffed by agency nurses. Again, we were not assured there were sufficient mitigation factors and improvement strategies to manage and reduce these risks.

There had been a risk summit for Goldhanger ward due to long-term concerns about this ward. The purpose of this was to “be sighted on the quality and staffing metrics for the ward, to listen to all those present, their views and contributions regarding the ward and to identify necessary actions and support [for the staff on the ward]”. The minutes of this risk summit showed discussion of main concerns, including the challenge of the increased number of specialities on the ward, concerns around the engagement and behaviours of some medical staff and the number of incidents on the ward. The concerns discussed at the risk summit matched many of the issues we had identified with the ward during our inspection.

There was an action plan following this, which included increasing the permanent lines of agency staff on ward to ensure greater continuity of care to patients, a focus on bed reconfiguration and additional support to be provided by a clinical risk manager to review reported incidents.

**Information management**

**Information management systems and processes were not always effective.**

We had concerns about the effectiveness of information management processes due to the poor record keeping across medical wards, which we have detailed in the ‘safe’ section. We were also concerned because agency staff did not have access to IT systems including the electronic patient records system (used for discharge letters and medical history among other aspects) so they would rely on passing this information to a nurse in charge, either during the same shift or at handover.

A ward clerk told us that as there was no one to cover when they were on leave, there were 16 boxes of medical notes for them to track onto the electronic system. This was a concern as paper records were not being transferred onto the electronic system in a timely manner.

Staff could access policies electronically and in hard copies, although a doctor on the acute medical unit (AMU) said some policies and guidelines were “difficult” to find and staff did not always have the time to review updates. Another doctor said that training on the use of the electronic system and other IT systems upon induction was limited.

Policies we reviewed were found to be in date for review.

Consultants were issued with smartphones to use on ward rounds for immediate access to information.

**Engagement**

Although staff showed commitment and dedication to their work, there was a lack of measures or initiatives in place from service leads to continually engage staff or reward achievement. Staff we spoke with on the wards were not aware of any specific plans in relation to the proposed merger and there had been minimal involvement of ward staff in these plans.

On Goldhanger ward it had been noted as a concern in the risk summit in August 2018 that there had been an impact on staff due to not being involved with bed reconfiguration plans. The service was about to issue a survey to ward staff to find out their views and suggestions for improvement, although this had not yet taken place at the time of our inspection.

There was a lack of forums to engage with the public or previous patients, except for the trust-wide ‘in your shoes’ initiative where patients could come back to the hospital and share their experience.
Learning, continuous improvement and innovation

There was limited evidence of improvement, development and innovation in the service.

We were concerned that the short staffing levels and the primary focus on achieving discharges promptly had meant there was a lack of focus on continuous improvement with a long-term view.

However, in oncology, there was evidence of gradual improvement in treatment times. We have reported on this fully in the ‘responsive’ domain. The director for elective and cancer services told us about initiatives implemented to achieve this, including weekly patient prioritisation meetings to identify the patients most at risk, and streamlined working with two other local trusts with some oncologists working across the sites to assess patients.

Surgery

Facts and data about this service

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

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

Broomfield Hospital has 149 surgical inpatient beds located across nine wards and units. The complete list of surgical wards, theatres and other reporting units at Broomfield Hospital is shown in the table below:

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>Speciality or description</th>
<th>Inpatient beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day stay unit</td>
<td>Surgical day stay with inpatient capacity</td>
<td>12</td>
</tr>
<tr>
<td>Heybridge ward</td>
<td>Upper and lower gastrointestinal surgery</td>
<td>20</td>
</tr>
<tr>
<td>John Ray ward</td>
<td>Elective orthopaedic ward</td>
<td>24</td>
</tr>
<tr>
<td>Lister ward</td>
<td>Orthopaedic rehabilitation</td>
<td>20</td>
</tr>
<tr>
<td>Notley ward</td>
<td>Trauma and orthopaedics</td>
<td>28</td>
</tr>
<tr>
<td>Preadmission service</td>
<td>Anaesthetic pre-assessment</td>
<td>-</td>
</tr>
<tr>
<td>Rayne ward</td>
<td>Urology and vascular</td>
<td>26</td>
</tr>
<tr>
<td>Surgical emergency ward (SEW)</td>
<td>Emergency surgical assessment unit</td>
<td>19</td>
</tr>
<tr>
<td>Theatre admissions unit</td>
<td>Nine trolley bays and one chair bay</td>
<td>-</td>
</tr>
<tr>
<td>Theatre suite</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

From April 2017 to March 2018, the trust had 35,439 surgical admissions. Emergency admissions accounted for 12,956 admissions (36.6%), 17,214 (48.6%) were day cases, and the remaining 5,269 (14.9%) were elective.
During this inspection, we visited the wards, operating theatres, recovery, day stay unit and interventional radiology. The trust’s discharge lounge was inspected as part of the medicine core service, due to its governance arrangements. We spoke with eight patients, one relative and 32 members of staff including medical and nursing staff, healthcare assistants, nursing staff, therapy and domestic staff. We observed care and looked at 20 sets of medical records. We also looked at a wide range of documents including policies, standard operating procedures, meeting minutes, action plans, prescription charts, risk assessments and audit results. Before our inspection, we reviewed performance information from, and about, the trust.

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

**Is the service safe?**

**Mandatory training**

The service provided mandatory training in safety systems, processes and practices but not all staff completed it. Staff told us that high levels of clinical demand meant that staff could not always be spared to attend training.

Staff completed a number of mandatory training modules as part of their induction and were required to update them in line with the training policy. Mandatory training included fire safety, information governance and infection prevention. Staff also received annual training on sepsis management, including the use of sepsis screening tools and care bundles. Training was delivered through a combination of online assessment and practical training days. On Notley Ward, the matron had started to run practical training days in the day room. This was improving practical training compliance as staff could attend the training without leaving the ward.

All healthcare assistants completed the care certificate. The certificate aimed to prepare health and social care support workers with the knowledge and skills to provide safe and compassionate care.

Ward sisters and the clinical training lead monitored training via an online tracker and would notify staff when their training was due for renewal. Staff were positive about the training they received and were supported to attend additional training, if relevant to their role.

**Mandatory training completion rates**
The trust set a target of 85% for completion of all mandatory training modules (with the exception of information governance where the target was 95%). A breakdown of compliance for mandatory training courses for surgical nursing staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2017 to May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Medicine management</td>
<td>262</td>
</tr>
<tr>
<td>Fire safety</td>
<td>243</td>
</tr>
<tr>
<td>Manual handling object</td>
<td>241</td>
</tr>
<tr>
<td>Manual handling people</td>
<td>233</td>
</tr>
</tbody>
</table>
The trust had an overall training compliance rate of 85% for surgical nursing staff. The trust’s training targets were met for four of the nine mandatory training modules for which nursing staff were eligible.

A breakdown of compliance for mandatory training courses for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rates (%)</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection prevention level 1</td>
<td>181</td>
<td>199</td>
<td>91.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>172</td>
<td>199</td>
<td>86.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety 1 year</td>
<td>169</td>
<td>199</td>
<td>84.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling object</td>
<td>167</td>
<td>199</td>
<td>83.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>162</td>
<td>199</td>
<td>81.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management</td>
<td>9</td>
<td>16</td>
<td>56.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>47</td>
<td>95</td>
<td>49.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Intermediate life support</td>
<td>1</td>
<td>11</td>
<td>9.1%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust had an overall training compliance rate of 81.3% for medical staff in surgery at Broomfield Hospital. The trust’s training targets were met for two of the eight mandatory training modules for which medical staff were eligible. Completion rates for medicines management, resuscitation and intermediate life support training were particularly low. Only one out of 11 eligible staff had completed intermediate life support training. Poor training compliance was not identified as a risk on the service’s risk register.

## Safeguarding

The surgery service had effective processes in place to keep people safe and protected from abuse. However, not all staff had received safeguarding training in line with national guidance.

Safeguarding training was part of the mandatory training programme and included information on female genital mutilation and child sexual exploitation and PREVENT. PREVENT is a government-led training programme, designed to identify and prevent the threat of terrorism. The trust set a target of 90% for completion of safeguarding training.

### Safeguarding training completion rates

A breakdown of compliance for safeguarding training courses for qualified nursing staff in surgery at Broomfield Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2017 to May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information governance</td>
<td></td>
</tr>
<tr>
<td>Infection prevention level 1</td>
<td>84.5%</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>79.8%</td>
</tr>
<tr>
<td>Fire safety 1 year</td>
<td>75.9%</td>
</tr>
<tr>
<td>Manual handling object</td>
<td></td>
</tr>
<tr>
<td>Information governance</td>
<td></td>
</tr>
<tr>
<td>Medicine management</td>
<td></td>
</tr>
<tr>
<td>Resuscitation</td>
<td></td>
</tr>
<tr>
<td>Intermediate life support</td>
<td></td>
</tr>
<tr>
<td>Name of course</td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>246</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>245</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>239</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>223</td>
</tr>
</tbody>
</table>

The trust’s 90% completion target was not met for any of the four safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses for medical staff in surgery at Broomfield Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2017 to May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>159</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>157</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>118</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>117</td>
</tr>
</tbody>
</table>

Safeguarding training rates for staff did not meet trust targets or national guidance. Medical staff training rates were notably lower than expected for safeguarding adults level 2 and safeguarding children level 2. The intercollegiate document ‘Safeguarding children – roles and competencies for healthcare staff’ 2014 published by the Royal College of Paediatrics and Child Health (RCPCH), provides guidance on the level of safeguarding training required for different staff groups. The document states that all clinical staff who have any contact with children, young people and/or parents/carers should be trained in safeguarding children level 2.

The trust had developed an action plan to try and improve safeguarding training compliance, which included a review of the current training content and delivery. The trust was also in the process of adopting NHS England’s online safeguarding training, which was hoped to improve compliance.

The trust had an adult safeguarding team to respond to all incoming incidents and serious case reviews. Staff knew what the term safeguarding meant and how to recognise signs of abuse. They could explain the reporting process and knew how to seek support if needed. Staff knew how to contact the trust’s safeguarding leads and gave examples of when the trust’s safeguarding team had supported them.

We saw safeguarding information displayed on ward areas, offering advice and guidance to staff and patients on how to recognise and report abuse. Staff knew how to access safeguarding policies and procedures on the trust intranet.

A safeguarding referral is a request made to the local authority or police to intervene, support or protect a child or vulnerable adult from abuse. From June 2017 to May 2018, there were 91 adult safeguarding referrals and 15 child safeguarding referrals made within surgery.
Cleanliness, infection control and hygiene

Although there were systems in place to prevent the spread of infection, standards of cleanliness and hygiene were not always maintained.

Most locations visited were visibly clean and tidy. Signed cleaning schedules were in place and housekeeping staff cleaned the departments daily. Staff labelled equipment with ‘I am clean’ stickers to indicate that it was ready for use. Personal protective equipment (PPE), such as gloves and aprons, was accessible for staff in all clinical areas to ensure their safety and reduce the risk of cross-infection when providing care. We saw staff using PPE appropriately.

Most staff disposed domestic and clinical waste correctly. However, on Heybridge Ward we found seven used needles and blood-stained gauze swabs inside a blood glucose monitoring kit. This finding raised two concerns. Firstly, sharp items, such as needles, are required under existing health and safety law to be safely disposed in a clearly marked and secure container. Staff were therefore non-compliant with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 and at risk of a sharps injury. Our second concern was that the blood-stained gauze swabs had been placed on top of clean blood glucose test strips, risking contamination. Blood-borne diseases, such as human immunodeficiency virus (HIV) and hepatitis B can be spread through blood contamination. We raised our findings with the junior sister who immediately removed the kit from the ward.

On all other wards, sharp bins were clearly labelled and tagged to ensure the appropriate disposal of sharp items. However, on the Surgical Emergency Ward we had further concerns around infection control. We found a blood-stained piece of card on top of a batch of clean needles, inside a blood glucose monitoring kit. Again, we had concerns around the risk of spreading blood-borne diseases through blood contamination. The kit was immediately removed from the ward once brought to the junior sister’s attention.

Staff used effective hand hygiene techniques and their arms were ‘bare below the elbow’ when providing care. Hand sanitiser points were widely available to encourage good hand hygiene practice and we saw staff washing their hands before and after contact with patients. This was in line with National Institute for Health and Care Excellence (NICE) Quality Standard 61, which states that staff should decontaminate their hands immediately before and after every episode of direct contact care.

Hand hygiene audits from June 2017 to May 2018 showed hand hygiene compliance varied by surgical directorate. For example, in the musculoskeletal directorate, hand hygiene was good and staff achieved 100% compliance in all audits. Within the same reporting period, hand hygiene audit results were poor in the anaesthetics and theatre directorate, with compliance below 95% on 34 occasions.

Staff did not always comply with the Control of Substances Hazardous to Health (COSHH) Regulations, 2002. On Heybridge Ward, we found methylated spirits (a hazardous substance) in an unlocked cupboard, within an unlocked sluice. The spirit should have been stored securely to reduce the risk of patient exposure to a dangerous chemical.

We observed theatre staff comply with NICE guidance (CG74) on infection prevention and control measures during the preoperative phase, intraoperative phase (including hand decontamination, incise drapes, sterile gowns, gloves antiseptic skin preparation) and the postoperative phase. The trust had a sterile services department on site and there were processes in place for decontamination of equipment.

All patients were required to be screened for infection on admission to a ward or unit. From June 2017 to May 2018, data from quality dashboards showed that 94% of elective patients were screened within the musculoskeletal directorate, 90% within the surgical specialties directorate.
and 89% within the anaesthetic and theatres directorate.

Staff took steps to prevent transmission of infections by isolating patients when infection was suspected. From June 2017 to May 2018, there were six cases of the hospital acquired infection methicillin-resistant staphylococcus aureus (MRSA) and 23 cases of the hospital acquired infection Clostridium difficile (C. diff) attributed to the surgical division. In an attempt to reduce the incidents of outbreaks, the trust was planning an annual deep cleaning programme. As of May 2018, the programme was awaiting executive sign off.

The IPC team ran a yearly programme of audits trust-wide, which included an audit of PPE usage, bed pan cleanliness and commode cleanliness. In the director of infection prevention and control’s monthly report March 2018, the division of surgery achieved 100% compliance for PPE usage, 98% for bed pan cleanliness and 88% for commode cleanliness against a target of 100%.

A surgical site infection is a type of healthcare-associated infection in which a wound infection occurs after an invasive (surgical) procedure. The service monitored the rate of surgical site infections (SSIs) following surgery and investigated any increases in surgical site infection rates.

Data provided by the trust showed that from June 2017 to May 2018, trust performance varied against the national average for colorectal SSIs. In June 2017, the trust’s SSI rate (12.9%) was worse than the national average (9.1%). However, as of May 2018, the trust was performing well against the national average (7.1%, against a national average of 8.6%). For gastric surgery, as of March 2018, the trust’s SSI rate was 0%, below the national average of 2.3%. All patients with a bowel or gastric SSI were seen regularly by the SSI clinical nurse specialist. The trust also collected data on orthopaedic SSIs, including infection after hip and knee replacement surgery, reduction of long bone fracture and repair of neck of femur. Data provided by the trust showed that during 2017/18, infection rates were below the national average.

Environment and equipment

The service had suitable premises and systems were in place to ensure equipment was maintained.

Throughout the inspection, we found that all wards were secure, with doors opened via an intercom system. Ward areas and corridors were spacious and free from obstruction. Fire exits were clear and fire extinguishers were available if required.

There was enough equipment to meet the needs of patients. Staff followed the trust’s medical equipment policy to ensure medical equipment was managed in compliance with Medicines and Healthcare products Regulatory Agency requirements.

All wards and theatres had a resuscitation trolley, for staff to use in the event of a cardiac arrest. Staff used tamper evident tags to alert staff if the resuscitation equipment had been used. Staff checked resuscitation equipment against an equipment checklist to ensure essential equipment was available and in working order. The top of each trolley was checked daily and the rest of the trolley was checked weekly or after each use. In each area, we found satisfactory checks had been completed for the previous three months (July to September 2018).

There was a rolling testing programme for all medical devices, overseen by the trust’s biomedical engineering department. We checked 27 pieces of medical equipment, including defibrillators and suction machines. We found all pieces of equipment had been electrical safety tested and were within the stated date for review, with the exception of two infusion pumps in recovery. Both pumps were due for review August 2018. We raised our finding with the junior sister to escalate to the engineering department. We also checked the expiry dates of consumable equipment,
including needles and syringes. We found all items had expiry dates clearly marked on them and were within date.

Staff told us they had enough equipment to deliver safe care and were able to order equipment when needed. Staff had access to specialist equipment to support the needs of bariatric patients.

Disposable curtains and wipeable chairs were used on most wards. We checked five disposable curtain tags and all had been renewed within the last six months.

Assessing and responding to patient risk

Staff knew how to assess, monitor and manage patient risk. However, we were not assured that risk assessments were accurately documented. We were also not assured that all aspects of The World Health Organisation’s Five Steps to Safer Surgery checklist were consistently completed.

All elective patients attended the pre-operative assessment clinic in the weeks prior to their surgery. Patients had their general health and suitability for surgery assessed and any required investigations would be performed. An anaesthetist would review all patients identified as a potential anaesthetic risk.

Staff completed risk assessments for patients admitted onto the wards. Risk assessments included assessing the risk of falls and pressure ulcers. We reviewed 20 patient records and found that although records contained numerous risk assessments, most contained a number of incomplete risk assessments. These included risk assessments for infection, malnutrition and pressure sores.

Staff took action to reduce any identified risk to patients. For example, for patients at risk of falling, staff could nurse patients close to the nurse’s station, assist with their movements and implement bed rails.

Patients were assessed by the therapy team upon admission. Therapists used specific tests, designed to measure a patient’s performance in the activities of daily living, to tailor treatment and care to individual needs.

Staff used the National Early Warning Score (NEWS) to assess patient deterioration. The NEWS is a tool, used by staff, to quickly determine the degree of patient illness, based upon six cardinal vital signs and patient observation. The NEWS was completed on an electronic, handheld device and a high scoring NEWS immediately flagged for escalation.

Staff followed a policy for the early identification and treatment of sepsis. Any patient with suspected or recognised sepsis, as identified using the NEWS, would be placed on the UK Sepsis Trust’s Sepsis Six care bundle. Sepsis Six is the name given to a set of clinical tasks, to be carried out within one hour of the suspected deterioration. Sepsis training was ongoing and annual requirement, capturing both new and existing staff. A trust-wide monthly sepsis audit was carried out to monitor compliance and address training needs.

Staff we spoke with had a good understanding of the signs and symptoms of sepsis and knew how to respond if they identified concerns. However, we found sepsis documentation was poor. For example, we found evidence in a patient’s record that the patient had not been screened for sepsis, despite the documentation stating that screening was required on admission.

The World Health Organisation’s Five Steps to Safer Surgery is a surgical safety checklist made up of five steps: briefing, sign-in, timeout, sign-out and debriefing. It is advocated by the National Patient Safety Agency (NPSA) for all patients undergoing surgical procedures in order to reduce
the number of patient complications and mortalities. Staff were required to complete the safer surgery checklist during all surgical procedures, including interventional radiology.

In late 2017, the trust began a major project to revitalise the checklist and ensure compliance. From this project, the trust introduced a modified checklist in December 2017. The modified checklist placed a higher emphasis on the initial brief stage. We observed staff in both main theatres and the Day Surgery Unit completing the checklist. Although most staff completed the checklist correctly, on two occasions we observed staff fail to complete the sign out stage of the checklist following interventional radiology.

The service audited safer surgery checklist compliance both at a managerial level and via anonymous staff surveys. Anonymity ensured staff felt confident to report when the checklist had not been complied with and the individual responsible. Data supplied by the trust showed that although staff compliance had improved from August 2017 to February 2018, there were still some aspects of the checklist that were not consistently completed. By not consistently completing all aspects of the checklist, staff were putting patient safety at risk.

Following the never event in May 2018 and subsequent thematic review, the trust was in the process of reviewing their local safety standards for invasive procedures (LocSSIPs). LocSSIPs are based upon the National Safety Standards for Invasive Procedures (NatSSIPs), and build on the safer surgery checklist, standardising key elements of procedural care and reinforcing the importance of education to patient safety.

Staff monitored the post-operative observations of patients who had undergone day surgery requiring general anaesthetic.

Staff had access to consultant input 24 hours a day, seven days per week. Staff confirmed that consultants could be accessed for advice at all times and junior doctors could contact surgical registrars for support when required.

Staff knew how to access specialist support for patients with mental health needs. Patient care records showed evidence of involvement from the mental health liaison team for patients with mental health needs. Staff reported that the team responded in a timely manner when requested.

**Nurse staffing**

**Although vacancy rates were high, ward staffing levels and skill mix were planned and reviewed so that patient needs were met. In theatres, the trust was trialling reduced staffing levels for some local anaesthetic procedures, against national guidance.**

The trust undertook a six-monthly staffing review to monitor staffing levels for patient safety, using a nationally recognised safer staffing tool. The tool assessed patient acuity and dependency to ensure nursing establishments reflected patient needs.

Staffing was also reviewed daily at the trust-wide bed meetings. The meetings identified wards and departments that had significant absences or required additional support. On a shift by shift basis, matrons ran daily safety huddles to adjust staffing levels based on patient acuity. From what we observed during inspection, staffing levels met the needs of patients and the demands of the service. Staffing levels were displayed on all the wards we inspected.

The table below shows the trust’s actual versus planned staffing levels within surgery. There were 66.5 whole time equivalent (WTE) vacancies for qualified nursing staff.
### Site

<table>
<thead>
<tr>
<th>Site</th>
<th>Actual staff (WTEs)</th>
<th>Planned staff (WTEs)</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broomfield Hospital</td>
<td>303.7</td>
<td>370.2</td>
<td>82.0%</td>
</tr>
</tbody>
</table>

**Vacancy rates**

From June 2017 to May 2018, the trust reported a vacancy rate of 17.9% for qualified nursing staff in surgery. This was higher than the trust target of 15.4%. Certain wards and areas had higher vacancy rates including in theatres, recovery, the Day Surgery Unit and John Ray Ward.

Service leads identified staffing as one of their biggest concerns and were actively looking at ways to recruit and retain staff, while mitigating risk. For example, the service had financially supported staff to undertake additional training and had introduced a number of junior sister positions to support senior sisters manage the wards. The trust also had an oversees recruitment programme and ran open days to promote recruitment.

As a result of the high vacancies within theatre, the trust had a high cancellation rate for elective operations, when compared to the national average. In an attempt to reduce the high cancellation rate, in September 2018, the service started trialling reduced staffing levels for some low-risk local anaesthetic surgery. Theatre sessions would be staffed in accordance with the acuity of patients booked. The service hoped the trial would reduce the dependency on agency and bank staff, subsequently reducing cancellations and improving care pathways.

However, during this trial, staffing levels in theatres did not meet best practice, as recommended by the Association for Perioperative Practice (AfPP). The AfPP is a national group supporting staff working in the perioperative setting. The guidance from the AfPP on ‘Staffing for patients in the perioperative setting’ (2014) recommends a minimum of one anaesthetic practitioner, two scrub practitioners, one circulating practitioner and one recovery practitioner. Staff in theatre expressed concerns around the trial and its deviance from national guidelines. Staff also felt their concerns were being dismissed by senior management.

**Turnover rates**

Although the service reported a turnover rate of 7.8% for qualified nursing staff in surgery, the trust declared an issue with the collection of their data. As a result, the turnover figure is likely to be higher than that submitted.

**Sickness rates**

From May 2017 to April 2018, the trust reported a sickness rate of 3.1% for qualified nursing staff in surgery. This was lower than the trust target of 4.24%.

**Bank and agency staff usage**

From May 2017 to April 2018, the trust reported that 7.9% of healthcare worker shifts in surgery were filled by bank staff, while 0.01% of shifts were filled by agency staff. In addition, 0.8% of shifts were left unfilled.

Over the same reporting period, the trust reported that 8.5% of qualified nursing shifts in surgery were filled by bank staff and 4.5% of shifts were filled by agency staff. In addition, 1.0% of shifts were left unfilled. The table below shows the total number of shifts filled for each staff group.

| Healthcare Worker | | | Total |
|--------------------|---------|---------|
| Number | %       | Number | %       | Number | %     |
| Bank   | 4,687  | 7.9%    | 8,331  | 8.5%    | 13,018 | 8.3%  |
Agency staff completed an orientation checklist before working on a ward or in theatres. Ward sisters told us that they tried to use the same bank and agency staff to promote continuity of care for patients.

Staff we spoke with felt confident to escalate any concerns about staffing to senior leaders. However, staff did not always feel senior staff listened to their concerns.

**Medical staffing**

**Medical staffing adequately met the needs of patients.**

Surgical medical staff worked on a rota, which provided medical cover to the wards 24 hours a day, seven days per week. Staff reported sufficient medical cover on the surgical wards we visited. In the event of gaps in the rota, the service used locum doctors. Many of these locum doctors were regular and considered part of the team.

**Vacancy rates**

From June 2017 to May 2018, the trust reported a vacancy rate of 10.4% for medical staff in surgery. This was lower than the trust target of 15.4%. The table below shows the trust’s actual versus planned medical staffing levels within surgery. There were 29.7 whole time equivalent (WTE) vacancies for medical staff.

<table>
<thead>
<tr>
<th>Site</th>
<th>Actual staff (WTEs)</th>
<th>Planned staff (WTEs)</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broomfield Hospital</td>
<td>172.8</td>
<td>202.5</td>
<td>85.3%</td>
</tr>
</tbody>
</table>

**Turnover rates**

As with nursing staff, the trust reported a turnover rate of 12.6% for medical staff but declared an issue with the collection of their data. As a result, the turnover figure is likely to be higher than that submitted.

**Sickness rates**

From May 2017 to April 2018, the trust reported a sickness rate of 0.4% for medical staff in surgery. This was lower than the trust target of 4.24%.

**Bank and locum staff usage**

The trust was unable to supply the total number of shifts worked by all medical staff, including permanent medical staff. This meant that the proportions of shifts worked by medical bank and locum staff could not be calculated.

Both nursing staff and junior doctors across the service reported timely access to consultants, if required. Within general surgery, there was an on-call (off site) consultant available 8pm to 8am, Monday to Friday. An anaesthetist was on site until 9pm during the week and on call 24 hours a day, seven days a week. For each surgical speciality, the trust had separate on call arrangements. During the week, consultants were on site until at least 6pm, and then available on call. At weekends, consultants were on site to complete ward rounds and emergency surgery when required.
Skill mix
As of March 2018, the proportion of consultant staff and junior (foundation year 1-2) staff working at the trust was similar to the England average. The graph below shows the staffing skill mix for the 245 WTE medical staff working in surgery at the trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>47%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>12%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>32%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>9%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

Records

Staff stored records in a secure way that ensured patient confidentiality. However, records were not completed or managed in a way that kept people safe.

In May 2017, the trust implemented a new electronic patient record system. Following this, various teething problems had emerged including inaccurate patient tracking and referral to treatment data. Therefore, at the time of our inspection, staff were still using paper records to document patient care and treatment. Paper records were stored securely in lockable trolleys.

Staff also used an electronic, handheld device to record a patient’s clinical observations. The device alerted users if the recorded vital signs were outside acceptable limits.

As part of our inspection, we reviewed the records of 20 patients. Patient care records were not completed or managed in a way that kept people safe. Records were poor in their completion and clarity. Most records contained various incomplete risk assessments including risk assessments for infection, malnutrition and pressure sores.

Sepsis documentation was poor. In one record we saw the patient had not been screened for sepsis, despite the documentation stating that screening was required on admission. In another record we found the sepsis checklist had not been completed. We found in another record, the sepsis pathway had been completed but there was no date or patient name attached to the documentation.

We also found the process of documenting venous thromboembolism (VTE) needed improvement. Staff completed the venous thromboembolism (VTE) risk assessments on an electronic, handheld device. They were then required to tick a box on the patient’s drug chart and paper record to confirm that this had been completed, ensuring all staff knew whether a patient had been risk assessed. However, the box on the patient’s paper record was rarely ticked. This meant staff did not always know by looking at a patient’s record, if a patient had had a VTE risk assessment or
not. Each time this was not ticked, staff had to manually check an electronic, handheld device to find out whether the patient had received a VTE assessment. Staff told us that this was a cumbersome and time-consuming process.

Service leads were aware that patient documentation needed to improve and regularly audited compliance. Results from an audit completed in March 2018 showed poor staff compliance with the trust’s clinical record keeping standards policy. The audit showed that staff working on both the surgical and medical wards were not consistently making legible entries to patient records, nor were they ensuring records identified the patient’s NHS number or were signed and dated. Following the audit, a documentation review was currently underway, with the aim to streamline the process trust-wide.

Staff used a ‘patient passport’ document for patients with additional needs. The passport provided important information for staff to ensure care was tailored to individual needs.

Discharge summaries were sent to the patient’s GP to ensure continuity of care within the community.

**Medicines**

**Medicines were stored securely. However, controlled drugs were not always appropriately managed, in line with trust policies.**

The trust’s clinical pharmacy service was available Monday to Friday, 9am to 5.15pm. The service provided medicine reconciliation, clinical advice, patient counselling and preparation for discharge. Outside of these hours, staff could contact an on-call pharmacist and had access to a secure emergency drug cupboard. Each surgical ward had a designated pharmacist and technician, available Monday to Friday. An aseptic service was available 8am to 5.15pm, Monday to Friday.

Medical staff prescribed medicines. The pharmacy department also had a number of pharmacists who were trained to prescribe certain medicines. Pharmacy staff completed medicines reconciliation in a timely manner. However, when patients were transferred between wards, their medicines were not always transferred with them.

We reviewed 10 prescription charts and found that they had all been verified by a pharmacist. Of the ten reviewed, three patients had been transferred from another ward. We found eight incidences where a transferred patient had missed a dose of medicine. We asked nursing staff what action had been taken following a missed dose and were told that the pharmacist had been informed.

We saw evidence of antimicrobial stewardship with regular multidisciplinary ward rounds and appropriate endorsements on drug charts. Drug charts also showed allergy statuses and venous thromboembolism (VTE) risk assessments had been completed, and the relevant low molecular weight heparin (LMWH) was prescribed, if required.

Medicines were stored securely. In each area we visited, staff stored all medicines in a locked cupboard or fridge, in secure clinical rooms. Oxygen cylinders were also stored securely. Staff checked and logged fridge and room temperatures daily to ensure medicines were stored at the correct temperature. We saw evidence that when an irregular temperature was recorded, staff escalated this to the pharmacy team.

In each area we visited, we undertook a random check of medicines and controlled drugs (CD). All medicines and CDs checked were within their expiry date.

We also reviewed the controlled drugs register on John Ray Ward, Notley Ward and Heybridge Ward. We found controlled drugs were not always appropriately managed and staff did not always
follow the trust's CD management policy. For example, we saw evidence that staff were not correctly documenting mistakes or missed doses. On Notley Ward, we found the Oxycontin stock did not match what was recorded in the controlled drugs register, following a missed dose. We raised this with the senior sister who was not aware of the incident.

The pharmacy team conducted quarterly CD audits and the results were sent to the ward managers to disseminate amongst staff. However, there was no accountability process to ensure that action plans were implemented to improve future audit outcomes. There was also no evidence of clinical audits to monitor compliance with medicine management policies or patient safety alerts, despite the service reporting a high number of medicine errors. From June 2017 to May 2018, there were 113 administration medication errors and 35 prescribing errors attributed to surgery.

Incidents

Systems to report, record and investigate medicine incidents were not robust. Staff received feedback from incidents they reported but we were not assured that learning from incidents was consistently shared amongst wider teams. Changes made from never events were not embedded in clinical practice.

Incidents were reported using the trust’s electronic recording system. Staff we spoke with knew how to report incidents and could give examples of the recent incidents they had reported. However, we found evidence to suggest that systems to report, record and investigate medicine incidents were not robust. On Notley Ward, for example, we saw that staff had not documented when a patient had missed their morning dose. Staff told us that this had not been recorded as an incident or discussed at their daily safety huddle. Staff could not give any examples of learning from medicine incidents. We had concerns that, as staff were not aware of any lessons learnt, there was a chance that an incident could be repeated.

Never Events

Never events are a type of serious incident that is wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

From August 2017 to July 2018, the trust reported five incidents classified as never events in surgery. The first never event was categorised as “retained foreign object post procedure” and occurred in August 2017. The root cause analysis (RCA) found the main contributing factors were that the safer surgery checklist had not been adhered to and that nursing staff did not feel empowered to escalate their concerns. Following the never event, the trust developed an action plan to address the concerns found in the RCA.

The remaining four never events were all categorised as wrong site surgery and occurred in November 2017, May 2018, May 2018 and June 2018. Following the second never event in May 2018, the trust conducted a thematic review to identify risk and common themes. The review highlighted that the safer surgery checklist had not been adhered to on each occasion and that there was a failure to embed the principles of the National Safety Standards for Invasive Procedures.

Service leads described various action that had been taken following each never event. Action included: collaborating with a neighbouring trust to review theatre process and policies; modifying the safer surgery checklist; researching staff behaviour; and creating flowcharts as an aide-memoir. The service tried to promote an open culture where staff felt confident to speak up regarding poor practice.

However, we were not assured that the actions plans were robust or that changes made from
each never event had become embedded in clinical practice. All never events had the same contributing factor (non-compliance with the safer surgery checklist) suggesting a poor safety culture. The service leads agreed that the safety culture had been poor but felt it was improving, as staff felt more confident to challenge poor behaviour.

Breakdown of serious incidents reported to the strategic executive information system (STEIS)
From August 2017 to July 2018, surgical staff reported 46 serious incidents. Serious incidents are adverse events, where the consequences are so significant or the potential for learning is so great, that a heightened level of response is justified.

The breakdown by incident type was as follows:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>No. of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcer</td>
<td>13</td>
<td>28.3%</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident</td>
<td>8</td>
<td>17.4%</td>
</tr>
<tr>
<td>Slips/trips/falls</td>
<td>6</td>
<td>13.0%</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>5</td>
<td>10.9%</td>
</tr>
<tr>
<td>Healthcare associated infection/infection control incident</td>
<td>3</td>
<td>6.5%</td>
</tr>
<tr>
<td>Treatment delay</td>
<td>3</td>
<td>6.5%</td>
</tr>
<tr>
<td>Diagnostic incident including delay (including failure to act on test results)</td>
<td>3</td>
<td>6.5%</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient</td>
<td>3</td>
<td>6.5%</td>
</tr>
<tr>
<td>Medical equipment/devices/disposables incident</td>
<td>2</td>
<td>4.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>46</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

The time taken by the trust to report these SIs to STEIS was variable:

<table>
<thead>
<tr>
<th>Time to report</th>
<th>No. of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 14 days</td>
<td>18</td>
<td>39.1%</td>
</tr>
<tr>
<td>15 to 30 days</td>
<td>4</td>
<td>8.7%</td>
</tr>
<tr>
<td>31 to 60 days</td>
<td>10</td>
<td>21.7%</td>
</tr>
<tr>
<td>61 to 90 days</td>
<td>5</td>
<td>10.9%</td>
</tr>
<tr>
<td>90 days or more</td>
<td>9</td>
<td>19.6%</td>
</tr>
</tbody>
</table>

Staff told us they would receive feedback from their manager if they had been directly involved in an incident. Staff also received information about incidents at the daily safety huddle and through trust safety alerts. Trust alerts were emails that contained important safety information and were disseminated to all staff. We saw ward managers had printed the emails and displayed them in staff rooms for all staff to see. A recent trust alert had followed a sharps injury and reminded staff of the trust policy when disposing dirty scrubs.

Staff gave examples of local changes in practice following an incident. For example, following an incident on the Day Surgery Unit where a patient suffered a cardiac arrest, all staff on the unit now received training in immediate life support.

However, we were not assured that feedback from serious incidents and never events was consistently shared among wider teams. During our inspection, we spoke with four medical staff, who had either little knowledge or interest in the recent surgical never events. There was a risk that incidents could reoccur if staff were not aware of the actions taken to improve patient safety.
The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Information about the duty of candour was included in the trust’s corporate induction programme. Staff we spoke with were aware of the principles of duty of candour and could give examples of when it should be triggered.

**Safety Thermometer**

Surgical services monitored safety performance using the NHS safety thermometer. The safety thermometer is a monthly snapshot audit, used to record the prevalence of patient harm and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. The types of harm the trust monitored included falls, catheter urinary tract infections (UTI) and pressure ulcers.

From June 2017 to June 2018, surgery services reported 49 new pressure ulcers, 12 falls with harm and 22 new UTIs in patients with a catheter. The graphs below show the prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and new UTIs in patients with a catheter within this period.

Safety thermometer data was presented to the board quarterly, via the integrated quality and performance board report. Staff gave examples of how they were working to reduce patient harm. For example, the trust’s tissue viability nurse had started to run healthcare support worker study days that focussed on pressure ulcer prevention.

**Is the service effective?**

**Evidence-based care and treatment**
Staff delivered care and treatment in line with evidence-based practice.

Staff had access to policies and guidance through the trust intranet and in paper format. The policies we saw were version controlled, ratified and included clear dates for review. For example, we reviewed the preoperative fasting policy for adults and children, and found it was ratified, in date for review and referenced various national guidance such as guidelines from the American society of Anaesthesiologists and the Association of Anaesthetists of Great Britain and Ireland (AAGBI).

Policies ensured discriminatory factors including age, gender or disability, were protected when making care and treatment decisions.

The clinical audit team were responsible for reviewing trust policies to ensure they were in accordance with the latest National Institute for Health and Care Excellence (NICE) guidance and updated them when required. Service leads were alerted to any new policy changes and would disseminate changes to their team.

Patients receiving rehabilitation had personalised care plans which were in line with relevant good-practice guidance and set out clear outcome goals. We spoke with physiotherapists and occupational therapists who could all describe the recognised assessment tools used for patients during their rehabilitation.

There were a number of evidence-based pathways for staff to follow for specific conditions. For example, for any patient with suspected or recognised sepsis, they would be placed on the UK Sepsis Trust’s Sepsis Six care bundle. The bundle was drawn from national guidelines and has been shown to reduce the risk of death by 46.6%.

There was a comprehensive local audit schedule to monitor performance. We saw that key findings from local audits were documented, with actions for improvement. For example, in June 2017, the service audited the general surgery weekend handover for compliance against the Royal College of Surgeons guidelines for safe handovers. The results were poor and subsequently a pro forma document was designed and made available to staff on the intranet. A re-audit following the introduction of the document showed a marked improvement.

Nutrition and hydration
Staff understood the importance of nutrition and hydration for effective care and treatment.

Aids for drinking and eating were available and we observed patients using them. On each ward, patient meal times were protected to ensure patients could have their meals without being interrupted. Staff told us they encouraged carers to support patients with eating and drinking where appropriate. The trust had also introduced mealtime companions to support patients with their meals.

Catering staff were able to accommodate special dietary needs, including food allergies and needs relating to religion and culture. Dietitians could provide specific instruction to the catering staff for special-request items.

Dieticians could also provide advice for patients who had undergone certain types of surgery, for example, bowel surgery.

Nutritional risk was assessed using the Malnutrition Universal Screening Tool (MUST). The tool is a five-step process, used to identify adults who are malnourished, at risk of malnutrition (undernutrition), or obese. Any patients found to be at risk of malnutrition would have a specialised care plan in place. Staff used a specific assessment tool to assess the nutritional
needs of patients living with dementia.

Staff followed good practice guidelines in relation to preoperative fasting, endorsed by the Association of Anaesthetists of Great Britain and Ireland. Preoperative fasting is intended to prevent pulmonary aspiration of stomach contents under general anaesthesia.

Pain relief

Staff assessed and managed patient pain well.

Staff used the national early warning score (NEWS) to assess patient deterioration. The tool included a numerical scale to assess and record patient pain. Staff used the Abbey Pain Scale to assess the pain in patients who could not verbalise, for example, in patients living with dementia.

Patients told us their pain was well managed and that nursing staff administered pain relief in a timely manner.

The service had a specialist pain team who visited the wards daily. They provided advice and support to patients and staff, for example, when using patient controlled painkillers.

Patient outcomes

Information about the outcomes of patient care and treatment was routinely collected and monitored.

Service leads updated key performance indicators monthly onto a quality scorecard. Quality performance data was also displayed on wards, allowing patients, visitors and staff to see how the service was performing.

Local audit programmes were used to measure outcomes for patients and drive improvements to the service. On Heybridge Ward, the matron had introduced a weekly assurance audit to monitor standards of cleanliness and hygiene, and to monitor equipment compliance with safety standards. There were also trust-wide audits, such as the falls and fragility fractures audit programme, aiming to improve the management of patient falls.

Relative risk of readmission

One way to assess the effectiveness of care and treatment is to review readmission rates. From March 2017 to February 2018, patients at the trust had a higher than expected risk of readmission for elective admissions, when compared to the England average. Over the same reporting period, patients at the trust had a similar to expected risk of readmission for non-elective admissions, when compared to the England average.

The service participated in national audit programmes to measure and compare performance against similar services. The service was performing in line with expected outcomes for most of the national audits in which it participated.

National Hip Fracture Database

In the 2017 National Hip Fracture Database, the trust’s risk-adjusted 30-day mortality rate was 9.0%, which was within the expected range.

The proportion of patients having surgery on the day of, or day after, admission was 71.7%, which failed to meet the national aspirational standard of 85%. This was within the middle 50% of trusts.
The crude perioperative medical assessment rate was 95.4%, which failed to meet the national aspirational standard of 100%. This was within the middle 50% of trusts.

The proportion of patients documented as not developing a pressure ulcer was 98.2%, which failed to meet the national standard of 100%. This was within the middle 50% of trusts.

The crude overall hospital length of stay was 16.5 days, which fell within the lower 25% of trusts.

The audit was reviewed by the trust and areas for improvement were identified, specifically the time patients were waiting to attend theatre. The trust told us that although no action plan had been created, time to theatre was discussed regularly at divisional governance meetings.

**National Bowel Cancer Audit**

The risk-adjusted two-year post-operative mortality rate was 26.2%, which was within the expected range.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 40.7%, which was within the expected range.

**National Vascular Registry**

The trust participated in the 2017 National Vascular Registry audit.

The trust achieved a risk-adjusted post-operative in-hospital mortality rate of 0.0% for abdominal aortic aneurysms, which was within the expected range.

For carotid endarterectomy, the median time from symptom to surgery was 74 days, which did not meet the audit aspirational standard of 14 days.

The 30-day risk-adjusted mortality and stroke rate for carotid endarterectomy was 0.0%, which was within the expected range.

Since the audit, the service has redesigned a new symptomatic carotid pathway. An internal re-audit showed the service had improved and was now meeting the 14-day aspirational standard.

**National Oesophago-Gastric Cancer Audit**

In the 2017 National Oesophago-Gastric Cancer Audit, the age and sex-adjusted proportion of the trust’s patients diagnosed after an emergency admission was 7.4%. The audit defines performance of below 15% for this metric as good. Although trust performance is presented, this metric is a reflection of how the strategic clinical network (East of England) functions, and cannot be ascribed to the trust individually. This metric is therefore indicative only.

The trust’s risk-adjusted 90-day post-operative mortality rate was 2.9%, which was within the expected range.

The proportion of patients treated with curative intent in the Strategic Clinical Network (East of England) was 37.5%. This was similar to the national aggregate of 38.6%.

**National Emergency Laparotomy Audit**

The National Emergency Laparotomy Audit awards one of three possible ratings for each indicator. Green ratings indicate performance of over 80%, amber ratings indicate performance between 50% and 80%, and red ratings indicate performance under 50%.

In the 2016 audit (based on data from December 2015 to November 2016), Broomfield Hospital
achieved a green rating for the crude proportion of cases with pre-operative documentation of risk of death. Risk of death was documented in 81% of cases compared to the national aggregate of 71%. This was based on 100 cases.

The hospital achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 58 cases.

The hospital achieved an amber rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 57 cases.

The hospital achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 43 cases.

The hospital’s risk-adjusted 30-day mortality was within the expected range. This was based on 100 cases.

**Patient Reported Outcome Measures**

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2016/17, the trust performed similar to the England average for groin hernias according to the EQ VAS index, but better than the England average according to the EQ 5-D index.

The trust performed worse than the England average for total hip replacement according to the EQ VAS indicator. However, according to the EQ-5D index and Oxford Hip Score, its performance was similar to the England average.

The trust performed similar to the England average for total knee replacement according to all three indexes.

The trust’s performance for varicose veins was similar to the England average according to the
Aberdeen varicose vein questionnaire, but better than the England average according to the EQ VAS and EQ-5D indexes.

Competent staff
Staff had the appropriate skills, knowledge and experience to deliver effective care and treatment.

New staff were required to attend a corporate induction and complete a local induction programme. There were also competency assessments for new nursing and healthcare staff. All new staff received a competency booklet dependent on their role and were allocated a mentor. Competencies included medicine management, swab instrument and scrub count, theatre management and environmental cleaning. All competencies required sign off by the mentor.

Due to high vacancy rates and to ensure safe staffing levels were met, the trust employed bank and agency staff. All agency staff working on the wards were required to complete an orientation checklist and those working in theatres were required to complete an induction pack. This ensured agency staff were competent and knew how to respond in an emergency. Despite the induction pack, theatre staff raised concerns that working with agency staff placed strains on the team as they had to constantly supervise agency nurses, while caring for their own patient. Divisional leads were aware of this risk and it was being monitored on the theatre risk register.

Appraisal rates
The trust had arrangements for staff supervision and appraisal. Staff identified their learning needs and development opportunities through their yearly appraisal. From June 2017 to May 2018, 79.3% of staff in surgery received an appraisal, matching the trust target of 79%. The table below shows appraisal data, broken down by staff group.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>June 2017 to May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Completed</td>
</tr>
<tr>
<td>Medical staff</td>
<td>168</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>16</td>
</tr>
<tr>
<td>NHS infrastructure support staff</td>
<td>42</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>201</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic, technician staff</td>
<td>34</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>123</td>
</tr>
<tr>
<td>Grand Total</td>
<td>584</td>
</tr>
</tbody>
</table>

Nursing staff told us they had been supported with their revalidation through clinical supervision. Revalidation is the process where nurses renew their registration with the Nursing and Midwifery Council.

The trust supported medical, nursing and therapy students on placement. All junior medical staff were allocated a clinical supervisor at consultant level. All clinical supervisors had completed training for their role and supported junior doctors with their local induction and end of placement report.

The trust provided staff with the training to deliver effective care, support and treatment. However, high levels of clinical demand meant that staff could not always be spared to attend training. Theatres ran a monthly audit session where staff received equipment demonstrations and face-to-face training. Staff could also make suggestions as to what training they would like to receive.
Additional training opportunities were publicised at team meetings and on staff notice boards. Staff told us that they were supported to pursue additional training opportunities, relevant to their role. For example, the service ran a ‘prevent the pressure’ study day following an increase in pressure ulcers. The trust’s tissue viability nurse led the day and taught staff how to safely care and manage pressure ulcers. The service also held three ‘bone’ study days where staff were shown how to correctly apply plaster casts.

**Multidisciplinary working**

**There was effective multidisciplinary working across the service. However, we were not assured that teams effectively shared information on never events.**

There were good working relationships between medical and nursing staff on the wards. In theatres, we were told that the relationship was improving, as staff felt more confident to challenge poor behaviour.

The service held weekly multidisciplinary team (MDT) meetings to discuss, in detail, the needs of patients. All members of the MDT were involved with assessing, planning and implementing patient care. Multidisciplinary teams included medical, nursing and therapy staff. Staff also held daily board meetings and safety huddles to discuss and plan patient care.

The service had daily input from physiotherapy, occupational therapy and pharmacy staff. The trust-wide pain team also visited the wards daily. Staff were able to make electronic patient referrals to the wider multi-disciplinary team, including for speech and language, dietary and psychology services. A microbiologist had started to attend wards on a weekly basis to improve the discharge process. Staff were positive about the addition of the microbiologist and felt they had learnt a lot.

We observed care was delivered and reviewed in a coordinated way across surgical wards and theatres. However, we were not assured that theatre and ward staff effectively shared information, specifically around never events. When asked, staff could not give an example of a never event that had occurred outside their speciality, despite five never events occurring between August 2017 and July 2018.

There was evidence of strong external MDT links. As part of the Mid and South Essex Success Regime, service leads were liaising with their counterparts in two local trust to develop county-wide pathways for certain specialities, such as ophthalmology. Staff also had strong working links with other services and agencies such as the Friends of Broomfield, local hospices and the voluntary sector.

**Seven-day services**

**Staff were working towards a seven-day service.**

Acute and emergency surgical services were available 24 hours a day, seven days a week. Medical cover, outside of normal working hours, was provided on a rota basis. There was also an on-call consultant surgeon, who could be contacted by telephone and attend the hospital within 30 minutes. An anaesthetist was on site until 9pm during the week and on-call out of hours.

Emergency computed tomography (CT) scans and x-rays were available 24 hours a day, seven days per week. There was also access to pathology services and the microbiology laboratory, 24 hours a day, seven days a week, to support clinical decision making. Magnetic resonance imaging (MRI) scans were available 8am to 8pm Monday to Friday, and 9am to 4pm at weekends. A consultant delivered interventional radiology 9am to 5pm during the week. At weekends,
consultants worked 9am to 6pm and covered both Mid Essex Hospital Services NHS trust and two local trusts.

The pharmacy service was available Monday to Friday, 9am to 5.15pm. Outside of these hours, staff could contact an on-call pharmacist. Physiotherapists and occupational therapists were available Monday to Friday.

The Day Surgery Unit was open from 7am Monday to 3pm Saturday. The unit ran a 24-hour advice line, manned by trained staff, for patients with concerns following discharge. Although the unit closed at 3pm on a Saturday, staff reported that the trust had been re-opening the unit on a Sunday as an escalation area. If the patients were still on the unit on a Monday morning, this had an impact on the day surgery service.

NHS England’s seven-day services programme was designed to ensure patients that were admitted as an emergency, received high quality consistent care at all times. The Academy of Medical Royal Colleges (AoMRC) proposed four priority standards that all seven-day services should achieve, no matter when or where patients were admitted. At the time of our inspection, the trust was not meeting Standard 5: access to diagnostic tests. However, in collaboration with two local trusts, the trust had plans to develop the emergency MRI service to 24 hours a day, seven days a week.

In March 2017, the trust conducted an audit to measure trust performance against Standard 2: time to first consultant review. The results showed that 88% of surgical patients were seen and assessed by a suitable consultant within 14 hours of their admission. This was against a national target of 90%. In a re-audit, completed in September 2017, trust performance had significantly declined to 65%. Following the results of this audit, seven-day service meetings were to be set up to plan and monitor progress against the standards.

Health Promotion

The service supported people to live healthier lives.

Staff in the pre-assessment clinic gave patients information on how to prepare for surgery and how to improve their recovery after surgery. This included information on early mobilisation with a physiotherapist and information on post-operative pain relief.

Staff gave patients written information on rehabilitation, including information on their post-operative exercises, prior to surgery. This allowed patients to familiarise themselves with the rehabilitation process before they went in for surgery. Patients also had access to information leaflets for smoking cessation support, diabetes support and mental health services.

Staff worked hard to help patients maintain their independence and manage their own health, in order to improve their outcomes. Patients were encouraged and supported to mobilise as soon as possible after surgery.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Consent to care and treatment was sought in line with legislation and guidance, however not all staff had completed Mental Capacity Act training.

The Mental Capacity Act (2005) is designed to protect patients who may lack capacity, to make certain decisions about their care and treatment. Information about the Mental Capacity Act (2005) and associated Deprivation of Liberty Safeguards (DoLS) was covered as part of staff mandatory training.

Mental Capacity Act and Deprivation of Liberty training completion
The trust identified some anomalies in their Mental Capacity Act (MCA) level 2 training in the process of compiling the data to send to us.

From June 2017 to May 2018, the trust reported that 87.5% of staff in surgery had completed Mental Capacity Act (MCA) level 1 training, against a trust target of 90%. Within the same reporting period, only 22.8% of staff in surgery had completed Mental Capacity Act (MCA) level 2 training, against a trust target of 90%. A breakdown of compliance for MCA training for surgical nursing staff and medical staff is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>June 2017 to May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Nursing staff – MCA Level 1</td>
<td>244</td>
</tr>
<tr>
<td>Nursing staff – MCA Level 2</td>
<td>70</td>
</tr>
<tr>
<td>Medical staff – MCA Level 1</td>
<td>162</td>
</tr>
<tr>
<td>Medical staff – MCA Level 2</td>
<td>22</td>
</tr>
</tbody>
</table>

Patients received information about their planned surgery during their pre-operative appointment. We observed staff explaining procedures to patients, identifying possible risks and seeking their consent. We observed theatre staff confirming patients’ consent to procedures and confirming the patient’s details before surgery was carried out.

We saw patient records contained consent forms and if appropriate, Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms. On one DNACPR form we found no evidence that a discussion with patient or healthcare team had taken place.

Inaccurate use of consent to surgery forms was identified as a risk on the theatre risk register. Local controls had been put in place and an observational audit in September 2018 showed improvements had been made.

From June 2017 to May 2018, there were 37 DoLS applications submitted within surgery. Staff were able to explain the process for submitting a DoLS application and ensured best interest decisions were made in accordance with legislation.

Is the service caring?

Compassionate care

Staff provided compassionate care, treating patients with dignity and respect.

There were dedicated male and female only bays, as well as side rooms, to help maintain patient dignity. Staff knocked and sought permission before entering patient rooms. We also saw examples of staff respecting patient confidentiality and privacy. Staff used coded symbols to restrict the amount of patient information on display, and we saw staff drawing curtains around bed spaces when treating patients or having sensitive conversations.
We observed all staff to be courteous, professional and kind when interacting with patients. We observed staff greet patients appropriately, and introduce themselves by name. Patients told us that staff were attentive and we observed that call bells were answered in a timely manner.

Patient feedback was consistently positive. The patients we spoke with said that staff were caring and considerate. Surgical wards and units displayed patient ‘thank you’ cards. Comments from the cards showed patients felt they had been treated with compassion.

Patients could provide feedback on the service using the Friends and Family Test (FFT). The FFT asks patients if they would recommend the services they have used to their friends and family. From July 2017 to June 2018, the FFT response rate for surgery was 22.8%, based on 8,696 responses. This response rate was lower than the England average of 28%.

The table below shows the FFT performance by surgical ward from July 2017 to June 2018. Although all wards scored 80% or more for their annual performance, Rayne Ward and the Surgical Emergency Ward scored less than 80% for several months within the reporting period.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Responses</th>
<th>Response Rate</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Surgery unit</td>
<td>5,654</td>
<td>21%</td>
<td>92%</td>
</tr>
<tr>
<td>Heybridge Ward</td>
<td>314</td>
<td>25%</td>
<td>87%</td>
</tr>
<tr>
<td>John Ray Ward</td>
<td>347</td>
<td>35%</td>
<td>87%</td>
</tr>
<tr>
<td>Rayne Ward</td>
<td>346</td>
<td>25%</td>
<td>71%</td>
</tr>
<tr>
<td>Surgical Emergency Ward</td>
<td>365</td>
<td>30%</td>
<td>86%</td>
</tr>
</tbody>
</table>

**Emotional support**

Staff understood the importance of providing emotional support to patients and those close to them.

We observed staff providing reassurance to anxious patients before their surgery. The trust employed specialist nurses to provide practical and emotional support to patients with specific conditions, such as diabetes.

Therapy teams helped patients develop their independence and regain confidence.

Each ward displayed information about the local support services available. For example, we saw posters on dementia-friendly swimming and support for carers.

Staff had access to a mental health liaison team who could support the mental health needs of patients. Staff reported that the team responded in a timely manner when requested.

Staff understood and respected the spiritual and religious needs of patients. The trust chaplain visited wards to offer emotional support and was available 24 hours a day, seven days a week. Quiet rooms were available for staff to take patients and their relatives when they had received upsetting news.

**Understanding and involvement of patients and those close to them**
Staff communicated with patients about their care and treatment in a way they could understand.

Staff provided patients with relevant information, both verbal and written, so they could make informed decisions about their care and treatment. Patients knew what their therapy goals were and were involved in their development.

The service was in the process of developing adapted information booklets for patients with a learning disability.

 Relatives and carers were treated as important partners in the delivery of care. Staff told us how they supported carers and relatives to provide care on the wards, in order to help prepare them for supporting patients after discharge.

Staff ensured patients and families were able to find further information and support, including community and advocacy services. Staff referred those with specialist needs to other support services within the trust, such as the psychology service.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and delivered services to meet the needs and demands of local people.

Senior leaders worked with the local clinical commissioning groups and healthcare services to improve patient care and access. As part of the Mid and South Essex Success Regime, the trust was developing joint plans in collaboration with two local trusts to bring together some specialist inpatient care, stroke services and planned operations in clinical hubs. This reconfiguration aimed to provide better care and recovery times.

Average length of stay – Broomfield Hospital

From March 2017 to February 2018, the average length of stay for elective patients at Broomfield was 3.6 days. This was slightly better than the England average of 3.9 days.

The table below shows the average length of stay for elective patients in plastics, trauma and orthopaedics, and urology compared to the England average. Plastics, trauma and orthopaedics, and urology were the top three specialties based on elective activity count.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This site</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>3.6</td>
<td>3.9</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>3.8</td>
<td>3.4</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>3.8</td>
<td>3.9</td>
</tr>
<tr>
<td>Urology</td>
<td>1.9</td>
<td>2.5</td>
</tr>
</tbody>
</table>

Within the same reporting period, the average length of stay for non-elective patients was 3.6 days. Again, this was better than the England average of 4.9 days.

The table below shows the average length of stay for non-elective patients in the top three specialities, compared to the England average.
The facilities and premises were appropriate for the services they delivered. The wards and theatres were well equipped and complied with department of health guidelines. The layout of the wards meant that all areas were accessible for people using a wheelchair or walking aids. Day room chairs were a mix of heights to help patients with mobility issues.

Mixed sex breaches are identified by the CQC as a breach of same sex accommodation, as defined by the NHS Confederation. From May 2017 to June 2018, surgery services reported two mixed sex breaches. Both breaches occurred during the same week in the anaesthetic department. The reason for both breaches was “bed capacity” and both were reported by staff using the trust’s electronic reporting system.

Meeting people’s individual needs

Staff planned and delivered services to meet individual needs.

Pre-admission screening was used to plan services to meet individual needs and choices. Patients were also assessed on admission by nursing staff using the nursing assessment tool. The tool assesses a patient’s level of hearing/vision, aids used and adjustments required.

An enhanced recovery programme was available for some surgical procedures led by a clinical nurse specialist. The programme enhanced patient recovery from major surgery within the colorectal, urology, gynaecology and orthopaedic specialities. The programme offered personalised care, support and practical advice prior to, during, and after surgery. All suitable patients were automatically entered onto the programme, ensuring all patients had the opportunity to enhance their recovery.

Staff told us they had access to interpreting services for patients who did not speak English. Patient leaflets and surveys were available in various languages and formats upon request. Staff recorded specific dietary needs at the patient’s pre-operative assessment or on admission. Menu options were available for patients who required special diets, for religious or cultural reasons.

The majority of wards had elected ward ‘champions’ who received additional training in their chosen speciality and attended working groups and conferences. Champions provided their colleagues with training, advice and support on various topics including pain, tissue viability and infection control.

In addition to champions, the trust had clinical leads to identify and meet the individual needs of patients. A learning disabilities specialist practitioner provided staff with support to help meet the needs of patients with a learning disability. Diabetes specialist nurses were responsible for all diabetes-related clinical matters and the delivery of training across the trust. The trust also had establishment for a dementia clinical nurse specialist but, as of May 2018, the post was vacant.

After trialling on Notley Ward, the service had rolled out enhanced support workers to work alongside nursing staff to support patients with complex needs. Enhanced support workers had completed additional training in dementia (Level 3), nutrition and end of life care. They ensured adjustments were made for patients coming onto a ward. They also completed a ‘this is me’
booklet with the patient and relatives, so that staff could better understand and care for the patient. On Lister Ward, the enhanced support workers had created three dementia-friendly side-rooms, which were decorated in soothing colours and had adaptive lighting.

Staff made adjustments to accommodate patients with additional needs. For example, staff could accommodate a relative or friend to stay overnight to support patient’s living with dementia. Staff were also able to enrol onto a virtual dementia course. The course allowed staff to experience how a patient living with dementia sees and hears the world, with the aim of improving care. In the national audit of dementia 2017, the trust was rated highly by dementia carers.

Staff ensured call bells were within reach and we observed call bells were answered in a timely manner by staff on the wards.

Access and flow

The trust was looking at ways to improve flow, as patients could not always access the services they need.

The service ran daily bed meetings to manage theatre access and flow. Wards also ran daily board rounds where staff went over the bed plan for the day, discussed patients ready for discharge and any issues that could present a challenge for timely discharge.

Delayed discharges

From June 2017 to May 2018, the overall delayed discharge rate for surgery was 0.7%. The table below shows the number of delayed discharges by ward/unit. Rayne Ward reported the highest number of delayed discharges. Delays were mainly due to the service awaiting care packages, rehabilitation or social care arrangements, rather than an internal issue in the discharge process.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>No. of delayed discharges</th>
<th>Total discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rayne Ward</td>
<td>97</td>
<td>1,773</td>
</tr>
<tr>
<td>John Ray Ward</td>
<td>13</td>
<td>1,958</td>
</tr>
<tr>
<td>Heybridge Ward</td>
<td>6</td>
<td>1,514</td>
</tr>
<tr>
<td>Notley Ward</td>
<td>5</td>
<td>1,157</td>
</tr>
<tr>
<td>Day Surgery Unit</td>
<td>4</td>
<td>3,718</td>
</tr>
<tr>
<td>Surgical Emergency Ward</td>
<td>2</td>
<td>3,290</td>
</tr>
<tr>
<td>Lister Ward</td>
<td>2</td>
<td>517</td>
</tr>
<tr>
<td>Theatre Admissions Surgical Unit</td>
<td>1</td>
<td>4,601</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>130</strong></td>
<td><strong>18,528</strong></td>
</tr>
</tbody>
</table>

The majority of patients were discharged directly from their bed, however, if needed, the service had access to the trust’s Discharge Lounge. The Discharge Lounge was open to all patients, across all divisions, who had been deemed medically fit for discharge.

The division identified where needs were not being met and set out to improve the service. For example, since June 2018, low-risk orthopaedic elective surgery had moved to the trust’s community hospital in Braintree. The service introduced a streamlined post-operative pathway at Braintree and subsequently reduced length of stay.

As a result of this change, John Ray Ward had spare beds that were not in use. The service had plans to add interventional radiology beds to the ward, with the aim to improve timely access to interventional radiology.
From April 2017 to August 2018, bed occupancy on surgical wards averaged 90.5%. In April 2018, the trust reduced the number of surgical beds and increased the number of medical beds, in the hope of improving emergency flow through the hospital. On Heybridge Ward, six beds were now allocated to respiratory care and six beds to oncology. On Rayne Ward, six beds were now allocated to haematology patients. Service leads recognised the potential impact this move could have on both elective surgery and emergency flow.

Staff on the Day Surgery Unit raised concerns that the unit regularly re-opened on a Sunday as an escalation area. Escalation patients impacted on the flow of the unit, as they all needed to be discharged by a doctor before the day’s surgery list could begin. Staff were reporting contingency patients as an incident for escalation, but felt their concerns were not being listened to by senior management. The senior sister and an anaesthetist consultant had begun to review the clinical operation policy for the unit, to ensure only suitable patients would be admitted. We raised our findings with the divisional leads who recognised this as a concern. They suggested that surgical patient flow would be improved if the unit was governed under the surgery division, rather than the cancer and clinical support services division.

Ward moves at night
Ward moves at night are avoided, where possible, as they can impact patient treatment and recovery. From June 2017 to May 2018, the service reported 516 ward moves at night. The table below shows the number of ward moves at night by ward/unit. The surgical emergency ward reported the highest number of ward moves at night.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>No. of ward moves at night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Emergency Ward</td>
<td>186</td>
</tr>
<tr>
<td>Theatre Admissions Surgical Unit</td>
<td>104</td>
</tr>
<tr>
<td>Notley Ward</td>
<td>97</td>
</tr>
<tr>
<td>Rayne Ward</td>
<td>42</td>
</tr>
<tr>
<td>Heybridge Ward</td>
<td>39</td>
</tr>
<tr>
<td>John Ray Ward</td>
<td>23</td>
</tr>
<tr>
<td>Day Surgery Unit</td>
<td>14</td>
</tr>
<tr>
<td>Theatre recovery</td>
<td>6</td>
</tr>
<tr>
<td>Lister Ward</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>516</strong></td>
</tr>
</tbody>
</table>

The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment. Trusts are required to submit data to NHS England outlining how long patients are waiting for non-urgent treatment.

Following the implementation of a new electronic patient record system, the service has been unable to capture accurate referral to treatment (RTT) data since November 2017. The trust requested and received approval from NHS Improvement to pause their reporting until the teething problems were rectified. The trust developed a recovery plan to return to reporting by July 2018.

Referral to treatment (percentage within 18 weeks) - admitted performance
The trust reported RTT data from June 2017 to October 2017 and in December 2017. The trust’s RTT time for admitted pathways for surgery was consistently worse than the England average. The graph below shows the trust’s RTT performance versus the England average.
Referral to treatment (percentage within 18 weeks) – by specialty

Based on data from June to October 2017, and December 2017, two specialties were above the England average for RTT, while five specialties were below the England average. In trauma and orthopaedics, and ophthalmology fewer than 50% of patients were admitted within 18 weeks of referral. The table below shows the RTT data by speciality against the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENT</td>
<td>77.4%</td>
<td>63.4%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>72.9%</td>
<td>61.3%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>66.6%</td>
<td>81.7%</td>
</tr>
<tr>
<td>Urology</td>
<td>62.2%</td>
<td>76.9%</td>
</tr>
<tr>
<td>General surgery</td>
<td>56.4%</td>
<td>72.8%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>48.9%</td>
<td>69.5%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>39.2%</td>
<td>60.7%</td>
</tr>
</tbody>
</table>

The trust was running additional ophthalmology clinics to reduce the delay in follow-up appointments. The delays were due to general demand exceeding capacity, with an increase in referrals. A reconfiguration project had been set up in ophthalmology, in recognition of an increasing demand for services. The project will review virtual clinics, orthoptist-led follow up clinics, and pathways for minor eye conditions and post-operative cataracts across Essex. The service was also looking to recruit further consultants to meet the demand.

Achievement of the national cancer standards is an indicator of the quality of cancer diagnosis, treatment and care delivered by a trust and is crucial to improving cancer survival rates. The trust had not achieved the 62-day RTT cancer standard since October 2013. The trust held weekly cancer backlog management meetings to discuss performance and review potential patient harm. Results of the cancer recovery plan showed performance was improving and the backlog of breaches was decreasing.

Cancelled operations
A last-minute cancellation is a cancellation for non-clinical reasons on the day of the patient's
operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach.

From April 2016 to October 2017, the percentage of last-minute cancellations at the trust was consistently higher than the England average. Trust performance has fluctuated between quarters, with no evident sustained trend.

The below graph shows the percentage of patients whose operation was cancelled and were not treated within 28 days.

Most cancelled operations were due to limited staffing. The service was trialling reduced staffing in theatres, in order to reduce cancelled operations, but this trial was against national guidelines and unpopular with staff.

**Learning from complaints and concerns**

**There were clear processes for staff to manage complaints and concerns.**

Staff followed an up-to-date complaints policy, which provided guidance on how to manage complaints efficiently. Staff could also refer to quick reference complaint guides displayed on wards. Staff logged all complaints and concerns onto the electronic recording system. The complaints manager triaged complaints and would appoint an appropriate investigating manager to each complaint.

**Summary of complaints**

From June 2017 to May 2018, the trust received 130 complaints about surgery at Broomfield Hospital. For the 114 complaints that had been closed, the trust took an average of 42.4 working days to investigate and close these complaints. This was in line with the trust’s complaints policy which states that complaints should be responded to within 25 working days, or 60 working days for more complex complaints.

The table below shows the nature and frequency of the complaints received within surgery.

<table>
<thead>
<tr>
<th>Subject</th>
<th>No. of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>112</td>
<td>86.2%</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>6</td>
<td>4.6%</td>
</tr>
<tr>
<td>Appointments</td>
<td>6</td>
<td>4.6%</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>3</td>
<td>2.3%</td>
</tr>
<tr>
<td>Communications</td>
<td>3</td>
<td>2.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>130</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>
Summary of compliments
From June 2017 to May 2018, the trust received 164 compliments about surgery at Broomfield Hospital.

The table below shows the number of compliments for each ward/location.

<table>
<thead>
<tr>
<th>Ward or location</th>
<th>No. of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>25</td>
<td>15.2%</td>
</tr>
<tr>
<td>Rayne Ward</td>
<td>20</td>
<td>12.2%</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>20</td>
<td>12.2%</td>
</tr>
<tr>
<td>Day Stay Unit/Theatre Admission Unit</td>
<td>14</td>
<td>8.5%</td>
</tr>
<tr>
<td>Urology</td>
<td>14</td>
<td>8.5%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>11</td>
<td>6.7%</td>
</tr>
<tr>
<td>Breast Care</td>
<td>11</td>
<td>6.7%</td>
</tr>
<tr>
<td>Surgical Emergency Ward</td>
<td>8</td>
<td>4.9%</td>
</tr>
<tr>
<td>Heybridge Ward</td>
<td>8</td>
<td>4.9%</td>
</tr>
<tr>
<td>Notley Ward</td>
<td>7</td>
<td>4.3%</td>
</tr>
<tr>
<td>John Ray Ward</td>
<td>5</td>
<td>3.0%</td>
</tr>
<tr>
<td>Anaesthetics Room</td>
<td>5</td>
<td>3.0%</td>
</tr>
</tbody>
</table>

There were procedures for sharing and learning from complaints across the service. Complaints were discussed at board level via the quarterly PALS and complaints report, and were also discussed locally at safety huddles and team meetings. The learning from complaints was presented within an annual report and shared with all staff. Staff gave examples of changes in the service following patient feedback and complaints. For example, nursing staff attended conflict resolution training with the aim to resolve conflict safely, efficiently and with minimal distress to those involved.

Complaints leaflets, describing the complaints procedure, and complaints posters were observed on wards and units. Patients told us they would feel confident to raise a complaint if necessary. The trust provided patients with information on how to progress a complaint with the ombudsman if they were not satisfied with the trust’s internal complaints process.

Is the service well-led?

Leadership

Service leaders had the capacity and capability to deliver high-quality, sustainable care.

Following a reorganisation, the trust’s surgical division (division two) was delivered across three clinical directorates: the specialist surgery directorate (ophthalmology, oral and maxillofacial, ears nose and throat, audiology) the musculoskeletal directorate (trauma and orthopaedics, and rheumatology) and the surgical specialities directorate (upper gastrointestinal, colorectal, breast, vascular and urology). The division was overseen by a divisional director, clinical director and associate director of nursing, who all reported directly to the executive team. Each directorate was led by a clinical lead, service manager and matron. The anaesthetics and theatres directorate was managed in the cancer and clinical support services division (division three) and followed the same management structure.

The wards and theatres were managed by visible, experienced and enthusiastic leaders. They were knowledgeable about their service and strived to continuously improve it. For example, flow charts had been developed on John Ray Ward describing how to source equipment out of hours.
The charts had been created to rectify a gap in staff knowledge and improve the service. Staff spoke positively about their local leadership. They described feeling valued and supported in their role.

At a senior level, there had been a lot of change and instability within the service. The divisional leads admitted that previous leadership had been disjointed with transient staff and a lack of consistency, but that they now had a full complement of leadership staff and some stability.

Divisional leads felt well supported by the executive team. However, staff working on the wards and in theatres felt the executive team did not always listen to staff concerns or spend much time in clinical areas. To rectify these concerns, the executive team had created a schedule to visit different wards and departments on a monthly basis, in order to improve leadership visibility.

Service leaders understood the challenges to quality and sustainability, and could identify the various actions needed to address them. Ward managers had good oversight of activity, performance, staffing and safety on their ward.

Staff had access to leadership skills and development opportunities. For example, the trust offered a leadership development program to team leaders. One of the matrons within the service had been presented with a leadership award in recognition of their positive leadership.

**Vision and strategy**

**Service priorities aligned with the overall trust strategy, with quality and sustainability as the top priorities.**

At the time of our inspection, there was ongoing work to develop shared working and learning between Mid Essex Hospital Services NHS trust and two local trusts, in the hope of creating a financially sustainable, modern health network. This included the harmonising of patient pathways, practices and procedures, as well as the reconfiguration of some services. The trust was also preparing to merge with the two local trusts into a single NHS Foundation Trust, allowing the trusts to pool resources and invest in the transformation programme.

As part of the reconfiguration, division leads were in the process of reviewing their clinical services to ensure they were delivering the best possible care models across the region. For example, in June 2018, all low risk elective orthopaedic surgery was moved to Braintree Community Hospital. This move allowed for a streamlined post-operative pathway for patients and has reduced the patient’s length of stay.

The trust’s vision was ‘to be a healthcare organisation that puts patient care first and whose reputation for excellence and innovation inspires our patients, staff and the population we service.’ The trust’s communications team ensured that the vision statement underpins key organisation messaging. The trust had developed its values in collaboration with staff and patients. The values were ‘kind’, ‘professional’, ‘positive’ and ‘team’. Staff incorporated the values into their work and our observations supported this.

**Culture**

**Leaders across the service promoted a positive culture that supported and valued staff. Some action had been taken to address behaviour that was inconsistent with the vison and values, but more work still needed to be done.**

Staff well supported in their role and there were opportunities for further learning and development. Staff told us that they were encouraged to go on courses that enabled them to develop personally and professionally.
Senior nursing and medical staff were visible throughout the surgical areas. They were actively involved in the daily management and support of their service. Staff felt able to raise a concern with their manager, and we observed leaders had an open-door policy.

The service was proactively trying to promote an open and honest culture where staff could raise concerns without fear of retribution. The service leads agreed that the safety culture had been poor in theatres, but felt it was improving. They described how previously nursing staff avoided working with certain plastic surgeons because of their poor attitude, but this had now changed.

Although the service had taken some action to address behaviour that was inconsistent with the vision and values, during our inspection, we found further work needed to be done. Some medical staff displayed behaviours that prohibited a positive safety culture. As individual behaviours and actions were identified as contributing factors to recent never events, we had concerns that, unless this changed, there would be a direct impact on patient safety. Theatres had recently introduced anonymous audits of the surgical safety checklist. Anonymity ensured staff felt confident to report when the checklist had not been complied with and the individual responsible.

The trust had appointed a ‘freedom to speak up guardian’. Guardians promoted an open culture, allowing staff to speak up about concerns easily. Eleven concerns had been raised with the trust guardian in 2017/18.

The associate director of nursing for surgery had recently introduced Schwartz Rounds for surgical staff. Schwartz Rounds provide staff with a structured forum to discuss the emotional and social aspects of working in healthcare.

**Governance**

There were clear responsibilities, roles and systems of accountability to support good governance and management. However, some staff felt their concerns were not escalated.

Staff were clear about their roles and understood what they were accountable for. Staff demonstrated a good awareness of governance arrangements and knew how to escalate their concerns. However, in some areas, such as on the Day Surgery Unit and in theatres, staff felt that their concerns were not escalated beyond their line manager.

Information was escalated from ward to board through regular team and management meetings. The minutes for team meetings were circulated to staff via email. These meetings fed into the directorate meetings which, in turn, fed into the surgery division governance meeting. The minutes of these operational meetings showed that incidents, staffing and risks were routinely reviewed by staff at all levels.

The trust had two sepsis leads, responsible for overseeing sepsis management within the trust.

**Management of risk, issues and performance**

There were clear processes for managing risks, issues and performance. However, we were not assured that service risks were always effectively identified.

Each directorate had an electronic risk register, maintained by the clinical lead, service manager and matron. Each risk was given a rating, based on the potential consequence of the risk and the likelihood that the risk would happen. Risks were also given a review date, responsible individual and action plan, in order to mitigate. Risks included high vacancy rates and cancelled elective operations. Progress was regularly recorded on the risk register, demonstrating active management of risks.
We were not assured that risks to the service were always effectively identified and managed. Some concerns we identified during our inspection, for example those relating to poor IPC practice, incomplete records and safety culture, had not been identified by the service as risks.

The service collected performance data via quality dashboards, which provided the board with an overview of how the service was comparing to key quality indicators. The clinical lead, service manager and matron of each directorate attended a monthly performance and accountability meeting, with the trust executive. At the meeting, agenda items included performance across quality and safety, operational performance, and finance.

There was also a programme of clinical audit across the service, which meant senior staff could monitor compliance with safety standards. Where audits had been carried out, there was evidence that service leads had used the results to implement improvements and changes to the service.

**Information management**

**Information management systems and processes were not always effective.**

Staff collected, analysed and managed information using secure electronic systems with security safeguards. However, we found poor record keeping across surgical wards and departments. Furthermore, the trust identified anomalies when collating requested training compliance data. We therefore had concerns about the quality of information collected by the trust.

In May 2017, the trust implemented a new electronic patient record system. Following this, various teething problems had emerged including inaccurate patient tracking and referral to treatment data. To mitigate this, a team of validators were individually reviewing patient waiting times, ensuring the service had accurate waiting time information. The trust’s data quality team actioned regular reports to ensure the information held by the trust was correct.

Service leads monitored quality and risk information through a number of systems, such as governance meetings, local audits and performance dashboards. Performance dashboards were submitted each month and contained information on quality and safety indicators. The dashboards included details on patient safety incidents and falls, staff fill rates, training compliance and appraisal figures.

There were named persons responsible for the timely submission of data and notifications to external bodies, for example, to participate in national audit.

**Engagement**

**Staff, patients and relatives were engaged and involved in the service, improving the care and treatment delivered.**

Patients could provide feedback on the service using the Friends and Family Test (FFT), inpatient surveys or by contacting the patient experience team.

Staff engaged and involved patients in the design and running of the service. For example, the trust held ‘in your shoes’ listening events, allowing patients to share their experience and identify areas for improvement.

In addition, as part of the ‘Your Care in the Right Place’ programme, patients, members of the public and stakeholders fed back their thoughts on proposals to reconfigure a number of acute services across Essex, including surgery services. As a result of the consultation, the trust amended its proposed future model of care, specifically in relation to emergency care.

Staff described how they acted on feedback. For example, magazines had been added to the relatives waiting room on the day stay unit following patient feedback.
Staff were engaged in the planning and delivery of the service. Staff attended regular team meetings to share ideas, opinions and feedback their concerns. Staff also completed a national staff survey and a health and wellbeing survey. From this, a programme of work had been developed to improve identified concerns, such as staff morale, leadership and engagement.

**Learning, continuous improvement and innovation**

There were systems in place to improve services by learning, continuous improvement and innovation.

We saw that the service was working hard to build strong links with the local NHS trusts, to create an economically sustainable, modern health network. This included the harmonising of patient pathways, practices and procedures, as well as the reconfiguration of some services. For example, urology leads were working on a project with their counterparts from two local NHS trusts, with the aim to reconfigure urology services across Essex. The project proposed that cancer, elective and emergency urology work will each be located at a dedicated site, with a cross-site emergency rota. The project aimed to pool resources and streamline pathways, in order to improve patient care.

In June 2018, low-risk orthopaedic elective surgery commenced at the trust’s community hospital in Braintree. The service introduced a streamlined post-operative pathway at Braintree and subsequently reduced length of stay.

The service was expanding its use of robotics within urology and ENT, having already been a success in upper and lower gastrointestinal surgery. The use of robotics allows surgeons to perform complex procedures that may have been difficult or impossible to perform otherwise. They can also perform minimally invasive surgery, resulting in fewer complications.

After trialling on Notley Ward, the service had rolled out enhanced support workers to work alongside nursing staff to support patients with complex needs. Enhanced support workers had completed additional training in dementia (Level 3), nutritional dementia and end of life care. They ensured appropriate adjustments were made for patients coming onto a ward.

### Services for children and young people

### Facts and data about this service

**Broomfield Hospital**

The trust has 50 inpatient paediatric beds at Broomfield Hospital:

- **E122 – Phoenix Ward**: This is a general inpatient paediatric ward with 24 inpatient beds. It also includes a paediatric assessment unit with four beds and four trolleys.

- **Ward A406 – The neonatal unit**: This ward has two intensive care beds, four high dependency beds and 10 special care cots for sick term - and preterm infants from 27 weeks gestation. Prior to 27 weeks gestation, babies are stabilised and transferred to a tertiary unit.

- **Wizard Ward**: This is a children's theatre day stay ward with 10 beds.

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

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

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

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

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

There was 24-hour provision of consultant paediatric rota cover across the service. In addition, there was a pathway for the access of children’s mental health services which is provided outside of the acute trust.

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

The trust’s services for children and young people had 3,106 spells from April 2017 to March 2018.

Emergency spells accounted for 78.1% (2,427 spells), 17.5% (544 spells) were day case spells, and the remaining 4.3% (135 spells) were elective.

**Percentage of spells in children’s services by type of appointment and site, from April 2017 to March 2018, Mid Essex Hospital Services NHS Trust**

![Percentage chart](image)

Please note that the trust did not specify the site at which the spells occurred in some cases. These spells have been reported as site unknown in the chart above.
Total number of children’s spells by site, Mid Essex Hospital Services NHS Trust

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broomfield Hospital</td>
<td>3,086</td>
</tr>
<tr>
<td>Unknown</td>
<td>15</td>
</tr>
<tr>
<td>This trust</td>
<td>3,106</td>
</tr>
<tr>
<td>England total</td>
<td>1,114,797</td>
</tr>
</tbody>
</table>

Please note that the trust did not specify the site at which the spells occurred in some cases. These spells have been reported as site unknown in the table above.

(Source: Hospital Episode statistics)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

The service provided staff with mandatory training in key skills and in safety systems, processes and practices, but not all staff completed it.

Senior nursing staff updated and displayed mandatory training compliance rates monthly in staff rooms and ward offices. This provided a visual reminder for staff to attend any outstanding training.

Mandatory training completion rates

The trust set a target of 85% for the completion of all mandatory training modules with the exception of information governance, where the target was 95%.

Broomfield Hospital

A breakdown of compliance for mandatory training courses from June 2017 to May 2018 for qualified nursing staff in services for children and young people at Broomfield Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2017 to May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Fire safety 1 year</td>
<td>81</td>
</tr>
<tr>
<td>Infection prevention level 1</td>
<td>81</td>
</tr>
<tr>
<td>Medicine management</td>
<td>78</td>
</tr>
<tr>
<td>Information governance</td>
<td>76</td>
</tr>
<tr>
<td>Manual handling object</td>
<td>71</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>71</td>
</tr>
<tr>
<td>Manual handling people</td>
<td>53</td>
</tr>
</tbody>
</table>

In services for children and young people, the hospital had an overall training compliance rate of 91.3% for qualified nursing staff. The trust’s training targets were met for five of the seven mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from June 2017 to May 2018 for medical staff in services for children and young people at Broomfield Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2017 to May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>9</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>28</td>
</tr>
</tbody>
</table>
In services for children and young people, the hospital had an overall training compliance rate of 93.6% for medical staff. The trust’s training targets were met for five of the seven mandatory training modules for which medical staff were eligible. Neither of the two eligible members of staff had completed medicine management training.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Safeguarding

The processes that were in place to safeguard people from abuse were not robust, the service had an action plan to improve but new processes were yet to be embedded. Compliance with safeguarding training was not meeting the trust target rates.

Safeguarding training completion rates

The trust set a target of 90% for the completion of safeguarding training.

Broomfield Hospital

A breakdown of compliance for safeguarding training courses from June 2017 to May 2018 for qualified nursing staff in services for children and young people at Broomfield Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2017 to May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>79</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>79</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>76</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>75</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>66</td>
</tr>
</tbody>
</table>

In services for children and young people, the hospital had an overall safeguarding training compliance rate of 90.4% for qualified nursing staff. The trust’s 90% completion target was met for four of the five safeguarding training modules for which qualified nursing staff were eligible. The safeguarding adults level 2 module had the lowest completion rate, at 79.5%.
A breakdown of compliance for safeguarding training courses from June 2017 to May 2018 for medical staff in services for children and young people at Broomfield Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 1</td>
<td>29</td>
<td>29</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>26</td>
<td>29</td>
<td>89.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>20</td>
<td>29</td>
<td>69.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>13</td>
<td>19</td>
<td>68.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>0</td>
<td>15</td>
<td>0.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In services for children and young people, the hospital had an overall safeguarding training compliance rate of 72.7% for medical staff. The trust’s 90% completion target was met for one of the five safeguarding training modules for which medical staff were eligible. None of the 15 eligible members of staff had completed safeguarding adults level 2 training.

(Source: Routine Provider Information Request (RPIR) – Training tab)

To address the non-compliance of safeguarding training, a trust wide safeguarding training improvement plan had been put in place. The plan was put in place from August 2018, with a number of the actions to be completed end of October 2018. Therefore, at the time of our inspection it was too early to see if the measures put in place were helping to increase safeguarding training compliance.

The systems and process for raising children safeguarding referrals was not robust as the service did not have a clear picture when safeguarding concerns had been escalated.

The interim safeguarding transformation lead told us that children safeguarding referrals were completed electronically and sent directly to the local safeguarding authority. This meant there had been occasions where children safeguarding referrals were made and the safeguarding team were unaware of the concerns until the local authority contacted them. However, staff on the children’s wards told us that they would complete the safeguarding electronic referral form and also complete an incident form to notify the safeguarding team. Therefore, we were not assured that the systems and processes that were in place for referring children safeguarding concerns worked effectively.

The trust, through the routine provider submission, informed us that from April 2018 local authority changed the way children safeguarding referrals were made and the new process had made it difficult for the trust to capture the number of referrals made. However, there was no process put in place in the last five months to accurately capture the number of children safeguarding referrals the trust had made.

The systems and processes that were in place for referring children safeguarding concerns did not work effectively. During our inspection the trust interim safeguarding transformation lead demonstrated that the systems and processes were not embedded and in some instances, use of systems could cause a lengthy delay in referrals being made. For example, it took over 20 minutes to access the correct page for making a referral on the intranet and then downloading the electronic referral form took a further five minutes. This meant that the task of making a referral could be delayed or omitted due to work pressures in the busy ward environment.

Prior to the inspection, the trust shared information through the routine provider information returns (RPIR) that a serious case review was underway in women’s and children’s services and shared...
the information around the immediate actions taken as a result of the incident. Following our inspection, we were made aware of the details of this incident which took place in June 2018 in the children’s ED which involved a missed safeguarding referral for a vulnerable child and mother. We requested for assurances of what steps had been taken and the associated action plan were provided by the trust. The investigation showed that experience of staff, the systems and processes in use for safeguarding referrals were not as robust as expected. Therefore, we were not assured that the arrangements to safeguard children were adequate.

The interim Director of Nursing was the safeguarding lead and accountable officer for safeguarding children within the trust. At the time of our inspection the named nurse for safeguarding children was a vacant post. We were told that this post has been recruited into and the new post holder would commence their role in November 2018.

The service was supported by an associate named nurse for safeguarding children and a paediatric liaison safeguarding nurse. A paediatrician was the named doctor for safeguarding children.

Nursing staff and allied health professionals (AHP) attended quarterly safeguarding supervision, although staff could seek supervision as and when required in complex cases. Medical staff participated in peer review sessions with consultant paediatricians for supervision when required.

The safeguarding children and young people policy 0-18 years v 6.1, was ratified and in date. This was a controlled document with document control showing updates and changes with each review. Staff were aware of who the lead nurses for safeguarding were. Staff told us they were accessible by phone and responsive to requests to attend the ward regarding any safeguarding issues and concerns. A number of staff had been identified to be safeguarding link nurses for the service and received support from the trust safeguarding leads in this role.

Safeguarding training was part of the mandatory training programme and included information on female genital mutilation (FGM) and child sexual exploitation (CSE) staff were familiar about these when we asked them.

PREVENT is a government-led training programme, designed to identify and prevent the threat of terrorism. This was delivers as part of safeguarding training.

There was a weekly safeguarding meeting, attended by the interim director of nursing, who is the executive lead and the named doctor for safeguarding children, to discuss any complex safeguarding issues. This meeting was also used to discuss current and expected inpatients and any requirements that may need to be implemented for those patients.

Chaperoning policy signs and information leaflets for patients were available and displayed throughout the service as were posters highlighting contact details for the safeguarding team.

Staff we spoke with stated that patients that did not attend for an appointment were highlighted to their consultant who would determine the next course of action. This was in line with best practice and there was a section on missed appointments and actions to be taken included in the safeguarding children and young people policy 0-18 years v 6.1.

Cleanliness, infection control and hygiene

Systems and processes were effective to ensure consistent good practice regarding cleanliness and infection prevention and control (IPC) processes.

The service was visibly clean throughout. There was signage above alcohol gel reminding staff to clean their hands immediately before and after touching patients. “I am clean stickers” were used to indicate equipment had been cleaned and was ready for use. Personal and protective
equipment (PPE) such as aprons, gloves and wipes were well stocked throughout the service. Staff were observed to adhere to the principal of being ‘bare below the elbows’.

There was a process in place to ensure all new admissions to the neonatal unit all had swabs taken to screen for *Methicillin Resistant Staphylococcus Aureus* (MRSA).

Cleaning checklists and audit results were noted to be displayed throughout the service for staff and visitors to review. Infection prevention and control (IPC) audit data was entered on to the trust dashboard, including hand hygiene, equipment cleaning, general cleaning and high impact intervention audits. Audit results were shared in staff briefings. Information was placed in staff areas.

Audit results demonstrated that IPC processes were embedded and effective across the service. The dashboard results for division four (Women and Children Cancer services) demonstrated environmental cleaning audit score results of 99% in May and June 2018 and 98% in July 2018 against a target of 98%. For the same time period, hand hygiene compliance scored 100% for May 97% for June and 99% for July, against a target of 95%.

Toys were checked and cleaned daily to ensure cross infection was minimised. In the children’s wards, play specialists had a cleaning rota and could show us evidence of the routine cleaning and checks made. In outpatients the nursery nurse cleaned toys daily.

Waste was appropriately segregated by colour coded waste bins for general waste and clinical waste. Waste was disposed of appropriately in accordance with trust policy. There were sharps bins in all clinical areas, which were labelled to identify when the bin was first used. Four sharps bins were checked throughout the service and all were appropriately labelled, signed and the contents were all below the fill lines.

Cytotoxic waste bins were emptied by an external contracted company, however, cytotoxic spillages were cleaned by nurses with a cytotoxic spill kit.

Phoenix ward, Wizard Ward and the neonatal unit (NNU) had an infection prevention and control (IPC) link nurse in post. Their role was to coordinate the IPC audits in the environment, liaise with the trust IPC team and attend IPC meetings along with the matron.

Parents and children were provided with education in relation to hand hygiene and infection prevention with both posters on display throughout the ward areas, and on a one to one basis where appropriate.

Phoenix ward had a child-friendly information board on infection control in the play room, including a dot to dot activity where the lines connected to form two hands and had information about hand hygiene.

**CQC Children and Young People’s Survey 2016**

In the CQC Children and Young People’s Survey 2016 the trust scored 9.34 out of ten for the question ‘How clean do you think the hospital room or ward was that your child was in?’ This was about the same as other trusts.

*(Source: CQC Children and Young People’s Survey 2016, RCPCH)*

**Environment and equipment**

The service had suitable premises and systems were in place to ensure equipment was maintained.
Phoenix ward consisted of 24 beds across 12 cubicles and three bays. It also included a paediatric assessment unit (PAU) with four beds and four trolleys.

The ward was spacious, secure and all areas were accessible only by badge access or key code, and decorated in a child-friendly way.

Reception was staffed from 8am to 4pm and there was CCTV at the nurse’s station.

The neonatal unit (NNU) had 16 cots inclusive of two intensive care cots, four high dependency care cots and 10 special care cots. It was spacious, free from clutter, and secured by key code access.

Children’s outpatients was contained within a dedicated area within the main outpatients department.

Equipment servicing and repairs were undertaken by the trust’s Electrical and Biomedical Engineering (EBME) department. The EBME team kept logs of equipment for servicing and repair. We checked a sample of equipment throughout the neonatal unit, Phoenix ward, children’s outpatient and Wizard ward and all were within date for servicing.

We checked the resuscitation trolley on Phoenix ward, Wizard Ward, Children’s Burns, NNU and children’s outpatients and saw that the contents matched the equipment checklist. The daily and monthly checks of these had been completed for the previous three months.

There were two resuscitation trolleys on Phoenix ward. Both trolleys did not have a defibrillator due to cost. However, staff had access to a defibrillator that was kept in the treatment room when required. This had been risk assessed. There was information on both trolleys to tell staff where the defibrillator was located.

**Assessing and responding to patient risk**

**There was a system in place to ensure staff could always assess and respond to patient risk promptly and appropriately.**

Staff used a children early warning tool (CEWT) when completing observations, such as pulse and respiration to alert them if a child’s condition was deteriorating and medical assistance was required. The system alerted staff when patients’ scores were over a set threshold and the need to escalate concerns.

The CEWT completion was audited on a quarterly basis. The aim of the audit was to assess level of compliance with the policy in place for the recognition of paediatric patients at risk of deterioration. We reviewed the information from the June 2018 audit where 33 observational charts were reviewed. The audit showed that there was increased compliance in the June audit compared to February 2018. For example, 91% of the records reviewed had a CEWT score completed and of these 94% were calculated correctly. This was an improvement from the February audit where 88% had a CEWT score completed and 92% were calculated correctly. In addition, the frequency of observations documented on the front of the chart had increased to 84% compared to 63% in February 2018.

As of September 2018, compliance with training in paediatric intermediate life support (PILS) was 83.3% for registered nurses and 60% for medical staff across all children’s services. We requested a breakdown between the different areas of the service, but this information was not provided.

The service had a ‘consultant of the week’ who was on call to respond to any concerns over patient risk or deterioration. There was always a registrar on call for all children’s areas so they...
could respond promptly to any patient deterioration.

The neonatal unit staff used an early warning scoring system that was reflective of the newborn early warning trigger and track tool (NEWTT).

The neonatal unit had a ‘hot week neonatal consultant’ who would conduct the daily ward round and also a consultant on call to respond to any concerns over patient risk or deterioration. There were always two registrars and two junior doctors on call for all children’s areas so they could respond promptly to any patient deterioration.

There was a sepsis screening pathway following the Sepsis six protocol which gave staff clear direction on escalating patients where there was a suspected infection. The Sepsis Six care bundle outlines six actions to be undertaken within one hour, for early management of sepsis.

A Guideline for Transferring Children (0-16) was in place to advise and inform staff on the transfer of a child with a time sensitive condition and managing a critically ill child for an extended period. This included a transfer checklist which indicated the minimum personnel, equipment and monitoring required depending on whether the patient was low risk, medium risk, high risk or critically ill. The guideline clearly set out the roles and responsibilities of each staff group involved in transferring a patient and included actions to be taken for every transfer.

The neonatal unit had an up to date admission guideline to the unit and the information was available by the nursing desk so that staff could advise callers about potential admissions for the unit and the other units in the regional neonatal network.

The entrances to all the children wards including phoenix, wizard, children’s burns and the neonatal unit were locked with secure keypad access and a buzzer system. This meant that there was less risk of children absconding or child abduction. There was an up-to-date trust wide missing and absconding patient policy and staff were familiar with this.

In the CQC Children and Young People’s Survey 2016 the trust scored 7.98 out of ten for the question ‘Were the different members of staff caring for and treating your child aware of their medical history?’ This was about the same as other trusts.

The trust scored 9.78 out of ten for the question ‘Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?’ This was also about the same as other trusts.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)
Nurse staffing

At the time of our inspection, Wizard ward was fully established and Phoenix ward had 0.2 whole time equivalent (WTE) band six registered nurse vacancies and a 1.08 WTE band four vacancy. Staff reported they felt able to manage the level of acuity of patients. At the time of our inspection, we observed that staffing was sufficient to meet patient needs.

The service mitigated the risk of low nurse staffing on children wards by being flexible with their workforce between different areas, for example moving staff from the NNU and where possible the paediatric emergency department to help cover the ward, if it was safe to do so.

We saw nurse staffing levels on the NNU meet standards set by the British Association of Perinatal Medicine (BAPM), and there was always a band six nurse or above leading the shift. During our inspection we saw nurse staffing levels safely met the needs of babies in the unit.

Broomfield Hospital

The trust reported the following qualified nursing staff numbers in services for children and young people at Broomfield Hospital as of March 2018 and May 2018:

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th></th>
<th>May 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Planned</td>
<td>Fill rate</td>
<td>Actual</td>
</tr>
<tr>
<td></td>
<td>staff</td>
<td>staff</td>
<td></td>
<td>staff</td>
</tr>
<tr>
<td></td>
<td>(WTE)</td>
<td>(WTE)</td>
<td></td>
<td>(WTE)</td>
</tr>
<tr>
<td>Broomfield Hospital</td>
<td>49.2</td>
<td>59.4</td>
<td>82.9%</td>
<td>47.1</td>
</tr>
</tbody>
</table>

The nursing staffing levels within services for children and young people were similar in both time periods.

(Source: Routine Provider Information Request (RPIR) – Total staff tab)

Vacancy rates

Broomfield Hospital

From June 2017 to May 2018, the trust reported a vacancy rate of 20.3% for qualified nursing staff in services for children and young people at Broomfield Hospital. This was higher than the trust target of 15.4%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

Broomfield Hospital

From June 2017 to May 2018, the trust reported a turnover rate of 4.0% for qualified nursing staff in services for children and young people at Broomfield Hospital. This was lower than the trust target of 18.05%.

Within the RPIR, the trust noted that there was an issue with their turnover data. The process used in ESR when staff leave and retain a staff bank contract means that they are not counted in ESR as a leaver. As a result, the turnover figures reported from ESR are lower than they actually are. The trust’s internal reports and the Joint Working Board report are adjusted to reflect the additional leavers, so that the correct turnover figures are reported. However, due to the manual recording of this data, and its limitations, it was not possible for the trust to analyse it to the level of detail required for the RPIR.
The trust reported that this process was changing and, in the future, all of their leavers would be included in reports from ESR.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

Broomfield Hospital

From May 2017 to April 2018, the trust reported a sickness rate of 3.9% for qualified nursing staff in services for children and young people at Broomfield Hospital. This was lower than the trust target of 4.24%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

The service had an established induction process in place for agency staff. We reviewed an agency staff folder on Phoenix ward which contained a completed checklist for essential competencies, signed off by the assessor and the member of staff, and certificates of intravenous (IV) competencies.

Broomfield Hospital

From May 2017 to April 2018, the trust reported that 12.2% of nursing assistant staff shifts in services for children and young people at Broomfield Hospital were filled by bank staff, while one shift was filled by agency staff. In addition, 23 shifts (0.2%) were not filled by either bank or agency staff to cover staff absence.

Over the same period, the trust reported that 5.8% of qualified nursing shifts in services for children and young people at Broomfield Hospital were filled by bank staff and 0.8% of shifts were filled by agency staff. In addition, 1.8% of shifts were not filled by bank or agency staff to cover staff absence.

The table below shows a breakdown by shift type and nursing staff role:

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Nursing assistants</th>
<th></th>
<th>Qualified nurses</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>Bank</td>
<td>1,328</td>
<td>12.2%</td>
<td>1,626</td>
<td>5.8%</td>
<td>2,954</td>
<td>7.6%</td>
</tr>
<tr>
<td>Agency</td>
<td>1</td>
<td>0.0%</td>
<td>223</td>
<td>0.8%</td>
<td>224</td>
<td>0.6%</td>
</tr>
<tr>
<td>Not filled</td>
<td>23</td>
<td>0.2%</td>
<td>504</td>
<td>1.8%</td>
<td>527</td>
<td>1.4%</td>
</tr>
<tr>
<td>Total shifts</td>
<td>10,920</td>
<td></td>
<td>27,804</td>
<td></td>
<td>38,724</td>
<td></td>
</tr>
<tr>
<td>available</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing

Broomfield Hospital

The trust reported the following medical staffing numbers in services for children and young people at Broomfield Hospital as of March and May 2018.
The medical staffing level within services for children and young people increased from 79.6% in March 2018 to 87.3% in May 2018 through the addition of three more staff in post.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

At the time of inspection, there were 10 consultants working in children’s services. There was ‘hot week’ neonatal consultant that worked Monday-Friday as well as a paediatric/neonatal ‘hot week’ consultant with 24-hour cover, seven days a week in NNU.

Two registrar level doctors and two middle grade doctors were physically present in the service 24 hours a day, seven days a week. They carried a bleep and were available via the switchboard to provide advice for all specialties. The service was also meeting standards having adopted a ‘consultant of the week’ system, giving access to the opinion of a consultant paediatrician 24 hours a day, seven days a week, for every child with an acute medical problem referred for a paediatric opinion being seen by or having their case discussed with a clinician before discharge.

Within children’s outpatients, clinics were consultant-led alongside the respective nurse specialists. General clinics all had a consultant and registrar. Parents of children on the ward reported they had adequate access to their child’s consultant for any questions or concerns.

Vacancy rates

Broomfield Hospital

From June 2017 to May 2018, the trust reported a vacancy rate of 17.1% for medical staff in services for children and young people at Broomfield Hospital. This was higher than the trust target of 15.4%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

Broomfield Hospital

From June 2017 to May 2018, the trust reported no turnover among medical staff in services for children and young people at Broomfield Hospital. The trust has a target turnover rate of 18.05%.

Within the RPIR, the trust noted that there was an issue with their turnover data. The process used in ESR when staff leave and retain a staff bank contract means that they are not counted in ESR as a leaver. As a result, the turnover figures reported from ESR are lower than they actually are. The trust’s internal reports and the Joint Working Board report are adjusted to reflect the additional leavers, so that the correct turnover figures are reported. However, due to the manual recording of this data, and its limitations, it was not possible for the trust to analyse it to the level of detail required for the RPIR.

The trust reported that this process was changing and, in the future, all of their leavers would be included in reports from ESR.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)
Sickness rates

Broomfield Hospital

From May 2017 to April 2018, the trust reported a sickness rate of 0.7% for medical staff in services for children and young people at Broomfield Hospital. This was lower than the trust target of 4.24%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

Although the trust provided the total numbers of shifts worked by medical bank and locum staff over the most recent year as requested in the Routine Provider Information Request (RPIR), they were unable to supply the total number of shifts worked by all medical staff, including permanent medical staff. This meant that the proportions of shifts worked by medical bank and locum staff could not be calculated.

However, the trust was able to supply the number of WTE medical staff budgeted for, the number of WTE permanent medical staff contracted and the number of WTE locum medical staff employed. These figures were used to calculate the proportions below.

In May 2018, the trust reported that medical locum staff made up 2.9% of budgeted WTE medical staff in services for children and young people. Over the same period 9.7% of budget WTE medical posts in medical care were left unfilled. The site at which the shifts occurred was not specified.

The table below shows a breakdown by shift type:

<table>
<thead>
<tr>
<th>Bank/locum</th>
<th>Number of shifts</th>
<th>Percentage usage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locum</td>
<td>1.1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Not filled</td>
<td>3.8</td>
<td>9.7%</td>
</tr>
<tr>
<td>Total</td>
<td>38.7 shifts</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical locum tab)

Staffing skill mix

In March 2018, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was the same.

Staffing skill mix for the 32 whole time equivalent staff working in children’s services at Mid Essex Hospital Services NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>31%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>3%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>59%</td>
<td>44%</td>
</tr>
<tr>
<td>Junior*</td>
<td>6%</td>
<td>6%</td>
</tr>
</tbody>
</table>
^ Middle Career = At least 3 years at SHO or a higher grade within their chosen speciality
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

People’s individual care records were written and managed in a way that kept people safe.

Records were paper-based and stored securely in Phoenix ward, Wizard ward, NNU, children’s outpatients and children’s burns unit to maintain confidentiality.

During our inspection we reviewed 12 sets of medical records and nine prescription cards. Records we reviewed were completed appropriately. For example, they were signed and dated by the clinician making notes, diagnoses and management plans were documented, nutritional status was consistently recorded, family discussions were documented and patient observations were documented.

Care plans and assessments on the wards were completed correctly and updated where needs had changed.

Pre-operative assessments were completed prior to attendance on the day of surgery and this identified those patients with high surgery risks and ensured that the appropriate investigations and plans were in place for the day of surgery.

Electronic discharge summaries were comprehensive and detailed. Copies of the summaries were sent to the patient’s GP and parents were provided with a copy.

Medicines

Medicines were generally managed in line with legislation and trust policy. However, there were some concerns regarding monitoring and escalation of fridge and room temperatures which exceeded the recommended guidance.

Medicines were stored securely in locked cupboards in key code locked rooms accessible only by staff. Controlled drugs were locked securely and separately from other medicines. The master keys were held by the nurse in charge. A stock check of controlled drugs was carried out daily with two members of staff required to sign this off. We saw this had been completed and signed off with no gaps from June to September 2018.
We reviewed nine prescription charts on the ward. These recorded allergies and patient’s weight in line with national guidance; regular medicines prescribed including route, frequency, all of which were signed by the prescriber with no missed doses recorded.

Medication fridge temperatures were not monitored and escalated in line with trust policy. The normal ranges were recorded daily with high and low monitoring. There was some evidence of temperatures outside of normal range being escalated and actions taken. However, in some cases there were gaps in fridge temperature monitoring where there was no evidence of escalation or actions taken. For example, on Phoenix Ward, we reviewed the drug fridge temperature monitoring checklist from 1 May to 11 September 2018. There were a number of gaps in the temperature monitoring; total of eight days missing for this period. In addition, there was evidence recorded that the fridge temperature was outside the normal range for 12 days throughout May and September 2018, however this had not been escalated in line with the trust policy. We raised this concern to the ward manager who acknowledged that the issue should have been reported and documented. Therefore, we were not assured that there was oversight and monitoring of drug fridge temperatures.

On Phoenix ward, daily log of the room temperature was kept, however there were a number of gaps in July, August and September 2018 records for all three medication storage rooms. In addition, there was also a number of times where the temperature exceeded the normal range. A mobile air conditioning unit had been provided to mitigate the risk of the heat to the medications stored in the room. However, the temperature log showed that this was not effective at reducing the room temperature. Therefore, we were not assured that the ambient room temperature where medications were being stored on Phoenix ward was being maintained appropriately.

Nurses dispensing medications during drugs rounds on the ward and NNU wore red disposable aprons, which signalled to other people on the ward that they were not to be disturbed, to reduce the risk of errors.

Children’s services had access to clinical pharmacy service from Monday to Friday, with access to an on-call pharmacist out of hours.

Incidents
Never Events

Broomfield Hospital

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

From August 2017 to July 2018, the trust reported no incidents classified as never events in services for children and young people at Broomfield Hospital.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

Broomfield Hospital

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SI) in services for children and young people at Broomfield Hospital which met the reporting criteria set by NHS England from August 2017 to July 2018. Both of these serious incidents took over 90 days to be reported.
The first of these serious incidents, which occurred in June 2017 at Broomfield Hospital, was classified as a diagnostic incident including a delay (including a failure to act on test results).

The second serious incident occurred in September 2017 and was classified as a maternity/obstetric incident relating to the baby only (this includes foetuses, neonates and infants).

(Source: Strategic Executive Information System (STEIS))

All staff we spoke with could clearly explain how they would raise an incident and give examples of where there had been learning or feedback shared with them from an incident, either raised by themselves or another member of staff.

Representatives from children’s services attended a daily trust-wide incident review meeting, which identified any incidents that had occurred in the trust and immediate actions and shared with staff a provisional categorisation of these incidents.

The services used the monthly ‘hot topic’ newsletter to share learning from incidents. We saw the newsletters displayed in NNU and phoenix ward in the staff room. Staff we spoke to were able to recall the serious incident that was shared the August newsletter.

We reviewed minutes of monthly mortality and morbidity meetings for children’s services from January to May 2018. These minutes included appropriate discussion of mortality and morbidity cases and causes and how things could have been done differently in individual cases, with actions from discussion documented.

Minutes of the monthly patient safety and quality meetings from February to July 2018 showed that mortality and morbidity meeting minutes were also shared in this forum.

Not all staff understood the term duty of candour when we asked this specifically. However, they were clearly aware of the need to be open and honest with patients and relatives. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. However, service leads showed clear understanding of the term duty of candour when asked.

Safety Thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from June 2017 to June 2018 for children’s services.

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment
The service used national guidelines such as those published by the National Institute of Health and Care Excellence (NICE) to inform their own local policies and protocols. For example, the service had an age specific sepsis assessment and a clear escalation flowchart for patients identified as being at risk and directions on medicines to administer in the event of an urgent ‘red flag’ case. This was based on best practice and guidance from NICE and referred to the Children’s Acute Transport Service (CATS) (2016) Clinical Guideline Septic Shock.

Many policies and guidelines were in place, with clear links to the evidence-based care they related to, such as guidance issued by the Royal College of Paediatrics and Child Health (RCPCH) and NICE. However, two out of 20 policies we reviewed on inspection were out of date.

The neo-natal unit (NNU) had recently undergone a peer review and the report was published in May 2018 with positive findings. This review assessed key indicators including staffing, training, compliance with standards and national guidance, patient experience and links with the regional neonatal networks.

There was an end of life care pathway in place for terminally ill children. This was based on the National Institute for Health and Care Excellence (2016) End of life care for infants, children and young people with life-limiting conditions: planning and management (NG61) and ‘Together for Short Lives’ national guidance.

The practice development nurses took a lead role in making the clinical guidelines available and accessible to all staff. We saw a folder on the neonatal unit for staff to access that had all evidence based-guidelines organised for staff to access quickly. The guidelines were also available to all staff electronically on the staff intranet.

The service participated in national audits to assess compliance with evidence-based care. For example, the service participated in the 2015/16 National Paediatric Diabetes Audit. There are seven key care processes recommended by NICE for children and young people with Type 1 diabetes (NICE NG18 and NG19) that should be performed at least once annually. Data from the audit showed that 10.7 of young people aged 12 years and older at Broomfield Hospital had received all seven care processes between April 2015 and March 2016 compared to 35.5% nationally. Structured patient education programmes are also recommended by NICE as part of the ongoing management of children and young people with diabetes. Data from the audit showed that 77.4% of patients were receiving structured education, which was above the national average of 71%. The audit results therefore showed that the service was not always following NICE guidance in the provision of diabetes care.

There was a monthly departmental meeting and paediatric safer surgery meeting where the results of audits were shared. The feedback was also shared at team huddles, ward meetings and by email newsletter, to ensure all staff were captured in this shared learning.

**Nutrition and hydration**

Children and their parents or carers were asked about eating and drinking preferences, appetite and ability to feed themselves. For infants this included the type of milk normally consumed, how much and how often.

We reviewed 12 care records and found that there had been an assessment of nutritional status in all cases where this was applicable. We also saw that handovers between staff included a consideration of patient’s nutritional status.

Paediatric dieticians were available for advice and guidance, as well as developing care plans for children.

There was a dedicated room on the neonatal unit for breastfeeding and expressing milk. Mothers
could also take expressing machines to their baby’s cot side if they wished. In addition, there was a separate feeding room on the unit.

There was a milk kitchen on Phoenix ward, with equipment for feeds.

There were feeding and breast-feeding information boards for children and their parents or carers.

There was a diabetic nurse specialist and a link nurse to provide support to diabetic patients. A booklet was available for newly diagnosed diabetic patients with information about what they could eat, with pictures of portion sizes and advice about snacks.

**Pain relief**

Children and young people’s pain was assessed through the use of the ‘Wong Baker’ faces pain rating scale. This scale asks a child to rate their pain on a scale of zero (no hurt) to 10 (hurts worst) by choosing which face best describes how much pain they are in. Staff also used the FLACC (Face, Legs, Activity, Cry, Consolability) scale as part of the assessment pathway. The FLACC scale is designed for use with younger children or those unable to communicate their pain and staff used the scale to assign a score to observations of a child’s behaviour.

The neonatal unit used the Neonatal Infant pain scale (NIPS) which is an observer rated tool and used for pre-term and term infants to assess and manage pain.

On children’s burns ward staff used a combined pain and itch assessment tool to assess and manage pain in burns patients.

We observed a pain assessment and the chart being completed appropriately using the physical and facial assessment tools. The nurse explained the different pain scales to us and how they selected which was the most appropriate to use. The outcomes of this were recorded and signed.

Staff used a pain ladder tool as a guideline for determining the most appropriate method of pain relief. Pain ladders use a stepped approach to pain relief, where patients can be started on nonopioids such as paracetamol for mild pain, then increasing to weak opioids like codeine for moderate pain and finally escalating to strong opioids like morphine for the highest level of pain. The general principle is to start with first step drugs, and then to climb the ladder if pain is still present.

There was a Managing your Child’s Pain at Home information leaflet for parents and carers. This included advice about using medication to manage a child’s pain, as well as other ways of managing a child’s pain, including exercise, controlled breathing, distraction, socialising and a good sleep routine.

In the CQC children’s survey 2017, the trust scored 9.4 for children’s assessment of whether staff did everything they could to help their pain. The trust scored 9.1 for the same question asked to parents and carers. Both of these were better than other trusts.

**Patient outcomes**

The children’s service participated in some national audits for which it was eligible. These included the National Paediatric Diabetes Audit (NPDA), and the National Neonatal Audit Programme (NNAP).

There was lack of initiative to measure and monitor patient outcomes as there was only six local and national audits listed on the services 2018/19 audit plan. Whilst the audits on the audit plan had a lead clinician, it did not include rationale and did not have a start date or
expected completion date.

We requested action or improvement plans for any national audits. Only limited formal action plans were available, where the actions related to sharing the findings of the audit rather than changes to practice. Many of the recommendations from audits therefore did not have formal actions attached to them, and lacked dates for completion and individuals allocated as responsible for completing actions.

**Paediatric diabetes audit 2015/16**

**Broomfield Hospital**

In the 2015/16 Paediatric diabetes audit, the proportion of patients receiving all key care processes annually at Broomfield Hospital was 10.7%, making the hospital a negative outlier. The national aggregate was 35.5%, while the hospital's score in the 2014/15 report was 5.9%.

HbA1c levels are an indicator of how well an individual’s blood glucose levels are controlled over time. The mean average HbA1c value (adjusted by case-mix) for this hospital was 63.7 mmol/mol making the hospital a positive outlier. The national aggregate was 68.3 mmol/mol. The hospital performed within the expected range for this metric in the previous year’s audit.

The median HbA1c value recorded amongst the 2015/16 sample for this hospital was 58.5 mmol/mol, which was a clinically significant improvement from the previous year’s median of 62.5 mmol/mol. The national aggregate was 65.0 mmol/mol.

*(Source: National Paediatric Diabetes Audit 2015/16)*

**Emergency readmission rates within two days of discharge**

The table below shows the percentages of patients (by age group) who were readmitted following an elective admission. The table show the three specialties with the highest volume of readmissions and only those specialties where six or more readmissions recorded are shown in the table.

From February 2017 to January 2018, there were no specialties with six or more readmissions following an elective admission recorded for the under one age group.

Over the same time period, the percentage of patients aged 1-17 years old that were readmitted following an elective admission in ENT (1.4%) was higher than the England average of 0.6%. However, this was based on only six readmissions over this time period.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Mid Essex Hospital Services NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>ENT</td>
<td>1.4%</td>
<td>415</td>
</tr>
</tbody>
</table>

No other speciality at this trust had six or more readmissions.

The tables below show the percentages of patients (by age group) who were readmitted following an emergency admission. The tables show the three specialties with the highest volume of readmissions and only those specialties where six or more readmissions recorded are shown in the table.

The data shows that, from February 2017 to January 2018, a lower percentage of patients aged
under one were readmitted following an emergency admission in paediatrics, based on 10 readmissions, compared to the England average.

### Emergency readmissions within two days of discharge following emergency admission among the under 1 age group, by treatment specialty (February 2017 to January 2018)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Mid Essex Hospital Services NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>1.4%</td>
<td>723</td>
</tr>
</tbody>
</table>

No other speciality at this trust had six or more readmissions.

In addition, a lower proportion of the trust’s patients aged 1-17 years old were readmitted following an emergency admission in paediatrics compared to the England average.

A similar proportion of the trust’s patients in this age group were readmitted following an emergency admission in general surgery compared to the England average.

### Emergency readmissions within two days of discharge following emergency admission among the 1-17 age group, by treatment specialty (February 2017 to January 2018)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Mid Essex Hospital Services NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>1.0%</td>
<td>1,571</td>
</tr>
<tr>
<td>General Surgery</td>
<td>3.6%</td>
<td>275</td>
</tr>
</tbody>
</table>

No other speciality at this trust had six or more readmissions.

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

### Rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes

From March 2017 to February 2018, similar proportions of the trust’s patients aged from one to 17 years of age had two or more admissions for asthma and epilepsy in comparison to the England rates. However, please note that this analysis was based on small numbers of multiple admissions.

### Rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes (for children aged under one year and from one to 17 years) (March 2017 to February 2018)

<table>
<thead>
<tr>
<th>Long term condition</th>
<th>Mid Essex Hospital Services NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Multiple admission rate</td>
<td>At least one admission (n)</td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1 to 17</td>
<td>18.0%</td>
<td>61</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1 to 17</td>
<td>*</td>
<td>29</td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>1 to 17</td>
<td>31.8%</td>
<td>22</td>
</tr>
</tbody>
</table>
Note: For reasons of confidentiality, numbers below 6 and their associated proportions have been removed and replaced with ‘*’. Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, an additional number (generally the next smallest) has also been suppressed.

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

National Neonatal Audit Programme

Broomfield Hospital

In the 2017 National Neonatal Audit, Broomfield Hospital’s performance in the four measures relevant to services for children and young people was as follows:

Babies <32 weeks gestation who had temperature taken within an hour of admission that was between 36.5ºc and 37.5ºc

Out of 28 eligible cases identified for inclusion, 66.8% of babies less than 32 weeks gestation had a temperature taken within an hour of admission that was between 36.5ºC and 37.5ºC. This was within the expected range when compared to the national aggregate of 61.0%.

The hospital did not meet the audit’s recommended standard of 90% for this measure.

Documented consultation with parents/carers by a senior member of the neonatal team within 24 hours of admission

Out of 309 eligible cases identified for inclusion, 89.1% of babies had a documented consultation with parents/carers by a senior member of the neonatal team within 24 hours of admission. This was within the expected range when compared to the national aggregate of 90.5%.

The hospital did not meet the audit’s recommended standard of 100% for this measure.

Babies of very low birthweight or <32 weeks gestation who receive appropriate screening for retinopathy of prematurity

Out of the 34 eligible cases identified for inclusion, 96.9% of babies of very low birthweight or less than 32 weeks gestation received appropriate screening for retinopathy of prematurity. This was within the expected range compared to the national aggregate of 94.2%.

The hospital did not meet the audit’s recommended standard of 100% for this measure.

Babies with gestation at birth <30 weeks who had received documented follow-up at two years gestationally corrected age

Out of the 20 eligible cases identified for inclusion, 60.0% of babies with a gestation at birth of less than 30 weeks received a documented follow-up at two years gestationally corrected age. This placed the hospital within the middle 50% of hospitals in England for this measure. The national aggregate was 61.2%.

The hospital did not meet the audit’s recommended standard of 100% for this measure.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

Competent staff
There were effective processes in place to ensure that staff working in children’s services had their training needs assessed and that they had the skills and knowledge to carry out their roles.

**Appraisal rates**

**Broomfield Hospital**

From June 2017 to May 2018, 93.4% of staff in services for children and young people at Broomfield Hospital received an appraisal, which was higher than the trust’s target of 79%. The 79% appraisal target was met for all staff groups.

A breakdown of appraisal completion by staff group is shown in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>June 2017 to May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Appraisals completed</td>
</tr>
<tr>
<td>Qualified healthcare scientists</td>
<td>1</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>26</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>69</td>
</tr>
<tr>
<td>Medical staff</td>
<td>22</td>
</tr>
<tr>
<td>NHS infrastructure support staff</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>127</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Staff had access to learning and development courses to help support them in their roles. The children and young people’s service had developed child health study days which included content specific to paediatric and neonatal care. For example, topics included paediatric diabetes, paediatric asthma and paediatric oncology. There was monthly simulation training on the neonatal unit.

On the neonatal unit, all band 6 nurses were qualified in specialty (QIS). Nurses who are QIS have completed a programme of post registration education. The service had secured funding for two band 5 nurses every year to complete their post registration training.

Royal College of Nursing (RCN) neonatal competency packs were used on the neonatal unit. New staff on the neonatal unit were required to complete competencies through study days within six months of starting their role. A practice development nurse was available to support staff on the unit.

We reviewed an agency staff folder on Phoenix ward which contained a completed checklist for essential competencies, signed off by the assessor and the member of staff, and certificates of intravenous (IV) competencies.

**Multidisciplinary working**

Staff consistently reported effective multidisciplinary team (MDT) working. MDT meetings on Phoenix ward involved all relevant staff and everyone had an opportunity to contribute. For example, the play specialist attended MDT meetings for children with whom they had a lot of interaction and said that doctors welcomed their input because they provided insight into the wider family and social context of the patient.

Nursing and medical teams worked well together as one team and we saw positive communication and interactions between them, including in handovers and in theatre, to best support children’s
needs. All nursing staff we spoke with said they had positive working relationships with doctors and would feel comfortable escalating any concerns directly to the consultant.

Weekly MDT meetings were held on the neonatal unit and these included consultants, the neonatal outreach team, dieticians, nursing staff, and the lead midwife for safeguarding. The children’s burns service held a weekly psycho-social meeting, which was also attended by play specialists and safeguarding staff to share and discuss concerns.

Children’s services did not have a dedicated mental health team, though the local Emotional Wellbeing and Mental Health Service (EWMHS) was accessible for patients admitted to the unit with mental health illness.

Staff reported that EWMHS was responsive when they called for advice or to ask for a mental health assessment and that usually someone from the service would attend within one or two hours. One member of staff described making proactive contact with EWMHS before the patient was fit for discharge. It enabled them to work collaboratively to plan an effective discharge and allowed the patient to have a timely discharge.

The service had a named link from EWMHS who carried out regular training sessions with ward staff on different techniques of asking questions to children with mental health difficulties and how to support them. There was also a mental health link nurse on Phoenix ward that went to the trust mental health forums and provided additional support to the service.

Multidisciplinary clinics were carried out for cardiology, epilepsy, asthma and diabetes.

The neonatal unit was part of the East of England Neonatal Operational Delivery Network.

Governance meetings were attended by multidisciplinary staff groups, including paediatricians, specialist nurses, pharmacists and staff from the neonatal unit.

Staff informed us that transition of care from children to adult services was delivered in a way that promoted continuity of care. If a patient aged 16 to 18 years, was well known to children’s services, they would be given the option to be admitted onto children’s ward to enable them to be treated by professionals who knew them well. Service leads told us, where required for an adolescent patient, adult and paediatric services would hold a complex care special planning meeting to gain input from both teams.

In the theatre case we observed, we saw that all members of staff were involved in the discussion, for example in the discussion of allergies and post-operative care.

When referrals were made to other organisations, this was documented in the patient records. We saw an example of this for a child with a complex condition requiring shared care.

We reviewed 12 care records and found that there was evidence of multidisciplinary input in all of the cases where this was applicable. There was evidence of a daily ward round including review with senior clinicians in all cases where this was applicable. Staff had access to paediatric pharmacy advice five days a week. At weekends staff had access to a general on-call pharmacist, who would not have specific paediatric expertise. A team of play specialists worked in the children’s department, including on children’s burn unit, Wizard and Phoenix wards six days a week.

**CQC Children and Young People’s Survey 2016 – Q23**

In the CQC Children and Young People’s Survey 2016 the trust scored 9.09 out of ten for the question ‘Did the members of staff caring for your child work well together?’ This was about the same as other trusts.
Seven-day services

There was a consultant on call to Phoenix ward and the neonatal unit at night and the weekends. The consultant was supported by middle grade doctors during these hours.

Pharmacy support was available 24 hours a day seven days a week to Phoenix ward and the neonatal unit through an on call rota.

The service had access to seven day diagnostic services with the exception of echocardiography (ECG) and MRI. However, there was seven-day access to ECG and MRI for emergency cases.

There was a 24 hours a day, seven days a week on-call rota for physiotherapy and diabetic support. The chaplaincy team provided a 24 hours a day, seven days a week service to patients, carers and staff.

There was an on call physiotherapy rota that ensured physiotherapy support was available to Phoenix ward and the neonatal unit if required out of hours. The ward manager for Phoenix ward told us they could always get a physiotherapist to review a patient on the same day if required.

Health Promotion

The use of the personal child health record (PCHR), also known as the red book, was actively encouraged in the children and young people’s service. Parents or carers were advised over the phone and by letter to bring the red books when attending the hospital. The PCHR is the main record of a child’s health and development. The parent or carer retains the PCHR, and health professionals should update the record each time the child is seen in a healthcare setting. This meant that parents and carers were involved in regularly monitoring their child’s health. The ongoing reviews that formed part of the record also provided an opportunity for staff to support national priorities to improve the population’s health, for example through discussions about diet.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

There was an up-to-date consent to examination or treatment policy referred to the Department of Health Reference guide to consent for examination or treatment (2009). The policy contained direct reference to Gillick competency, which assesses whether a child has the appropriate understanding and maturity to consent to care.

We reviewed 12 care records and found that there was evidence of documented consent in all but one of the cases that this was applicable for.

However, the service was not carrying out regular consent audits to monitor documentation of consent and identify any areas for improvement.

Leaflets which provided information about consent were available on Phoenix and Wizard wards.

Mental Capacity Act and Deprivation of Liberty training completion

Broomfield Hospital

The trust reported that from June 2017 to May 2018 Mental Capacity Act (MCA) level 1 training was completed by 90.0% of staff in services for children and young people at Broomfield Hospital, meeting the target of 90%.
This included 89.2% of qualified nursing staff and 93.3% of medical staff. Therefore the 90% target was met for medical staff but not met for qualified nurses in services for children and young people.

The breakdown by staff group for qualified nursing staff and medical staff is shown in the table below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2017 to May 2018</th>
<th></th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>74</td>
<td>83</td>
<td>89.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medical staff</td>
<td>14</td>
<td>15</td>
<td>93.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The trust reported that from June 2017 to May 2018 Mental Capacity Act (MCA) level 2 training was completed by 24.0% of staff in services for children and young people at Broomfield Hospital, compared to the trust target of 90%.

This included 22.4% of qualified nursing staff and 20.0% of medical staff. Therefore the 90% target was not met for either qualified nurses or medical staff in service for children and young people.

The breakdown by staff group for qualified nursing staff and medical staff is shown in the table below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2017 to May 2018</th>
<th></th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>13</td>
<td>58</td>
<td>22.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medical staff</td>
<td>3</td>
<td>15</td>
<td>20.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Deprivation of Liberty Safeguards training is covered under the MCA levels 1 and 2 training modules.

(Source: Routine Provider Information Request (RPIR) – Training tab)
Other CQC Survey Data

CQC Children and Young People's Survey 2016 Data

The trust performed better than other trusts for two questions and about the same as other trusts for the remaining four questions relating to effectiveness in the CQC Children and Young People's Survey 2016.

CQC Children's Survey questions, effective domain, Mid Essex Hospital Services NHS Trust

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>Did you feel that staff looking after your child knew how to care for their individual or special needs?</td>
<td>0-15 adults</td>
<td>8.83</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>9</td>
<td>Did staff play with your child at all while they were in hospital?</td>
<td>0-7 adults</td>
<td>8.10</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>19</td>
<td>Did different staff give you conflicting information?</td>
<td>0-7 adults</td>
<td>8.54</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>33</td>
<td>During any operations or procedures, did staff play with your child or do anything to distract them?</td>
<td>0-15 adults</td>
<td>8.57</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>54</td>
<td>Did hospital staff play with you or do any activities with you while you were in hospital?</td>
<td>8-15 children</td>
<td>5.46</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

0-7 adults = asked of parents and carers of children up to seven years of age.
0-15 adults = asked of parents and carers of children up to 15 years of age.
8-15 children = asked of children aged from eight to 15 years of age.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)
Is the service caring?

Compassionate care

Staff demonstrated a sensitive and supportive attitude towards patients and their families. On Phoenix ward we observed staff providing reassuring and compassionate care to a young patient. The member of staff spoke directly to the child in a caring and appropriate way, providing lots of praise and physical reassurance to help the child to feel calm.

Staff were considerate of people’s personal and social needs. They demonstrated this in the way they delivered their care. A patient’s mother informed us that staff go the extra mile and had offered to look after her baby so that she could sleep or get a drink. Another mother told us that staff were attentive, regularly checking if they needed anything, and provided their family with practical support during a crisis. Patients and their families reported that staff took time to interact with them in a respectful way. They also told us that they explained things in a way that they could understand.

Staff made sure that people’s privacy needs were respected. We observed staff ensuring that people’s privacy was protected by privacy curtains. Patients and carers also informed us that they felt their privacy was respected. Staff informed us that they did their best to consider patients’ age and gender when admitting them to the ward and placing them in rooms to help maintain their privacy and dignity.

Staff responded in a timely and compassionate way when people experienced pain or distress. We saw staff responding promptly to call bells. Staff informed us that they cared for patients with sensory needs by using a play specialist who provided sensory items. These patients had access to a cubicle to keep their environment quieter.

Staff tailored their communication to best suit the age and needs of each child. Staff provided support to children with behavioural or mental health difficulties. In the garden area on Phoenix ward they were developing a mental health corner which they described as a ‘chill zone’ that could be used as a private area. Families we spoke to described that staff throughout the children’s service treated them with a non-judgemental attitude.

CQC Children and Young People’s Survey 2016

The trust performed better than other trusts for three questions and about the same as other trusts for the remaining seven questions relating to compassionate care in the CQC Children and Young People’s Survey 2016.

CQC Children and Young People’s Survey 2016 questions, compassionate care, Mid Essex Hospital Services NHS Trust

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Did new members of staff treating your child introduce themselves?</td>
<td>0-7 adults</td>
<td>8.97</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>14</td>
<td>Did you have confidence and trust in the members of staff treating your child?</td>
<td>0-15 adults</td>
<td>9.20</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>22</td>
<td>Were members of staff available when your child needed attention?</td>
<td>0-15 adults</td>
<td>8.37</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>42</td>
<td>Do you feel that the people looking after your child were friendly?</td>
<td>0-7 adults</td>
<td>9.33</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>43</td>
<td>Do you feel that your child was well looked after by the hospital staff?</td>
<td>0-7 adults</td>
<td>9.47</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>----</td>
<td>-----------------------------------------------------------------------</td>
<td>------------</td>
<td>------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>44</td>
<td>Do you feel that you (the parent/carer) were well looked after by hospital staff?</td>
<td>0-15 adults</td>
<td>8.83</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>58</td>
<td>Was it quiet enough for you to sleep when needed in the hospital?</td>
<td>8-15 children</td>
<td>6.27</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>64</td>
<td>If you had any worries, did a member of staff talk with you about them?</td>
<td>8-15 children</td>
<td>8.89</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>74</td>
<td>Do you feel that the people looking after you were friendly?</td>
<td>8-15 children</td>
<td>9.74</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>75</td>
<td>Overall, how well do you think you were looked after in hospital?</td>
<td>8-15 children</td>
<td>9.30</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

0-7 adults = asked of parents and carers of children up to seven years of age.
0-15 adults = asked of parents and carers of children up to 15 years of age.
8-15 children = asked of children aged from eight to 15 years of age.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Emotional support**

Staff understood the impact that a patient’s care can have on them and those close to them. Staff informed us that they had access to a psychology team who could support children as well as their parents if they required support to come to terms with some bad news. Staff explained that there was a referral process and that the psychology team responded in a timely manner. They provided ongoing support if required.

People were given appropriate support to cope emotionally with their care. The service had play specialists who helped to provide patients with information and support. They used various techniques to show patients what to expect during a procedure. They spent time with the children, which made them feel more at ease and provided them with the emotional support to undergo the procedure. They used an app to show children the processes and explained them in a way that they understood. They also used games with the children like sleeping lions to help them prepare for their treatment.

Pastoral care was available to children and their families from the chaplaincy team.

The service could access the trust bereavement nurse for support and reflection.

The trust provided various information to patients and those close to them on how to access other organisations for emotional and bereavement support if needed.

**CQC Children and Young People’s Survey 2016**

The trust performed better than other trusts for four questions and about the same as other trusts for the remaining question relating to emotional support in the CQC Children and Young People’s Survey 2016.

**CQC Children and Young People’s Survey 2016 questions, emotional support, Mid Essex Hospital Services NHS Trust**
<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Was your child given enough privacy when receiving care and treatment?</td>
<td>0-7 adults</td>
<td>9.31</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>29</td>
<td>If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?</td>
<td>0-15 adults</td>
<td>9.13</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>45</td>
<td>Were you treated with dignity and respect by the people looking after your child?</td>
<td>0-7 adults</td>
<td>9.63</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>65</td>
<td>Were you given enough privacy when you were receiving care and treatment?</td>
<td>8-15 children</td>
<td>9.50</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>67</td>
<td>If you felt pain while you were at the hospital, do you think staff did everything they could to help you?</td>
<td>8-15 children</td>
<td>9.35</td>
<td>Better than other trusts</td>
</tr>
</tbody>
</table>

0-7 adults = asked of parents and carers of children up to seven years of age.
0-15 adults = asked of parents and carers of children up to 15 years of age.
8-15 children = asked of children aged from eight to 15 years of age.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Understanding and involvement of patients and those close to them

Staff communicated with people so that they understood their care, treatment and condition. Patients and their families told us that information was explained to them in a way they could understand. We observed staff communicating appropriately with children, young people and their families.

The play specialists used visual aids with younger children to help them understand their care and treatment.

Staff routinely involved patients and those close to them in decisions about their care. Patients told us that they felt involved in decisions about their care. They felt listened to and that their views were considered. They were treated as partners in their own care and described that they were given options, rather than being told what to do. We saw from reviewing patient records that care and treatment options were regularly discussed with patients and their carers, and was documented appropriately.

CQC Children and Young People’s Survey 2016

The trust performed better than other trusts for three questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People’s Survey 2016. It performed about the same as other trusts for the remaining 17 questions. No score was available in relation to question 66 ‘If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?’

CQC Children and Young People’s Survey 2016 questions, understanding and involvement of patients, Mid Essex Hospital Services NHS Trust

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Question</td>
<td>Score Range</td>
<td>Score</td>
<td>Comparison</td>
</tr>
<tr>
<td>-----</td>
<td>--------------------------------------------------------------------------</td>
<td>-------------</td>
<td>-------</td>
<td>---------------------</td>
</tr>
<tr>
<td>11</td>
<td>Did members of staff treating your child give you information about their care and treatment in a way that you could understand?</td>
<td>0-15 adults</td>
<td>9.28</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>12</td>
<td>Did members of staff treating your child communicate with them in a way that your child could understand?</td>
<td>0-7 adults</td>
<td>8.00</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>13</td>
<td>Did a member of staff agree a plan for your child’s care with you?</td>
<td>0-15 adults</td>
<td>9.46</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>15</td>
<td>Did staff involve you in decisions about your child’s care?</td>
<td>0-15 adults</td>
<td>8.29</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>16</td>
<td>Were you given enough information to be involved in decisions about your child's care and treatment?</td>
<td>0-15 adults</td>
<td>8.87</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>17</td>
<td>Did hospital staff keep you informed about what was happening whilst your child was in hospital?</td>
<td>0-15 adults</td>
<td>8.77</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>18</td>
<td>Were you able to ask staff any questions you had about your child’s care?</td>
<td>0-15 adults</td>
<td>9.24</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>31</td>
<td>Before your child had any operations or procedures did a member of staff explain to you what would be done?</td>
<td>0-15 adults</td>
<td>9.60</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>32</td>
<td>Before the operations or procedures, did a member of staff answer your questions in a way you could understand?</td>
<td>0-15 adults</td>
<td>9.66</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>34</td>
<td>Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>0-15 adults</td>
<td>8.89</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>39</td>
<td>When you left hospital, did you know what was going to happen next with your child's care?</td>
<td>0-15 adults</td>
<td>8.87</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>41</td>
<td>Do you feel that the people looking after your child listened to you?</td>
<td>0-7 adults</td>
<td>8.96</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>59</td>
<td>Did hospital staff talk with you about how they were going to care for you?</td>
<td>8-15 children</td>
<td>9.40</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>60</td>
<td>When the hospital staff spoke with you, did you understand what they said?</td>
<td>8-15 children</td>
<td>8.57</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>61</td>
<td>Did you feel able to ask staff questions?</td>
<td>8-15 children</td>
<td>9.75</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>62</td>
<td>Did the hospital staff answer your questions?</td>
<td>8-15 children</td>
<td>9.85</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>63</td>
<td>Were you involved in decisions about your care and treatment?</td>
<td>8-15 children</td>
<td>6.18</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>66</td>
<td>If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?</td>
<td>12-15 children</td>
<td>No Score</td>
<td>No Score</td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td>8-15 children</td>
<td>Mean</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------------------------------------------------</td>
<td>---------------</td>
<td>------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>69</td>
<td>Before the operations or procedures, did hospital staff explain to you what would be done?</td>
<td>8-15 children</td>
<td>9.76</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>70</td>
<td>Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>8-15 children</td>
<td>8.15</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>72</td>
<td>When you left hospital, did you know what was going to happen next with your care?</td>
<td>8-15 children</td>
<td>8.14</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

0-7 adults = asked of parents and carers of children up to seven years of age.
0-15 adults = asked of parents and carers of children up to 15 years of age.
8-15 children = asked of children aged from eight to 15 years of age.
12-15 children = asked of children aged from 12 to 15 years of age.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The children’s service developed plans for service delivery to meet the needs of the local population. This included working with external stakeholders such as GP services and children’s mental health services. For example, the service held a listening event in March 2017 which included eleven children; six aged 5-9 and five aged 11-15 who were asked about their experiences of Phoenix ward and children’s ED. The children’s parents were also present. The service collected the children’s feedback in a combination of ways that were age appropriate.

The feedback generated a number of actions. Some of the actions included improving explanations for children, reducing disturbances at night, reducing delays and improving the environment. Some of the actions that have already been completed include an outside area allocated for adolescents and garden project to develop the space on Phoenix ward. Another action that was developed directly from the feedback was introducing pets as a form of therapy. The service now provides pet therapy twice a month.

The service worked with partners in health and social care to plan improvements to the service. They identified that it is important for children to access healthcare as close to home as possible to ensure that disruption to education is as low as possible. The service planned to address this need by increasing access to GPs with a specialist interest in paediatrics and where possible, enabling paediatric consultants to deliver more services in the community such as outpatient clinics.

The service had access to a qualified teacher to support children with their educational needs. Staff told us that there was a teacher who visited the wards two days a week. The teacher liaised with the play specialists and families to assess children’s needs and followed up on children who were there for a longer period of time, setting homework where appropriate. It depended upon the children’s needs and how unwell they were, ensuring that the education provision was based upon individual need.

Breastfeeding women were supported to stay with their babies and provided with a bed. The service also provided these women with three meals per day. Patients reported that staff approached them to ask if there was anything they needed and were provided with refreshments.

On the neonatal unit (NNU), mothers were encouraged to stay overnight with babies who were...
nearing discharge to promote bonding, and suitable facilities were provided for them.

Within NNU there was a separate breastfeeding room for mothers to express their breast milk or breastfeed their infant. Portable expressing pumps were also available for bedside use should they wish.

Parents had access to a sitting room, waiting room and kitchen in NNU. The kitchen had hot drink and snack making facilities. The waiting room had a child friendly play and seating area.

On Phoenix ward there was a room which was dedicated for the use of teenagers and their parents. There was a sign on the door which was written in a way that addressed teenagers directly to make them feel like it was their own space. The room had a television, a mixture of games, consoles and a pool table. The wall was designed with a graffiti style to give the appearance of a designated teenager's space.

There was a playroom for the under twos on Phoenix ward which included age appropriate toys and books, bouncers and a sensory corner with a range of multi-sensory toys and activities.

The service, wherever possible, had one bay allocated to younger children and the other bay to older children/adolescents.

There was a secure garden play area, accessed from Phoenix ward, with outdoor play facilities. This had recently been redesigned, with a vegetable patch, flowers and plants to make it bright and appealing to children. Within the garden there was also a small building or shelters for the children on the ward to relax and get fresh air. At the time of our inspection we were told that team have put plans to convert one corner of the garden that would be dedicated to adolescent patients on the wards as a relaxing area away from the ward.

There was a dedicated room for adolescents in the ward to relax in and had gaming facilities, sound systems, and various age appropriate games.

There was a parents’ room in Phoenix ward with comfortable chairs, which was a facility for parents to have some quiet time away from the main ward area. There was a kettle and microwave for parents to make food and hot drinks.

**CQC Children and Young People’s Survey 2016**

The trust performed better than other trusts for six questions relating to responsiveness in the CQC Children and Young People’s Survey 2016. The trust performed about the same as other trusts for the remaining 11 questions.

**CQC Children and Young People’s Survey 2016 questions, responsive domain, Mid Essex Hospital Services NHS Trust**

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>For most of their stay in hospital what type of ward did your child stay on?</td>
<td>0-15 adults</td>
<td>10.00</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>5</td>
<td>Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?</td>
<td>0-15 adults</td>
<td>9.26</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>25</td>
<td>Did you have access to hot drinks facilities in the hospital?</td>
<td>0-15 adults</td>
<td>8.71</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------</td>
<td>------------</td>
<td>-------------</td>
<td>----------------</td>
</tr>
<tr>
<td>26</td>
<td>Were you able to prepare food in the hospital if you wanted to?</td>
<td></td>
<td>6.96</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>How would you rate the facilities for parents or carers staying overnight?</td>
<td></td>
<td>7.53</td>
<td></td>
</tr>
<tr>
<td>55</td>
<td>Was the ward suitable for someone of your age?</td>
<td>7.99</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Were there enough things for your child to do in the hospital?</td>
<td>8.83</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Did your child like the hospital food provided?</td>
<td>6.68</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>Did a staff member give you advice about caring for your child after you went home?</td>
<td>9.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>Did a member of staff tell you who to talk to if you were worried about your child when you got home?</td>
<td>9.40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>Were you given any written information (such as leaflets) about your child’s condition or treatment to take home with you?</td>
<td>8.54</td>
<td></td>
<td></td>
</tr>
<tr>
<td>56</td>
<td>Were there enough things for you to do in the hospital?</td>
<td>8.18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>57</td>
<td>Did you like the hospital food?</td>
<td>7.69</td>
<td></td>
<td></td>
</tr>
<tr>
<td>71</td>
<td>Did a member of staff tell you who to talk to if you were worried about anything when you got home?</td>
<td>8.17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>73</td>
<td>Did a member of staff give you advice on how to look after yourself after you went home?</td>
<td>9.20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Did the hospital give you a choice of admission dates?</td>
<td>2.82</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Did the hospital change your child’s admission date at all?</td>
<td>9.21</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

0-7 adults = asked of parents and carers of children up to seven years of age.
0-15 adults = asked of parents and carers of children up to 15 years of age.
8-15 children = asked of children aged from eight to 15 years of age.
12-15 children = asked of children aged from 12 to 15 years of age.

(Source: CQC Children and Young People's Survey 2016, RCPCH)

**Meeting people’s individual needs**

The service had systems and processes in place to support staff to meet patients’ individual needs. For example, the learning disabilities support practitioner identified and recorded the patients with learning disabilities and complex needs. People’s individual needs were recorded on the electronic patient record system which acted as an alert for hospital staff caring for the patients.

Staff on Phoenix ward were developing their outside space to include a mental health corner, which was a quieter, lower stimulus space designated for those struggling with their mental health to get away from the busy areas of the ward and take some time to reflect, or they used it to sit and talk to somebody if that was more appropriate.
There were clear pathways that supported children who had a learning disability. Staff liaised with their learning disability lead for the trust to seek assistance in developing the care plans of patients who were admitted to the hospital with a learning disability. The service had link nurses for a number of areas including learning disability, cystic fibrosis, epilepsy and diabetes to help support the teams and ensure that patients with complex needs were receiving appropriate care that met those needs.

On Phoenix ward staff used sensory equipment to introduce to children with a learning disability or autism.

The service made efforts to ensure that services were delivered and made accessible in a manner that met the needs of individuals, including those with protected characteristics in line with the Equality Act. For example, longer appointment times were offered to patients who required additional support.

Staff on NNU informed us that when planning a patient’s discharge, they liaised with the community children’s nursing team and GP, if they had children with complex needs, for example being discharged with nasogastric tubes, to ensure that the child and family had the appropriate support when they left hospital.

The service had play specialists, who used distraction techniques to help reduce anxiety in children throughout their stay and whilst receiving treatment, including in the pre-operative stage before a child went into theatre.

Staff used various tools to help communicate with children with a disability or sensory loss. They used communication cards for children with learning disabilities, autism or a hearing impairment, and were also able to access sign language interpreters to ensure children and their families were involved in their care and supported to understand their treatment.

Staff could access an interpretation service for children and parents whose first language was not English. This included both phone and face-to-face interpretation options, and staff reported they were quick to respond.

The service had an end of life link nurse who linked with the wards to ensure people who may be approaching the end of life received personalised care and were supported to make decisions about their care. The service also accessed the chaplain who provided patients and their families with additional support if needed. The play specialists and psychology team have supported patients and their families to understand and come to terms with life limiting conditions.

**Access and flow**

There were effective processes in place to ensure that patients had timely access to initial assessment. The children’s assessment unit provided a 24 hour service for children aged 10 days up until 16. Their policy stated that children and young people should be assessed on arrival, vital signs recorded, a children’s early warning score calculated and a written assessment made of their condition within 15 minutes.

Admission to Phoenix ward included elective admissions as well as emergency admissions from the paediatric assessment unit, the emergency department, and transfers from other trusts. The community paediatric nursing team and GPs could refer children directly to the ward for urgent assessment. The ward had an assessment facility and cared for children and young people requiring medical or surgical treatment. Wizard ward provided planned surgical facilities. Babies admitted to NNU were admitted from the labour ward or community midwifery teams.
The trust had taken action to attempt and reduce waiting times for speech and language therapy which was not offered as a seven-day service. The trust had mitigated this by providing a training programme for nurses in specific clinical areas. The trust informed us that there were ongoing recruitment and funding discussions taking place to improve the speech and language service.

Our review of patient records demonstrated that discharge planning began at the point of admission. Forthcoming discharges were discussed in handover meetings as well as other meetings throughout the day. The MDT identified and acted on any discharge issues that arose during those meetings.

Electronic discharge summaries were comprehensive and detailed. Copies of the summaries were sent to the patient’s GP and parents were provided with a copy. We reviewed the notes of an inpatient who had previously had another admission to the service and been discharged. We saw a discharge letter which confirmed that an outpatient appointment would be sent and the service had arranged an appointment with the community team. Take home medication was well documented and it was documented that the plan was for family to administer some medication by injection. The family had been supported with this – they had been shown how to do it, observed doing it and expressed that they felt comfortable with it.

The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment. Trusts are required to submit data to NHS England outlining how long patients are waiting for non-urgent treatment.

Following the implementation of a new electronic patient record system, the service has been unable to capture accurate referral to treatment (RTT) data since November 2017. The trust requested and received approval from NHS Improvement to pause their reporting until the teething problems were rectified. The trust developed a recovery plan to return to reporting by July 2018.

However, at the time of our inspection we requested RTT date for the Children and Young people service and this was not provided.

**Neonatal Critical Care Bed Occupancy**

From July 2017 to June 2018, the trust had six open neonatal intensive care and high dependency cots in every month. The neonatal bed occupancy rate at the trust fluctuated. However, occupancy was lower than the national average in nine of the 12 months over this time period. All six of the beds were filled in August and November 2017.

![Graph of neonatal critical care bed occupancy](image)

Please note that data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)
In the event that the NNU could not care safely for patients due to high demand for access, babies with the most appropriate clinical circumstances would be transferred to a neighbouring unit as part of the local neonatal network. Babies would be repatriated to the trust when capacity on the unit had reduced.

Staff within the children’s outpatient department had a process in place to monitor patients who did not attend (DNA) their appointments. They informed us that after a second DNA they offered a third appointment if it was required. There were systems for liaising with health visitors and GPs, so that relevant information was shared to ensure the patients’ safety. People were supported to access care and treatment again as soon as possible following missed appointments.

Learning from complaints and concerns

Summary of complaints

**Broomfield Hospital**

From June 2017 to May 2018 the trust received 13 complaints about services for children and young people at Broomfield Hospital. The trust took an average of 38.5 working days to investigate and close these complaints. Their complaints policy states that complaints should be responded to within 25 working days, or 60 working days for more complex complaints.

There were two complaints open at the time of reporting and these had been ongoing for an average of 125.5 days. This was not in line with the trust’s complaints policy of 60 working days for complex complaints. One of these complaints exceeded the 60 day target, having been open for 206 days at the time of reporting while the other had been open for 45 days.

The breakdown of the complaints by subject is shown in the table below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
<th>Percentage of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient care</td>
<td>9</td>
<td>69.2%</td>
</tr>
<tr>
<td>Communications</td>
<td>2</td>
<td>15.4%</td>
</tr>
<tr>
<td>Prescribing</td>
<td>1</td>
<td>7.7%</td>
</tr>
<tr>
<td>Facilities</td>
<td>1</td>
<td>7.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Complaints tab)*

Patients knew how to raise a complaint. Leaflets were displayed throughout the paediatric wards and NNU which provided information to patients about how to raise a complaint or a concern.

On phoenix ward there was a communication book in the playroom which parents and children could express any complaints or suggestions. There was also a board displaying ‘tops and pants’, which patients used to describe what they found positive or negative about the ward. It was a way of including children and making the process accessible to them.

Staff on NNU informed us that it was often possible for complaints to be managed at a ward level, however they signposted complainants to Patient Advice and Liaison Service (PALS) if their complaint could not be resolved by the ward. PALS was accessible; it was situated near the main hospital entrance, so patients and visitors were likely to pass it on their way through the hospital. We saw leaflets on the wards we visited which provided people with information on how to make a complaint. The trust website included details of how to make complaints including in person, via telephone, letter or email.
Feedback and outcomes from complaints and compliments were communicated to staff via team meetings and briefings. Complaints were discussed and monitored at patient safety group meetings.

We reviewed the investigation into one recent complaint, which showed that the complaint was investigated thoroughly and managed appropriately. The trust provided a letter to the complainant which addressed all points raised in the complaint and what action had been taken.

**Number of compliments made to the trust**

**Broomfield Hospital**

From June 2017 to May 2018 the trust received 24 compliments relating to services for children and young people at Broomfield Hospital.

The breakdown of compliments by ward/unit/team is shown in the table below:

<table>
<thead>
<tr>
<th>Ward/unit/team that the compliments related to</th>
<th>Number of compliments</th>
<th>Percentage of compliments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phoenix Ward</td>
<td>15</td>
<td>62.5%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>6</td>
<td>25.0%</td>
</tr>
<tr>
<td>Wizard Ward</td>
<td>3</td>
<td>12.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>24</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

In the RPIR the trust did not provide a breakdown of the compliments by either subject or theme.

*(Source: Routine Provider Information Request (RPIR) – Compliments tab)*
Is the service well-led?

Leadership

Services for children and young people sat in division four, women’s and children’s services.

The children and young people’s service was led by a clinical lead, an associate director of nursing and head of midwifery, and a divisional director of operations. These senior leaders were supported by a matron for paediatrics and a matron for neonates, who in turn supported the Phoenix ward, Wizard ward and neonatal unit managers.

The leadership structure of the service was established and all staff were clear about their roles and responsibilities. All areas of the service had ward/service managers, who received leadership from the matrons.

The matrons reported to the associate director of nursing and head of midwifery. Medical leadership came from the clinical lead for paediatrics who was a practicing consultant at the trust. Both nursing and medical staff consistently reported they had good relationships with service leads and described managers as approachable and supportive.

Vision and strategy

The trust wide vision was: ‘Patient care first… always’. The trust strategy recognises priorities, which include the respect and dignity agenda. Broomfield hospital is part of the Mid and South Essex Success Regime.

The leaders of the children and young people’s service said that there was no formal strategy for the service; however, each year a service business plan which was in line with the trust strategy was submitted to the board. The service was also focusing on staffing levels, retaining existing staff and recruiting to meet planned staffing levels in the service. It was included in the plan that they aimed to support the development and progress of staff, for example in training neonatal nurses.

Culture

The service promoted a positive culture that supported and valued staff.

There was a positive, team-based culture across the service. For example, two members of staff on Phoenix ward told us they felt valued and encouraged to raise ideas and pursue their areas of interest.

Staff consistently reported they felt empowered and confident to raise concerns if they felt the need, and were supported by their managers to do this. They could access the trust whistleblowing policy and procedure if they needed to.

Staff told us there was good teamwork within the teams and we observed this during our inspection. Staff worked together to resolve issues and worked flexibly to accommodate service
needs. Staff told us that local managers and senior nurses all worked in clinic when staffing shortages required it and that the whole team pulled together to provide the best care to patients possible.

There were processes in place to provide staff with career development opportunities. Staff told us that they received regular appraisals and these included discussions around career development. Staff told us that the trust was supportive of training and they felt encouraged to undertake additional training when funding and scheduling allowed.

**Governance**

All staff we spoke with could clearly describe the senior management structure at the hospital and discussed their specific roles and responsibilities.

While there were examples given by senior staff of shared learning, when we asked the service leads about a recent serious case review, they were not aware. Information of a safeguarding serious case review was disclosed as part of the routine provider information submitted by the trust which included lessons learnt and actions taken. In addition, there was a lack of awareness by the service leads regarding the inconsistent systems and lack of robust governance systems to support children safeguarding.

Clinical governance in relation to staff appraisals and training, clinical indicators, infection control, audit and incidents and complaints for the service took place at the monthly women and children directorate governance group and divisional board meeting.

The monthly women and children directorate governance group and divisional board meeting were attended by senior staff from both medical and nursing teams as well as governance leads and representatives from Patient Advice and Liaison Service (PALS) and complaints department.

**Management of risk, issues and performance**

We reviewed the risk register for the children and young people’s service. Current risks were identified, with ratings and action required. Senior staff updated the register when a new risk was identified.

We reviewed 18 open risks on the service risk register that included staffing, resources, security, absence of children safeguarding nurse and delays in reporting radiology results. Each risk had an appropriate person allocated to overseeing it and appropriate actions in place to mitigate them as far as possible. They also had target risk levels to help drive improvement, and target dates for addressing the risks.

For example, in relation to the lack of paediatric oncology nurse specialist, which was red/amber/green (RAG) rated as amber, actions included discussion with site directors for the plan to recruit to a band seven oncology nurse and for the funding to be secured. The service leaders told us that the funding had been secured and that the role was in the process of being advertised.

The shortfall of children safeguarding nurses and the absence of a named safeguarding nurse (Band 8) was RAG rated red. At the time of our inspection the trust had recruited in to the post of associate named nurse for safeguarding children and that a safeguarding nurse the children’s burns team had been seconded in the post in the interim.

The risk register was on the agenda at women and children directorate governance group and divisional board meetings. Staff who did not attend the meeting received minutes or received the
information as part of the monthly staff meeting.

The top three local risks were displayed on an information board on Phoenix ward and NNU to ensure everyone remained aware of them.

Information management

Information needed to deliver effective care and treatment was available to staff in a timely and accessible way via paper patient records and the staff intranet.

The trust held policies and procedures in electronic format on the hospital wide intranet. All nursing and medical staff could access them.

There was a process for the review and ratification of policies to ensure they were fit for purpose; however, we found the protocol for administering intra-nasal diamorphine to children 0-16 years was several years out of date. We also found the clinical operational policy for the children’s assessment unit to be a working draft which had a review date of December 2011. We highlighted these concerns to the senior leadership team who told us that they have put a working group together that was looking at all trust policies and guidelines for accuracy and relevance.

Babies admitted to NNU had data collected and stored securely (with parental consent and in line with the Data Protection Act 1998) on Badgernet, a database used in all neonatal units in the region. The data collected supports the ongoing development of neonatal care.

There was a quarterly women’s and children’s services newsletter to share information from the patient safety and quality committee, best practice, learning from incidents, fundraising events, letter of thanks from patients and their families and other service related news.

Engagement

The trust has undertaken public engagement in the last year regarding proposals to reconfigure a number of acute services as part of the Essex success regime. The engagement process included public talks, meetings, and a formal public consultation document. The trust also used various means to engage with the public including social media, local media coverage, telephone survey of the local population and online questionnaire.

Daily morning trust wide safety huddle ‘moving on with Mid’ took place, where staff could raise any safety concerns with senior leaders. Managers held regular team meetings on wards. Meeting minutes showed discussion of incidents, complaints and staffing.

The service held staff listening events which was an opportunity to provide staff another avenue to give feedback, their thoughts and suggestions about the service. The results of this was circulated through ‘You Said, We Did’ posters, highlighting how the senior management team have responded to the feedback and acted on it. For example, NNU had limited training due to funds from Charity Budget, the service responded by securing funding for a neonatal course for two members of staff every year. In addition, a competencies booklet was produced and in use on the neonatal unit.

The service held a children’s patient listening event which was an opportunity for patients and their families to give their feedback on their experiences of being cared for by the service. Feedback from the listening event was used to improve the service. For example, improving the environment by redecorating Phoenix ward, revamping the outdoor space on Phoenix ward to include a garden project where patients can take part and a dedicated adolescent corner of the outdoor space.

Senior leaders recognised staff that had made an outstanding contribution to patient care. For example, staff on Phoenix Ward won the annual NHS staff outstanding service, as nominated by
patients. A staff member had won a ‘star of the month’ award for their extensive work in end of life care.

Learning, continuous improvement and innovation

Service leaders and staff were involved in continuous learning and improvement to deliver care to patients.

Staff we spoke with said they were encouraged to make suggestions for improvement or change. For example, the service had secured funding for training staff to progress to advanced nurse specialist.

Staff on NNU told us how they provide keepsakes for parents by taking hand and foot prints, as well as other personalised messages to allow parents to document their child’s life from birth and during the neonatal admission.

Outpatients

Facts and data about this service

The outpatient department at Mid Essex Hospital services NHS Trust covers several sites, which include Braintree Community Hospital, St Peter’s Hospital, Brentwood Community Hospital, St Peter’s Hospital, Brentwood Community Hospital, St Michael’s and Broomfield Hospital.

The trust covered a wide range of specialities such as ophthalmology, gynaecology, surgical and the St Andrews burns and plastics regional unit at Broomfield hospital.

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

Information relating to children’s outpatient attendance is reported on in the core service report for children and young people’s services.

Reference to Colchester General Hospital have been made in the report because some services are contracted to Colchester General by the trust.

First and follow up appointments

The trust had 535,882 first and follow up outpatient appointments from April 2017 to March 2018. The graph below represents how this compares to other trusts.
Total number of first and follow up appointments compared to England

(Source: Hospital Episode Statistics)

Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from April 2017 to March 2018.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Number of spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broomfield Hospital</td>
<td>513,783</td>
</tr>
<tr>
<td>Braintree Community Hospital</td>
<td>22,203</td>
</tr>
<tr>
<td>Mid Essex Hospital Services NHS Trust</td>
<td>20,113</td>
</tr>
<tr>
<td>St Peter’s Hospital</td>
<td>14,445</td>
</tr>
<tr>
<td>Colchester General Hospital</td>
<td>5,986</td>
</tr>
<tr>
<td><strong>This Trust</strong></td>
<td><strong>583,038</strong></td>
</tr>
<tr>
<td><strong>England</strong></td>
<td><strong>105,566,870</strong></td>
</tr>
</tbody>
</table>

Please note that the trust did not specify the site at which the appointment occurred in some cases. These appointments have been reported at trust level in the table above.

(Source: Hospital Episode Statistics)

Type of appointments

The chart below shows the percentage breakdown of the types of outpatient appointments from April 2017 to March 2018:

Number of appointments at Mid Essex Hospital Services NHS Trust from April 2017 to March 2018 by site and type of appointment
Please note that the trust did not specify the site at which the appointment occurred in some cases. These appointments have been reported at trust level in the chart above.

(Source: Hospital Episode Statistics)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

The service provided mandatory training in key skills but not everyone completed the training in line with the trust’s target. Staff told us that high levels of clinical demand meant that staff could not always be released to attend training.

Mandatory training completion rates

The trust set a target of 85% for the completion of all mandatory training modules with the exception of information governance, where the target was 95% (Please see the table below).

Broomfield Hospital

A breakdown of compliance for mandatory training courses from June 2017 to May 2018 for qualified nursing staff in outpatients at Broomfield Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2017 to May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Medicine management</td>
<td>33</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>32</td>
</tr>
<tr>
<td>Infection prevention level 1</td>
<td>32</td>
</tr>
<tr>
<td>Manual handling people</td>
<td>25</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>29</td>
</tr>
<tr>
<td>Information governance</td>
<td>29</td>
</tr>
<tr>
<td>Fire safety 1 year</td>
<td>28</td>
</tr>
<tr>
<td>Manual handling object</td>
<td>27</td>
</tr>
</tbody>
</table>

In outpatients, the hospital had an overall training compliance rate of 83.9% for qualified nursing staff. The trust’s training targets were met for three of the eight mandatory training modules for which qualified nursing staff were eligible. The manual handling object module had the lowest completion rate, at 75.0%.

Delivery of mandatory training was by a variety of methods, including e-learning and face to face sessions. Mandatory training included fire safety, manual handling people, information governance, infection governance and resuscitation.

Staff could book their training online and received a reminder via email when they were due to complete a module. Staff that we spoke with confirmed they knew how to access the training booking system. Staff were responsible for booking their training, however in some departments due to staff shortages time off was not always available to attend training sessions.

The trust did not provide any separate mandatory training data for medical staff in outpatients. They informed us that these staff members were assigned to the specific specialties.

(Source: Routine Provider Information Request (RPIR) – Training tab)
Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff had training on how to recognise and report abuse. We spoke with 30 members of staff and most could describe their responsibilities regarding safeguarding concerns. Some of the staff we spoke with could give examples of when they had to contact the safeguarding representative to assist with a vulnerable patient.

The trust had an adult safeguarding policy in place, including guidance on identifying domestic violence and neglect. The trust also had a children’s safeguarding policy, implemented on 13 June 2016 with a review date of June 2019. The policy included guidelines for child sexual exploitation, child trafficking, self-harming and suicidal behaviour.

We reviewed the trust’s adult safeguarding policy, implemented on 14 April 2016 with a review date of March 2019. We found this was up-to-date, reflected relevant national legislation and guidance including information on honour based violence and modern slavery.

Both policies had information on the relevant local authorities contact details and referral pathways. Staff could access both policies through the hospital intranet and the trust website. Safeguarding training was part of the mandatory training programme, which was communicated and monitored during appraisals and performance reviews. Staff told us that they knew how to access the safeguarding policy.

One member of staff told us that though they had not dealt with patients who were victims of female genital mutilation (FGM), however they knew how to contact the safeguarding team for advice. Another member told us that when they had treated victims of FGM in the past, that they had known about their abuse by reading their notes beforehand and were aware of who to contact if additional support was needed.

Safeguarding training completion rates

The trust set a target of 90% for the completion of safeguarding training.

Broomfield Hospital

A breakdown of compliance for safeguarding training courses from June 2017 to May 2018 for qualified nursing staff in outpatients at Broomfield Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2017 to May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>31</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>31</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>31</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>29</td>
</tr>
</tbody>
</table>

In outpatients, the hospital had an overall safeguarding training compliance rate of 84.7% for qualified nursing staff. The trust’s 90% completion target was not met for any of the four safeguarding training modules for which qualified nursing staff were eligible. The safeguarding adults level 2 module had the lowest completion rate, at 80.6%. To improve compliance rates, managers told us that there were plans to recruit more staff and that bank nurses were used to cover shifts. With these measures in place staff would then have more time to complete...
training.

The trust did not provide any safeguarding training data for medical staff in outpatients. They informed us that these staff members were assigned to the specific specialties.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Cleanliness, infection control and hygiene

The service controlled infection risk, measures were used to prevent the spread of infection.

The department had infection control measures in place in most of the areas we visited. Equipment and the premises were visibly clean. However, “I am clean stickers” were not regularly used to indicate that equipment and rooms had been cleaned. We checked the daily schedule in four clinic rooms and it showed that they had been cleaned daily from June 2018 to the day of the inspection.

We checked one treatment room in the eye clinic and the schedule showed that it had been cleaned from June 2018 to the day of the inspection. The outpatient’s matron confirmed that cleaning schedules were archived every three months.

The trust had a cleaning policy in place, implemented 24 October 2014 with a review date of November 2018. The cleaning policy supported the strategic cleaning plan which was developed for the trust to comply with all relevant legislation and guidance, such as the health and social care act (2008) and the national specifications for cleanliness in the NHS (2007).

The trust had an MRSA policy, issued by the infection and prevention directorate with a review date of November 2018. The policy stated that high risk MRSA patients were put on the MRSA care pathway and admitted into a side room where appropriate.

Staff were aware of how to treat patients with a suspected infectious disease such as tuberculosis. Staff told us that patients with suspected infectious diseases were isolated in a single room vented to the outside of the building.

Personal protection equipment (PPE) such as disposable gloves and plastic aprons were available throughout the outpatient department in clinical areas.

Senior staff told us that monthly safety ‘walkabouts’ were completed. Walkabouts included cleaning rota spot checks to see whether they were signed and up to date. Hand gel was available and staff areas were clean and tidy. Senior staff told us that regular monitoring of cleanliness and hand hygiene was in place via monthly local audits. For example, in ENT outpatient department the hand hygiene compliance was 100% from April 2017 to July 2018.

The trust managed the decontamination of medical devices in line with NICE guidelines for endoscopes and the heath Act 2006. We reviewed the endoscopy decontamination policy implemented on 21 August 2018 with a review date of 2019. The policy stated that endoscopes were decontaminated in the endoscopy decontamination unit. The decontamination process included assembly and dismantling of endoscopes, manual cleaning, accessories, disinfection, washer/disinfector, drying, storage, transportation, tracking and traceability.

Environment and equipment

The design and use of the treatment centre was suitable for purpose. The outpatient department environment was clear and uncluttered.
The streaming and disposal of waste, including clinical waste was in line with national guidance and legislation.

Equipment servicing and repairs were undertaken by the trust’s clinical engineering department, who were responsible for monitoring when equipment was due for servicing. Staff could contact the department to highlight concerns about any items of equipment. The outpatient’s matron advised that some equipment was due for safety testing in October 2018 and that estates management had been contacted and were aware of this.

All sharps bins were correctly assembled and labelled. Containers were within the recommended fill levels. We saw that waste bins were available with the correct colour coded disposal bags to enable waste to be segregated appropriately.

Treatment rooms were visibly tidy and equipment stored appropriately.

We checked a range of consumable items including, syringes and dressings. We found all items were within their expiry date and staff confirmed that processes were in place to check that stock was regularly rotated to ensure the use of short dated items.

All staff knew where the nearest resuscitation equipment was located and described their role in a patient emergency. Resuscitation trolleys were often shared by clinics within an area in outpatients.

Daily checks were completed and tamper proof tags were used to show if the contents had been accessed. Full internal checks of the trolleys were completed daily, and overall, records of these checks were found to be complete.

Assessing and responding to patient risk

Risks to adult patients were assessed, and their safety monitored and managed so they were supported to stay safe.

Risk assessments were carried out for patients who used the services and risk management plans developed in line with national guidance. There were pathways and processes for the assessment of people within the outpatient clinics.

There were processes in place for the assessment of people within outpatient clinics who became clinically unwell. Patients’ observations were taken upon arrival and entered into the National Early Warning Score (NEWS) to assess and monitor them. Patients who showed signs of deterioration were initially assessed by staff in the department and then taken to the emergency department (ED). Staff were also aware of how to contact the resuscitation team if a patient deteriorated rapidly.

Staff had access to a mental health liaison team and mental health specialist nurses from the local mental health trust which was based within the hospital grounds. We spoke with a member of staff who described how the process for making a referral to the mental health team worked, this included arrangements for safe transfer to an appropriate facility.

Outpatient areas used an adapted version of the ‘World Health Organisation (WHO) Surgical Safety Checklist and five steps to safer surgery’ prior to performing invasive procedures such as biopsies and intravitreal injections. Managers ensured that there was a plan to develop local safety standards for invasive procedures (LocSIPPs) using national safety standards for invasive procedures. The outpatient’s manager told us that they were part of a LocSIPPs group that met regularly. Following the never event in dermatology (see incidents section for detailed information) the LocSIPPs group introduced a pre-injection checklist to double check the patients name and site of injection.
Nurse staffing

The service did not always have enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment. Staff told us that there was a high reliance on bank staff. However, patients’ needs were met at the time of inspection and plans were in place to improve this.

Staffing levels and skill mix were planned and reviewed to help ensure that patients received safe care and treatment. Senior staff told us that the level of staffing and skill mix was dependent on the type of clinic. Main outpatients employed consultants, one senior sister for each department and one junior sister. Ophthalmology clinics were run by one senior and one junior sister with support from the matron if necessary. One registered nurse, healthcare assistant and band five nurses ran the rheumatology clinics.

Broomfield Hospital

The trust reported the following qualified nursing staff numbers in outpatients at Broomfield Hospital as of March 2018 and May 2018:

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTE)</td>
<td>Planned staff (WTE)</td>
</tr>
<tr>
<td>Broomfield Hospital</td>
<td>10.1</td>
<td>12.6</td>
</tr>
</tbody>
</table>

The nursing staffing level within outpatients decreased from 80.6% in March 2018 to 69.5% in May 2018. This was mainly due to an increase of 2.5 WTE planned posts.

(Source: Routine Provider Information Request (RPIR) – Total staff tab)

Vacancy rates

Broomfield Hospital

From June 2017 to May 2018, the trust reported a vacancy rate of 23.2% for qualified nursing staff in outpatients at Broomfield Hospital. This was higher than the trust target of 15.4%.

Senior staff told us that there was a plan in place to help fill the vacancies. This included a planned recruitment day specifically for outpatients. The service used bank staff to cover some of the shifts and part-time staff were working extra hours to meet demands of the service.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

Broomfield Hospital

From June 2017 to May 2018, the trust reported a turnover rate of 11.7% for qualified nursing staff in outpatients at Broomfield Hospital. This was lower than the trust target of 18.05%.

Within the RPIR, the trust noted that there was an issue with their turnover data. The process used in ESR when staff leave and retain a staff bank contract means that they are not counted in ESR as a leaver. As a result, the turnover figures reported from ESR are lower than they actually are. The trust’s internal reports and the Joint Working Board report are adjusted to reflect the additional leavers, so that the correct turnover figures are reported. However, due to the manual recording of this data, and its limitations, it was not possible for the trust to analyse it to the level of detail required for the RPIR.
The trust reported that this process was changing and, in the future, all of their leavers would be included in reports from ESR.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

**Broomfield Hospital**

From May 2017 to April 2018, the trust reported a sickness rate of 4.6% for qualified nursing staff in outpatients at Broomfield Hospital. This was slightly higher than the trust target of 4.24%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and agency staff usage**

**Broomfield Hospital**

From May 2017 to April 2018, the trust reported that 6.3% of nursing assistant staff shifts in outpatients at Broomfield Hospital were filled by bank staff, while no shifts were filled by agency staff. Fifty-one shifts (0.4%) were not filled by either bank or agency staff to cover staff absence.

Over the same period, the trust reported that 7.7% of qualified nursing shifts in outpatients at Broomfield Hospital were filled by bank staff and 4.4% of shifts were filled by agency staff. In addition, 0.8% of shifts remained unfilled.

<table>
<thead>
<tr>
<th>Bank/ agency</th>
<th>Nursing Assistant</th>
<th>Qualified nurses</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>Bank</td>
<td>730</td>
<td>6.3%</td>
<td>1,050</td>
</tr>
<tr>
<td>Agency</td>
<td>0</td>
<td>0.0%</td>
<td>596</td>
</tr>
<tr>
<td>Not filled</td>
<td>51</td>
<td>0.4%</td>
<td>106</td>
</tr>
<tr>
<td><strong>Total shifts available</strong></td>
<td>11,593</td>
<td></td>
<td>13,691</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Nursing bank agency tab)

Staff in the orthopaedic and dermatology clinics told us that they were working twelve-hour shifts to address the patient back log. We were told by senior staff that there were plans to recruit four new nursing staff. No agency staff were employed by the outpatient department. There were some bank nurses who worked regular shifts in specific clinics. This meant that they were familiar with the service and the processes. For example, bank staff worked regular shifts in ophthalmology to assist with the backlog, glaucoma patients and to cover vacancies and sickness.

**Medical staffing**

**Broomfield Hospital**

All workforce data for medical staff is recorded under the specific speciality and where relevant reported upon in the relevant core service report.

**Records**
Staff did not always keep detailed records of patients’ care and treatment. Records were not always clear, up-to-date, and easily available to all staff providing care.

Medical records were available electronically in the majority of clinics. However, some records were still paper based. Staff told us that in cases where medical records were not available for clinics, letters could be pulled off the electronic system and the patient medical history could be looked into. Due to the movement of the dermatology clinic, staff in the dermatology clinic told us that paper based medical records were sometimes delivered to the wrong area within outpatients. To locate paper based records staff told us that they used the electronic tracking system or called the records library. The service did not routinely monitor the availability of records for clinics to identify areas for improvement in continuity of care.

We reviewed seven electronic patient records and found that in one record, chaperone details were not recorded where staff were confident that one would have been present. In two records medical staff had not included their grade. In another record, no time or date was entered next to the staff members signature. Staff had electronic access to diagnostic results. However, diagnostic imaging results were not always available in a timely manner due to delays in reporting of scans (this is reported on fully in diagnostic imaging core service report).

**Medicines**

The service followed national guidance and trust policy when prescribing, administering, recording and storing medicines. However, the storage and management of medicines related stationery did not always follow national guidelines.

Medicines were stored in locked cupboards and refrigerators. We checked a range of medications and found them to be in date and stored appropriately. Keys to the drug cupboards were stored securely in a locked container which required a combination to be entered for access. This was kept in an area that could only be accessed by members of staff.

No controlled drugs (CDs) were stored in the areas we inspected which included main outpatients, ophthalmology, gynaecology and dermatology.

There were processes in place to monitor and record temperatures of rooms and fridges where drugs were stored. For example, for one of the treatment rooms we visited we saw that daily temperature checks had been completed between April and September 2018 and were within range. Fridge temperature checks were also monitored daily.

Clinicians used electronic prescribing appropriately and medicines were administered and supplied to patients in the correct manner.

Medicines related stationery such as prescription forms were stored within some consulting rooms in an unlocked drawer. Consulting rooms we visited were unlocked and left unattended when consultations were not taking place. National guidance states that prescription forms should be treated as controlled stationery and stored in a locked room or area and not left unattended (NHS Protect ‘Management and Control of Prescription forms’, March 2018). Our review of prescription management processes demonstrated that there was not an effective system in place to monitor and record the use of prescription forms to provide a clear audit trail. This included a lack of the use of unique identifiers. We were not assured that the processes in place to minimise the risk of unauthorised access to controlled stationery was robust. We escalated our concerns about the storage of medicines related stationery to management. Consulting rooms were locked when the department was closed.

**Incidents**

The service mostly managed patient safety incidents well. Staff recognised incidents and reported them appropriately. However, there were still areas for improvement to be made to ensure that learning from serious incidents was embedded in practice.
There was a clear process for reporting incidents. All staff we spoke with understood the incident reporting process and described how they would report an incident. Incidents were reported and investigated through the trust’s electronic reporting system. Staff understood their responsibility to report incidents both internally and externally.

Our review of incident reports and action plans demonstrated that incidents were appropriately investigated with a full root cause analysis (RCA) completed to help identify areas for improvement. However, we were not assured that the processes for sharing learning from incidents was effective.

**Never Events**

**Broomfield Hospital**

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

From August 2017 to July 2018, the trust reported two serious incidents classified as never events for outpatients at Broomfield Hospital. Both were surgical/invasive procedure incidents meeting SI criteria.

(Source: Strategic Executive Information System (STEIS))

The first never event occurred in October 2017 in the dermatology clinic when an incorrect mole was removed. The findings of the RCA demonstrated that the WHO surgical safety checklist had not been followed. Other factors were a lack of comprehensive induction for doctors and the procedure had been undertaken without the patient’s notes due to issues with the implementation of the new electronic patient management system (implemented in May 2017). An action plan had been developed and included improvements in the induction process, ensuring that minor operating theatres were staffed with one registered nurse and one HCA, improving the process for recording the sites for lesion removal and ensuring that no procedures should take place unless patient notes were available. Learning from the incident had been disseminated via a trust wide safety alert that was sent by email to staff. Senior staff told us that following the recommendations, the induction of locum doctors into the dermatology outpatient department was being improved to provide clarity about paperwork requirements and good governance. Staff in dermatology clinics were aware of the minimum staffing requirements for minor operations.

The action plan following the dermatology incident stated that learning was shared through outpatient and governance meetings, human factors training, retraining in the WHO checks and consent processes and a discussion with staff involved and wider team regarding the investigation outcome.

The second never event, in May 2018, occurred when an intravitreal injection was given in the wrong eye within ophthalmology outpatients. Recommendations made included, marking of the eye should be completed by the clinician completing the procedure. Adaptation of the WHO surgical safety checklist to include version control and all members of the ophthalmology team to attend human factors team-building training. In an effort to share learning following the never event in May 2018, senior staff told us that patient safety posters reminding staff to check the patient’s name, date of birth and address were now on treatment room walls. Pre-injection checklists were being conducted and staff were double checking electronic databases to confirm patient identity and treatment. Staff in ophthalmology told us that the WHO surgical safety checklist had been updated following the recommendations made in the investigation report. However, the checklist was not regularly audited.

Arrangements for shared learning following the never event in ophthalmology included, sharing of
the details of the report at department meeting, distribution to ophthalmology consultants. The report was shared with the chair of the LocSSIPs group, at specialist surgery governance meetings and a trust safety alert was sent to staff.

The trust had conducted a thematic analysis of never events from November 2016 to May 2018. The analysis highlighted that the wrong lesion removal in dermatology was due to a failure to share learning from a previous never event in plastics. We were therefore not assured that learning from lessons was appropriately shared to minimise the risk of reoccurrence.

We reviewed the Root Cause Analyses (RCA) for both never events mentioned above and noted that duty of candour had been applied.

**Breakdown of serious incidents reported to STEIS**

**Broomfield Hospital**

In accordance with the Serious Incident Framework 2015, the trust reported eight serious incidents (SIs) in outpatients at Broomfield Hospital which met the reporting criteria set by NHS England from August 2017 to July 2018.

A breakdown of these serious incidents by incident type is shown in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Proportion of incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment delay</td>
<td>3</td>
<td>37.5%</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident</td>
<td>2</td>
<td>25.0%</td>
</tr>
<tr>
<td>Diagnostic incident including delay</td>
<td>1</td>
<td>12.5%</td>
</tr>
<tr>
<td>(including a failure to act on test results)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pressure ulcer</td>
<td>1</td>
<td>12.5%</td>
</tr>
<tr>
<td>Screening issues</td>
<td>1</td>
<td>12.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

*(Source: Strategic Executive Information System (STEIS))*. 


Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

The service had systems in place to ensure compliance with relevant best practice and national guidance. Policies were aligned and referenced to national guidance such as National Institute of Health and Care Excellence (NICE) guidance.

For example, staff knew how to identify patients with mental health needs such as depression, and the rights of people subject to the Mental Health Act 1983 were protected. Staff told us that they knew how to make referrals to the mental health team when needed and adhered to the Mental Health Code of Practice.

Staff told us that they knew how to contact dementia nurses if they needed advice on how to manage patients with dementia and learning disabilities.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs whilst in the Outpatient’s Department.

Water dispensers were available for patients use in the outpatient departments. There were facilities close to the main outpatient department where patients and visitors could purchase refreshments.

Staff offered patients and visitors drinks and food if they had been waiting for a long period for example if they were waiting for patient transport.

Staff reported that they always checked if a patient had specific dietary requirements, such as patients with diabetes and provided the appropriate refreshment in the event of a long wait or when waiting for transport.

Pain relief

Staff assessed and managed patients to see if they were in pain.

We reviewed six sets of patient care records during our inspection, and found that staff routinely recorded the patient’s level of pain in line with the trust’s policy. We spoke to staff in the pain management clinic who advised that they were available for advice and consultation.

Staff in the pain management clinic told us that they held sessions to educate staff further on how to effectively manage pain.

Staff used specialist assessment tools for patients who could not verbalise, for example the Abbey Pain Scale for people with dementia or communication difficulties.

Patient outcomes

Follow-up to new rate

Information about the outcomes of people’s care and treatment was routinely collected and monitored. Patient follow up rates improved significantly from June 2017 to March 2018.
Broomfield Hospital

In April and May 2017, the follow-up to new rate for Broomfield Hospital was slightly lower than the England average. However, in the subsequent 10 months, June 2017 to March 2018, the hospital's follow-up to new rate was consistently higher than the England average.

The chart below shows the follow up to new rates over time for each of the sites at which the trust provides outpatient services:

**Follow-up to new rate, Mid Essex Hospital Services NHS Trust**

![Graph showing follow-up rates over time]

(Source: Hospital Episode Statistics)

Competent staff

The service made sure staff were competent for their roles.

A senior member of staff told us that there were training opportunities to encourage staff development. The trust held training programmes with two local universities for staff who wanted to further their studies and acquire a new vocation to help further their career and skills.

Appraisal rates

Broomfield Hospital

From June 2017 to May 2018, 76.0% of staff in outpatients at Broomfield Hospital received an appraisal, which was slightly lower than the trust’s target of 79%. The target was not met by the qualified nursing staff group, which had the lowest completion rate, at 60.6%. A breakdown of appraisal completion by staff group is shown in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>June 2017 to May 2018</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Appraisals completed</td>
<td>Individuals required</td>
<td>Completion rate</td>
</tr>
<tr>
<td>Qualified healthcare scientists</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic, technician staff</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>NHS infrastructure support staff</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>8</td>
<td>9</td>
<td>88.9%</td>
</tr>
</tbody>
</table>
Support to doctors and nursing staff | 31 | 41 | 75.6%  
Qualified nursing staff | 20 | 33 | 60.6%  
Total | 76 | 100 | 76.0%  

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Multidisciplinary working

Staff in different teams, services and organisations were involved in assessing, planning and delivering care and treatment.

Outpatient teams worked together to plan and deliver care and treatment. Staff in different teams and services worked together to assess, plan and deliver co-ordinated care. Specialist nurses attended clinics to assist staff.

Outpatient services were run by multidisciplinary teams. Nursing staff, healthcare assistants and doctors told us, and we saw that they worked collaboratively in outpatient areas. Nursing staff spoke positively about the advice and support provided by medical staff.

Multidisciplinary team (MDT) meetings were held across all specialties to provide effective assessment and treatment.

Seven-day services

Outpatient services were provided from 9pm to 5.30pm, Monday to Friday. Some specialities, for example dermatology and ophthalmology offered clinics until 7pm on Saturdays. This offered appointment times which were more accessible for patients and to help clear a backlog of patients that had not been treated due to staff shortages.

Health Promotion

A range of leaflets, literature and posters relating to health promotion were displayed in information areas throughout the outpatient department. For example, advice about smoking cessation, exercise and the healthy heart. There was also information on mental health and wellbeing, and substance misuse.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They understood how and when to assess whether a patient had the capacity to make decisions about their care.

The trust had a policy for compliance with the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). We reviewed version three of the policy which provided guidance for staff on the assessment of mental capacity, when consent should be sought and the information that should be given to patients. The policy also mentioned the process for documenting discussions and recording consent, and how to respond to the refusal of treatment.

Staff in outpatients were expected to complete MCA and DoLS training as part of their mandatory training. However, compliance did not meet trust targets and was significantly low in some areas.

Mental Capacity Act and Deprivation of Liberty training completion

Broomfield Hospital

The trust reported that from June 2017 to May 2018 MCA level 1 training was completed by 89.7% of staff in outpatients at Broomfield Hospital, compared to the trust target of 90%.
This included 83.3% of qualified nursing staff (30 out of 36 eligible staff), which was below the trust’s target of 90%.

The trust reported that from June 2017 to May 2018 MCA level 2 training was completed by 13.2% of staff in outpatients at Broomfield Hospital, compared to the trust target of 90%.

This included 11.8% of qualified nursing staff (two out of 17 eligible staff), which was below the trust’s target of 90%.

Deprivation of Liberty Safeguards training is covered under the MCA levels 1 and 2 training modules.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Although training levels did not meet the trust target for compliance, staff we spoke with understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Two members of staff described how they would support a patient who lacked the mental capacity to decide about their care.

Staff demonstrated an understanding of best interest decision making and knew how to seek advice when patients were not able to give valid informed consent due to a lack of mental capacity.

We observed nursing staff asking patient consent both verbally and implied before carrying out care.
Is the service caring?

**Compassionate care**

**Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.**

Staff respond in a compassionate timely and appropriate way when people experience physical pain, discomfort or emotional distress. Patients gave positive feedback about the care provided by staff, who they described as friendly and helpful. Patients told us that they “can’t fault the hospital and that they were seen on time.”

We observed staff of all grades interacting with patients. Staff were friendly and welcoming and were quick to offer help when required.

Chaperones were available in outpatient areas and patients were encouraged to bring their own chaperone to clinics. During clinics both male and female staff were available to attend as chaperones when patients requested it, for example for intimate examinations during gynaecology clinics.

Staff maintained the privacy and dignity of patients. Privacy sheets were available in consultancy rooms to cover the patient during a procedure or examination to respect their dignity. Staff used curtains during patient examinations and knocked on doors before entering rooms to ensure privacy and dignity for patients.

The department had a queuing system at each reception desk with signs clearly stating, ‘stand back until called.’ Patients could speak to staff without being overheard so their confidentiality was protected.

**Emotional support**

**Staff provided emotional support to patients to minimise their distress.**

During the oncology clinic we found a variety of leaflets including some with information about the Epilepsy society, Crohn’s disease and Colitis. Staff told us that trollies with leaflets relevant to the clinic being held at the time were left in waiting areas. Staff directed patients to information so that they could further understand their illness, what to expect, medication and any side effects and support available.

Staff could use quiet rooms to help support distraught or upset patients and their families, for example if they were upset about receiving a life changing diagnosis.

**Understanding and involvement of patients and those close to them**

**Staff involved patients and those close to them in decisions about their care.**

Staff communicated with patients so that they understood their care, treatment and condition. We spoke to a patient who advised that they had been involved in the decision-making process where their treatment was concerned, that they knew what to expect and when they were likely to be discharged.

Staff made sure that patients who used the service and those close to them could find further information, including community and advocacy services.
Staff involved people who use the service and those close to them in planning and making shared decisions about their care and treatment. We spoke with patient relatives who advised that they knew what to expect and who to contact if they needed support whilst caring for their loved one.
Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of local people.

The hospital site was accessible by public transport and there were bus timetables located at hospital entrances. There was on-site parking and appropriate drop off points around the hospital to assist patients who had difficulty with mobility.

Senior staff told us that there were plans to merge Broomfield Hospital with two neighbouring trusts to help share resources so that they can better cater for the growing population that used the service. Plans to share staff across all three sites would also help tackle the staff shortage.

Different areas of the hospital were allocated different colour schemes and letters. The main outpatient department was on the ground floor at the front of the building. All outpatient clinics were clearly signposted and there were volunteers at the reception desk to assist if needed. Patients told us that they found it easy to find their way around the hospital.

Upon arrival patients had the option to either check in using the electronic system or they could visit the reception desk. Once patients had checked in they were directed to a specific area in the main outpatient departments which was called the atrium. Leading off the atrium were seven waiting areas for different clinics. For example, waiting area one was near the vascular clinic and waiting area three was near the Eye clinic and the Breast unit. Each clinic area was colour coded, numbered and sign posted. Outpatient clinics were located on the ground and first floor in zone A, B, D and E. Zone A had pink signage, Zone B was, blue Zone D was orange and Zone E was green. We observed volunteers assisting patients with the electronic check in system and escorting them to their waiting areas.

There were electronic screens located in different areas within the outpatient area which displayed patients’ names and the location of the clinic. While using the electronic check in system or booking in at reception patients were asked whether they wanted their name to appear on the screen. Patients who wanted to keep their details private could request a ticketed number instead. If a patient sat in the wrong area or went to the shops due to a late running clinic they would be able to track their appointment and correct zone when their name or number appeared on a nearby screen.

Patients could choose to wait in the atrium near the shops and cafés or go straight to the waiting area in the zone where their clinic was located. There were reception desks attended by staff within each zone. Reception staff could direct patients to their zone if needed. Once in the correct waiting area patients could sit and wait for their name to be called into a treatment room by a clinician for their appointment.

In all outpatient areas there was enough seating for patients and relatives. There were toilet facilities, magazines, water dispensing machines and a separate play area in ophthalmology.

Meeting people’s individual needs

The service took account of patients’ individual needs.

The trust identified and met the information and communication needs for those with disability and sensory loss.

The department had processes in place to allow the identification of patients’ individual communication needs and provide them with appropriate support. Reception staff were made aware of anyone attending an appointment who had a disability, was living with dementia, visual impairment or a learning disability. An electronic flag notified staff on the patient record system but the booking staff usually informed them in advance. Disabled toilets were easily accessible within the foyer and outpatient waiting areas.

Patients living with dementia, learning disabilities, autism, mental health conditions and visual
impairment were allocated a member of staff or volunteer in advance of the appointment. Allocated staff members could sit in and act as a chaperone if required. We spoke with staff who told us that they had training around dementia awareness. Staff also told us that dementia and learning disabilities specialists were easy to contact by phone and were available to assist during appointments. Patients were also encouraged to bring in a chaperone of their own. The trust had a dementia nurse that could offer support if required to patients living with dementia when attending an outpatient appointment.

Transport was organised in advance for patients with mobility issues who could not make their way to the hospital and then home after their appointment.

There was a hearing loop to assist patients with hearing difficulties. The trust could access sign language interpreters to attend appointments to support patients when required.

Staff told us that they used a telephone translation service for patient whose first language was not English. Leaflets in other languages were available on request from the trust’s intranet.

Access and flow

Patients could not always have timely access to initial assessments, test results, diagnoses or treatment.

Senior staff told us that following technical issues with Lorenzo (the trust’s online record management system), the ability to accurately report on RTT was lost. The trust made an agreement with NHSI and commissioners to stop reporting on the RTT until they could do so accurately.

Senior staff advised that the trust had an established process to review patients waiting for appointments, which ensured their level of risk was assessed. This included a system, which set out actions that should be taken when there was an inability to book all new and follow-up appointments within allotted waiting times and required timescales.

As part of the RTT recovery plan, staff advised that RTT training was provided to staff who managed or facilitated any part of a patient’s 18-week pathway, to ensure accurate and timely data collection and recording to enable the trust to clear the backlog of patients waiting for appointments.

Senior staff told us that the recovery plan involved retraining the bookings team on how to effectively use the electronic system to manage bookings. A hub for each clinical speciality was created. Within each hub the bookings member of the team would have weekly meetings with the clinical team to pull patients through pathways according to risk. Weekly meetings were attended by consultants so well informed clinical decisions were made on how urgently a patient needed an appointment.

Senior staff told us that “Net Call” an electronic booking system had been introduced to help efficiently book patient appointments and reduce the number of cancelled appointments. Text messages were sent to patients giving them a variety of dates to book themselves in at their convenience. The bookings team would call patients to book them if they did not have access to electronic devices.

Referral to treatment (percentage within 18 weeks) – non-admitted pathways

From July 2017 to September 2018 the trust’s referral to treatment time (RTT) for non-admitted pathways was similar to the England overall performance, while it was lower than the average for England in October and December 2017.
The trust reported no referral to treatment (RTT) data for non-admitted patient pathways to NHS England for November 2017 or for January to June 2018. In their RPIR the trust stated that, following the implementation of Lorenzo as their electronic patient record system in May 2017, management of access for patients on RTT pathways “lost visibility” (meaning patients with appointments due were not being flagged up for booking). In response the trust requested and received approval from NHS Improvement to pause reporting. The trust developed a recovery plan to return to reporting through data validation for every patient on a RTT pathway. The trust reported that this plan was due to complete in July 2018. However, during inspection senior staff told us that this had now been delayed until December 2018.

**Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Mid Essex Hospital Services NHS Trust**

![Graph showing referral to treatment rates](image)

(Source: NHS England)

To clear the pathways that had “low visibility” extra clinics were running on evenings and weekends. The booking team manager told us that they were working with the clinical teams to triage patients so that high risk patients could be attended to as soon as possible.

**Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty**

Five specialties were above the England averages for non-admitted RTT (percentage within 18 weeks) from July 2017 to June 2018:

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plastic surgery</td>
<td>94.6%</td>
<td>91.0%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>93.5%</td>
<td>89.3%</td>
</tr>
<tr>
<td>Urology</td>
<td>91.8%</td>
<td>87.6%</td>
</tr>
<tr>
<td>General surgery</td>
<td>90.8%</td>
<td>89.0%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>85.7%</td>
<td>81.7%</td>
</tr>
</tbody>
</table>

Thirteen specialties were below the England average for non-admitted RTT (percentage within 18 weeks). Cardiology and neurology had the lowest RTT rates, with 66.2% and 58.6% respectively.
Referral to treatment (percentage within 18 weeks) – incomplete pathways

From July 2017 to October 2018 and in December 2017 the trust’s referral to treatment time (RTT) for incomplete pathways was lower than the England overall performance.

The trust reported no referral to treatment (RTT) data for incomplete patient pathways to NHS England for November 2017 or for January to June 2018. In their RPIR the trust stated that, following the implementation of Lorenzo as their electronic patient record system in May 2017, management of access for patients on RTT pathways “lost visibility”. In response the Trust requested and received approval from NHS Improvement to pause reporting. The trust developed a recovery plan to return to reporting through data validation for every patient on a RTT pathway. The trust reported that this plan was due to complete in July 2018.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Mid Essex Hospital Services NHS Trust.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

One specialty was above the England average for incomplete pathways RTT (percentage within
Seventeen specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks). Cardiology had the lowest RTT rate, at 63.5%.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurosurgery</td>
<td>85.0%</td>
<td>82.9%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

**Did not attend rate**

**Broomfield Hospital**

From April 2017 to March 2018, the 'did not attend' rate for Broomfield Hospital was higher than the England average in eight of the 12 months. The rate was consistently higher than the England average from May to October 2017, before decreasing to a similar level to England in the subsequent five months, November 2017 to March 2018.

The chart below shows the 'did not attend' rates over time for each of the sites at which the trust provides outpatient services:

**Proportion of patients who did not attend appointment, Mid Essex Hospital Services NHS Trust**
The department recognised that a high DNA rate had an impact on service delivery and had a process in place to help avoid DNAs. For example, the bookings team would contact patients two weeks (or whatever it is) prior to their appointment time to confirm they were still attending. If a patient was unable to attend they had the option to reschedule. The bookings team manager told us that they were sending text message reminders to patients to try and ensure that they attended. If a patient could not attend they had the option to reschedule their appointment to a more convenient time. The bookings team also called patients to remind them of their appointments two weeks beforehand. Patients were asked if they could still attend or if they wanted to reschedule if they could not attend.

**Cancer waiting times – Percentage of people seen by a specialist within two weeks of an urgent GP referral (All cancers)**

The trust’s performed in relation to the percentage of all cancer patients seen by a specialist within two weeks of an urgent GP referral fluctuated from April 2017 to March 2018.

Senior staff told us that there was a multidisciplinary cancer team in place to tackle the delay in cancer referrals. The team was specifically created to ensure that cancer patients are referred within the two-week period. The team is made up of consultants and members of the booking team. They meet regularly to discuss patient’s conditions and triage them according to the urgency of treatment.

The trust performed better than the 93% operational standard for people being seen within two weeks of an urgent GP referral and similarly to the England average from April to June 2017 (2017/18 quarter 1) and from October to December 2017 (2017/18 quarter 3). However, in the other two quarters, July to September 2017 (2017/18 quarter 2) and January to March 2018 (2017/18 quarter 4), the trust performed below both the 93% operational standard and the England average.

The performance over time is shown in the graph below.

**Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), Mid Essex Hospital Services NHS Trust**
Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

The trust performed worse than the 96% operational standard and the England average for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat) in all four quarters from April 2017 to March 2018. The performance over time is shown in the graph below.

Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), Mid Essex Hospital Services NHS Trust

Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust performed worse than the 85% operational standard and the England average for patients receiving their first treatment within 62 days of an urgent GP referral in all four quarters from April 2017 to March 2018. The performance over time is shown in the graph below.

Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, Mid Essex Hospital Services NHS Trust
Learning from complaints and concerns

Summary of complaints

Broomfield Hospital

From June 2017 to May 2018 the trust received 72 complaints about outpatients at Broomfield Hospital. The trust took an average of 33.6 working days to investigate and close these complaints. Their complaints policy states that complaints should be responded to within 25 working days, or 60 working days for more complex complaints.

There were eight complaints open at the time of reporting and these had been ongoing for an average of 61.9 days. This was not in line with the trust’s complaints policy of 60 working days for complex complaints. Two complaints exceeded the 60 day target, having been open for 115 and 206 days, respectively, at the time of reporting. We reviewed the outpatient governance group meetings minutes dated 11 July 2018 and 8 August 2018. At both meetings staff spoke about the number of complaints waiting for investigation and approval after investigation. Staff spoke about reassigning investigations to those with more capacity so that investigations could be completed.

The breakdown of the complaints by subject is shown in the table below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
<th>Percentage of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient care</td>
<td>38</td>
<td>52.8%</td>
</tr>
<tr>
<td>Appointments</td>
<td>23</td>
<td>31.9%</td>
</tr>
<tr>
<td>Communications</td>
<td>7</td>
<td>9.7%</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>2</td>
<td>2.8%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>1</td>
<td>1.4%</td>
</tr>
<tr>
<td>Facilities</td>
<td>1</td>
<td>1.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>72</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

The trust’s Complaints Policy Procedure for dealing with patient and service user complaints was available to all staff through the trust’s intranet. The policy set out the process for investigating, responding to and learning from complaints.

Staff told us that they were aware of the complaints procedure and would try to resolve complaints at the time that they were raised. If they were unable to resolve the issues they would refer the patient to a senior colleague. Patient Advice and Liaison Service (PALS) posters were available in the areas we visited. The PALS office was also located in the atrium close to
the hospital entrance, in plain view for patients to see and access.

Staff were aware of themes in complaints received in their area, which staff in dermatology identified as delays in appointment referrals. Staff advised that complaints were discussed at clinical governance meetings. We reviewed clinical governance meeting minutes dated July and August 2018, where outstanding complaints investigations and investigations reviewed.

Number of compliments made to the trust

Broomfield Hospital

From June 2017 to May 2018 the trust received 43 compliments relating to outpatients at Broomfield Hospital.

The breakdown by ward/unit/team is shown in the table below:

<table>
<thead>
<tr>
<th>Ward/unit/team that the compliments related to</th>
<th>Number of compliments</th>
<th>Percentage of compliments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatients department</td>
<td>28</td>
<td>65.1%</td>
</tr>
<tr>
<td>ENT outpatients</td>
<td>5</td>
<td>11.6%</td>
</tr>
<tr>
<td>Audiology</td>
<td>4</td>
<td>9.3%</td>
</tr>
<tr>
<td>Fracture clinic</td>
<td>4</td>
<td>9.3%</td>
</tr>
<tr>
<td>Pain relief centre</td>
<td>2</td>
<td>4.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>43</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

In the RPIR the trust did not provide a breakdown of the compliments by either subject or theme.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
Is the service well-led?

Leadership

The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. Matrons and managers were visible and supportive.

There were five divisions within the trust and outpatients sat within division five. The division was led by assistant director of operations for outpatients daily and the leadership team consisted of assistant director of nursing and divisional director of nursing. The service manager and matron had overall responsibility for the outpatient department. The outpatients booking team was led by the associate director of operations for division five. The service manager and assistant service managers led the bookings daily.

Leaders understood the challenges to quality and sustainability. However, due to recent changes in the management structure being embedded, leaders were still in the process of identifying and drafting plans to address the challenges.

Senior staff told us that challenges included the number of nursing vacancies across the region, the competition with London wages that made it harder to find and retain staff. The plan to recruit and retain staff was to hold an open day so that preceptive employees were aware had a better understanding of the outpatient department. To help retain the current workforce, staff told us that further training for high performing staff was available. Another challenge was the budget deficit that brought up issues of sustainability and clinical benefit. Staff told us that a planned merger with two other local trusts would mean that staff and finances could be shared across all sites, therefore alleviating the pressures.

The outpatient manager had the skills, knowledge, experience and integrity having been employed by the trust for 15 years and had been the matron for the department for three years. The manager attended regular governance meetings, safety huddles and LocSSIPs groups. Staff told us that they found their manager visible and approachable.

Vision and Strategy

There was no separate formal strategy for outpatients and staff were not aware of the trust’s strategy and values.

The trust’s overall vision was “To be a healthcare organisation that puts patients care first and whose reputation for excellence and innovation inspires our patients, staff and the population we serve.” Staff we spoke with knew that they could find the vision and strategy on the intranet and posted in various areas within the hospital.

A senior member of staff told us that they were developing a strategy for the outpatient department, however this was not yet in draft format due to a recent change in leadership.

Senior staff told us about plans to merge with Southend University Hospital NHS Foundation Trust and Basildon and Thurrock NHS Foundation Trust. The merger would allow the trust to share staff and expertise to better cater for the growing population in Essex and to alleviate pressures due to staff shortages.

Senior staff told us that the outpatient ‘Fresh Start’ improvement plan was introduced in March 2018. Management met with the booking team twice a week to address concerns with accurately gathering data from the records management system and the backlog of patients waiting for appointments. The improvement plan included retraining so that the bookings team were suitably equipped to consistently use the records management system correctly. Super users would be identified so staff could approach them for help. The bookings team had been split into hubs depending on speciality. The booking administration team had day to day interactions with the
clinical team within their hub to manage appointments. Staff told us the hub model within the booking team applied across the three merged trusts would be an opportunity to work closely with clinicians within their speciality to develop a collaborative approach to managing the outpatient services.

Culture

Managers across the service worked together to promote a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Most staff spoke about an open and transparent culture where concerns could be raised.

Staff told us there was good team work within the teams and we observed this during our inspection. Staff worked together to resolve issues and worked flexibly to accommodate service needs. Staff told us the whole team pulled together to provide the best care to patients possible despite the pressures related to staff shortages.

In most areas we visited staff felt able to raise concerns and challenge where necessary. Staff described “an open door” policy when they needed to access line management. However, in the bookings team some staff felt unsupported by the human resources team following a complaint about a senior member of staff. We escalated these concerns to the senior leadership team and were provided with assurance that measures had been put in place to help support staff.

A senior member of staff told us that recruitment and retention was improving in the bookings team and that due to new ways of working, sickness and absence had improved. Assistant managers in the bookings team had won a staff recognition award due to their ongoing efforts to improve team morale.

Senior staff were in the process of creating a ‘culture board’ for outpatients where staff could make suggestions or raise concerns via a link on the intranet.

Governance

Staff were clear about governance processes and how and where information was shared.

Senior members of staff told us that they attended monthly governance meetings for the outpatient department. We reviewed the directorate governance action logs dated 11 July 2018 and 8 August 2018, where plans for the new directorate governance group structure were discussed. Actions agreed included improving database cashing up issues and to review the staffing of the reception area for evening and weekends.

The trust had a governance improvement plan in place. This highlighted the need to strengthen the risk and governance team. The recommendation was that each division would have a quality partner and a governance administrator assigned and embedded in the divisional leadership team and report professionally to the head of quality and patient safety.

Staff reported that managers shared important information during the morning ‘safety huddle’ meetings. During our inspection we attended a ‘safety huddle’ where traffic conditions and evening clinics discussed with staff.

Management of risk, issues and performance

There were not always robust arrangements for identifying, recording and managing risks.

The outpatient services had their own local risk register. However, some of the concerns we identified during our inspection had not been highlighted as risks to be monitored, for example the lack of learning from serious incidents and staffing levels. There were three risks listed on the register two were in relation to Referral to Treatment (RTT) time and the implementation of
Lorenzo and one was related to lack of space. One risk had a review date from November 2016 and another July 2017. Some controls had been put in place and senior staff told us that review of the risk register took place at monthly clinical governance meetings for each speciality. However, we were not assured that the processes and systems in place to identify risks was robust, there was not a systematic approach to audit to ensure that there was a holistic view of performance and risks.

The service did not have a comprehensive audit programme which included areas like the availability of records for clinics, completion of safer surgery checklists or security of controlled stationery to identify areas for improvement.

A senior member of staff told us that at the time of our inspection, there were 7300 overdue patients on the follow up list that had been waiting for an appointment for more than six months. The electronic records system had not flagged up these appointments so that they could be booked by staff at the appropriate time. This was on the trust risk register and had been escalated to the trust’s board of directors.

We reviewed the ‘Fresh Start’ improvement action plan dated 18 September 2018, that was implemented to tackle the issues with RTT and the follow up lists mentioned above. The plan listed issues within the bookings team, such as patients being booked into wrong clinics, high bank staff utilisation and backlog in clinics. The plan set deadlines for improvement and the action taken to make improvements. A member of the senior staff told us that the booking team held weekly structured meetings to ensure that the ‘Fresh Start’ improvement plan was working. Weekly improvement meetings were held with service managers and the hub administration team to ensure that changes implemented by the ‘Fresh Start’ improvement plan were working. Bookings team administration staff attended meetings with clinical staff within the outpatient department and reported back to management during improvement meetings.

Information Management

The service did not always collect and use information well to support its activities.

Staff had access to policies, standard operating procedures and patient information leaflets electronically through the intranet. Staff confirmed that this ensured that information was easily accessible.

The trust introduced an electronic patient management system in May 2017 which has had a number of technical issues since. This included the ability to accurately report on RTT. Staff told us that the initial issues had been addressed and that they now had more confidence in the system. A senior member of staff told us that the bookings team together with the RTT validators had created a new way to track and have visibility of patients as part of a ‘patient access plan’. The plan was launched in May 2018 and it helped clear appointments. However, the trust is not collecting or reporting on RTT until the backlog has been cleared so we were unable to see how effective the patient access plan was.

Engagement

The service was taking steps to engage with patients and staff to plan and manage services.

Staff said that they felt engaged through regular team huddles, where they were encouraged to provide feedback. Staff said that the senior leadership team held open forums to discuss changes on a regular basis and sent out regular email updates about any changes in management and new ways of working.
Staff told us that managers engaged with them at team meetings. We reviewed the outpatient department meeting minutes dates January 2018. New starters and vacancies, where consent forms were kept and when new management was set to start on site for five days a week.

Staff told us that updates were sent via email or posted on the intranet and on notice boards in staff rooms.

Senior staff told us that the trust had a patient liaison team that regularly met with patients to discuss their experiences with the trust and feedback on the service provided. We spoke to a remember of this team and they advised that some of the issues that they discussed with patients was the waiting time for transport after an appointment.

**Learning, continuous improvement and innovation**

*The service had been involved in work which demonstrated a commitment to continuous improvement. However, there was a need for systems that supported innovation.*

Senior staff told us that the assistant managers within the bookings team had won one of the trust recognition awards for helping to improve morale and staff motivation within the bookings team. The new matrix working between the bookings team and clinical team meant that staff met weekly to effectively manage patient appointments. The bookings team together with the RTT validators created a new way to track and have visibility of patients leading to the launch of a new patient access plan in May 2018.

A senior member of staff told us that a group of band five nurses were attending the Schwartz round panel (a panel of 140 organisations clinicians from different organisations met to discuss innovative care). The group were going to feedback their discussion to their colleagues at the trust during staff meetings.

Staff in the audiology clinic told us that due to lack of funding they could not conduct research into more innovative ways of working. However, the team had successfully worked together to place a hearing implant in a patient who was under a year old.

**Diagnostic imaging**

**Facts and data about this service**

The main radiology department at the trust is located at Broomfield Hospital, offering diagnostic imaging services to emergency, GP, outpatient and inpatient referrals. All imaging modalities, with the exception of PET-CT (positron emission tomography-computed tomography), are provided. There are satellite units offering plain film and ultrasound services at Braintree Community Hospital and St Peter's Hospital in Maldon.

The emergency radiology department offers 24/7 cover for plain film, mobile and theatre radiography and CT (computed tomography). There is on site consultant radiologist cover seven days per week, with out of hours reporting covered by a tele-radiology service.

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

(Source: Routine Provider Information Request (RPIR) - Acute context tab)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

The service provided staff with mandatory training in key skills and in safety systems, processes and practices by a combination of face to face sessions and electronic learning. However, compliance was not always in line with the trust target.

Mandatory training completion rates

The trust set a target of 85% for the completion of all mandatory training modules with the exception of information governance, where the target was 95%.

Broomfield Hospital

A breakdown of compliance for mandatory training courses from June 2017 to May 2018 for medical staff in diagnostics at Broomfield Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2017 to May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Fire safety 1 year</td>
<td>15</td>
</tr>
<tr>
<td>Information governance</td>
<td>15</td>
</tr>
<tr>
<td>Infection prevention level 1</td>
<td>14</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>12</td>
</tr>
<tr>
<td>Manual handling object</td>
<td>12</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>7</td>
</tr>
</tbody>
</table>

In diagnostics, the hospital had an overall training compliance rate of 70.1% for medical staff. The trust’s training targets were not met for any of the six mandatory training modules for which medical staff were eligible. The resuscitation module had the lowest completion rate, at 41.2%.

A breakdown of compliance for mandatory training courses from June 2017 to May 2018 for qualified allied health professionals in diagnostics at Broomfield Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2017 to May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Information governance</td>
<td>61</td>
</tr>
<tr>
<td>Infection prevention level 1</td>
<td>60</td>
</tr>
<tr>
<td>Fire safety 1 year</td>
<td>56</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>49</td>
</tr>
</tbody>
</table>
In diagnostics, the hospital had an overall training compliance rate of 77.1% for qualified allied health professionals. The trust’s training targets were met for two of the seven mandatory training modules for which qualified allied health professionals were eligible. The resuscitation module had the lowest completion rate, at 53.8%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

During our inspection, the leaders of the diagnostic imaging service indicated that compliance with mandatory training had improved and we therefore requested up-to-date mandatory training data. Data for medical staff showed that compliance with fire safety training had improved to 92.2%, information governance to 94.1%, health and safety to 78.4%, manual handling to 84.3% and resuscitation training to 58.8%. We did not receive updated data for radiographers (qualified allied health professionals). Data was provided for radiologist assistants, and this showed that the information governance training completion rate was 100%, fire safety was 93.75%, health and safety was 93.75%, moving and handling was 100%, and resuscitation was 68.75%.

Mandatory training completion data was sent to leaders in the diagnostic imaging service on a monthly basis through a spreadsheet which contained information about individual members of staff and the courses that they were required to complete. The spreadsheet used a red, amber, green system to highlight whether staff were compliant with mandatory training completion (green), or were shortly due to undertake training (amber), or were overdue to complete training (red). This allowed the leaders of the diagnostic imaging service to monitor training compliance on an ongoing basis. Governance meeting minutes showed that mandatory training compliance was discussed at each meeting.

Staff did not receive dedicated time to complete mandatory training. Whilst some staff said that they found time to complete their training during night shifts as the majority of mandatory training could be completed electronically, other staff said that they found it difficult to complete mandatory training due to staffing shortages and other demands within the department.

**Safeguarding**

Effective systems and processes were in place to protect people from abuse and neglect. However, compliance with safeguarding training was not meeting the trust target.

The trust had a safeguarding team comprised of a named nurse, doctor and midwife for safeguarding children, a safeguarding adult lead and an adult safeguarding specialist. Staff in diagnostic imaging were aware of the safeguarding team.

Most of the staff we spoke with knew how to raise a safeguarding concern. Some staff said that if they identified a safeguarding concern then they would initially approach a more senior member of staff or the safeguarding team for advice. Staff were able to provide examples of how they had responded appropriately when safeguarding concerns were identified. Staff said that if safeguarding concerns were identified during reporting, this information would be passed on to the referring clinician and an incident report would be made by the member of staff reporting the image, which would automatically be passed to the safeguarding team. Staff showed an awareness of female genital mutilation (FGM).

There was a guideline on the trust intranet which set out what action staff should take both in and out of hours if a safeguarding concern arose. In addition, a safeguarding adults matrix was available for quick reference by all staff and to inform decisions around safeguarding.

There were three radiographers trained to level three safeguarding children, all other radiographers and radiologists were trained to level two safeguarding children. Information provided by the trust prior to our inspection showed that from June 2017 to May 2018, 1.13% of

<table>
<thead>
<tr>
<th>Manual handling people</th>
<th>45</th>
<th>65</th>
<th>69.2%</th>
<th>85%</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual handling object</td>
<td>45</td>
<td>65</td>
<td>69.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>35</td>
<td>65</td>
<td>53.8%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
Overall attendances in diagnostic imaging were children 17 and under. However, guidance within the *Safeguarding children and young people: roles and competencies for healthcare staff* intercollegiate document (2014) states that “all clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person” should be trained to level three children’s safeguarding. This meant that there was a risk that not all staff working with children or reporting their images had the right level of understanding of how to recognise and escalate potential signs of abuse.

### Safeguarding training completion rates

The trust set a target of 90% for the completion of safeguarding training.

**Broomfield Hospital**

A breakdown of compliance for safeguarding training courses from June 2017 to May 2018 for medical staff in diagnostics at Broomfield Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2017 to May 2018</th>
<th></th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults level 1</td>
<td>15</td>
<td>18</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>14</td>
<td>18</td>
<td>77.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>14</td>
<td>18</td>
<td>77.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>13</td>
<td>18</td>
<td>72.2%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In diagnostics, the hospital had an overall safeguarding training compliance rate of 77.8% for medical staff. The trust’s 90% completion target was not met for any of the four safeguarding training modules for which medical staff were eligible. The lowest completion rate was for safeguarding children level 2, with 72.2%. Information provided by the trust after our inspection showed that safeguarding training compliance levels for radiologists had improved; safeguarding children level one and two had improved to 90.2%, safeguarding adults level two had improved slightly to 80.4%. However, compliance with safeguarding adults level one had reduced slightly to 82.4%.

A breakdown of compliance for safeguarding training courses from June 2017 to May 2018 for qualified allied health professionals in diagnostics at Broomfield Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2017 to May 2018</th>
<th></th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 1</td>
<td>58</td>
<td>65</td>
<td>89.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>56</td>
<td>65</td>
<td>86.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>53</td>
<td>65</td>
<td>81.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>53</td>
<td>65</td>
<td>81.5%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In diagnostics, the hospital had an overall safeguarding training compliance rate of 84.6% for qualified allied health professionals. The trust’s 90% completion target was not met for any of the four safeguarding training modules for which qualified allied health professionals were eligible.

(Source: *Routine Provider Information Request (RPIR) – Training tab*)
The trust's electronic patient record system did not hold safeguarding alerts. This meant that staff may not always be alerted to previous safeguarding concerns. However, the child protection information system did alert staff via the patient record system when a child was subject to a child protection plan or was under the care of the local authority.

Information regarding safeguarding from abuse was not displayed where service users would see it, such as in waiting or clinical areas.

Processes were in place to ensure the right person got the right radiological scan at the right time. The service used the Society of Radiographer’s “pause and check” checklist. Pause and check signs were placed in imaging areas and staff were observed using this during our inspection.

**Cleanliness, infection control and hygiene**

**Systems and processes were in place to maintain cleanliness and control infection, although these were not always consistently implemented or documented.**

The service areas we visited were visibly clean. Some storage areas were cluttered, which may have limited the ability of cleaning staff to access and clean all areas. There were sufficient quantities of personal protective equipment for hygiene and infection control, such as gloves and aprons. Hand hygiene points were located at regular intervals. Staff were also observed adhering to hand hygiene policies and bare below the elbows infection control standards. We observed rooms and equipment being cleaned appropriately after procedures. However, ‘I am clean’ stickers were not observed to be routinely used in the service; the stickers were not in place on the majority of equipment checked during our inspection. These stickers are used to clearly show that object has been sanitised, including when this took place and by whom.

Chairs in the outpatient diagnostic imaging area had significant rips, which posed a potential infection control risk as they did not enable effective cleaning. However, plastic chairs were available in the emergency diagnostic imaging waiting area to enable effective cleaning.

Fabric curtains were in use in some areas of diagnostic imaging. There were no markings on the curtains to indicate when they should next be cleaned or replaced. Staff said that curtains would be changed every three months or when they became contaminated. However, information provided by the trust after our inspection stated that cubicle curtains should be replaced annually as a minimum. Records checked on inspection showed that curtains in the whole department had been changed in July 2018. However, records indicated that prior to this the curtains had not been changed since July 2016. After our inspection the trust stated that their central records confirmed that curtains had also been changed in April 2017.

Records of cleaning were not always available. Domestics and radiographers had separate cleaning responsibilities and each kept their own records of cleaning that had been carried out. Staff said that cleaning records for cleaning carried out by domestics were held in cleaning folders stored in clinical areas. In the outpatient x-ray area, the cleaning folder contained cleaning records which were all dated 2017, except for one record dated the week of our inspection. In nuclear medicine, domestic cleaning records were available in the cleaning folder for April to July 2018, but no records were available for August 2018. A record for the week of our inspection was available. The records that were available showed that there were gaps in cleaning being carried out; records showed that there were 16 days between April and July where cleaning had not been recorded and there was no indication that the department was closed on that date. We could therefore not be assured that cleaning was regularly being carried out in these areas. However, separate cleaning records for cleaning carried out by radiographers were available and demonstrated that the cleaning they were responsible for had regularly taken place. However, ‘end of day’ checks, such as ensuring cubicles were clean and empty and ensuring the shredding bin had been emptied were not always completed. The cleaning records for the toilets in diagnostic imaging areas showed that the majority had been cleaned regularly.
Cleaning policies held within the cleaning folders that were stored in clinical areas for staff reference were significantly out of date for review. The policies were all due for review between 2011 and 2014. This meant that staff may have been referring to outdated guidance and processes. This was highlighted to staff on inspection.

Processes were in place for patients who had infectious diseases and staff were aware of these processes. When requests for imaging were made on the electronic system, referrers were required to answer a question about whether the patient was barrier nursed. Staff described how patients with known infectious diseases were seen at the end of imaging lists and rooms were deep cleaned afterwards to reduce the risk of the spread of infection. If a patient in the emergency department had a severe infection risk then staff would arrange for the patient to go straight into an imaging room or make use of the anaesthetic room as an isolation room.

Cleaning procedures were in place for ultrasound probes, following an intimate examination. This included the use of sanitising wipes and chlorine dioxide in a foam, designed specifically for the high-level disinfection of endocavity ultrasound probes.

We requested the results of local cleaning and hand hygiene audits as part of our inspection. Compliance in hand hygiene audits had been between 97 and 100% in June 2018 for diagnostic imaging areas. Compliance in the cleaning and decontamination of equipment audit was 100% in June 2018. Departmental leaders said that audits had not highlighted any specific concerns that they had needed to implement actions to address.

Cleaning folders stored in clinical areas contained details of Control of Substances Hazardous to Health (COSHH) risk assessments.

Patients confirmed that the diagnostic imaging environment was always visibly clean and that they had observed staff washing their hands appropriately.

**Environment and equipment**

The design and use of facilities and premises in diagnostic imaging kept people safe. However, the service did not have appropriate systems in place for the management of consumable stock and checks on the environment and equipment were not always carried out consistently.

There had been some developments to the environment and equipment in the diagnostic imaging service since the time of our last inspection. This included new x-ray rooms, a new MRI scanner and all imaging equipment in the plain film modality had become digital. However, some of the environment within diagnostic imaging remained dated and worn, and some older equipment remained in use, such as a 14-year-old MRI scanner which staff described as being at the ‘end of life’. In the proposal to replace the scanner, service leaders had stated that “Recent Benchmarking data recently showed that MEHT had one of the oldest scanners in the country.” The service had an equipment replacement programme in place and equipment replacement was prioritised based on risk. The service was in the process of replacing the MRI scanner, and at the time of our inspection had successfully bid for cancer transformation funding and were awaiting approval from the trust to fund the infrastructure and building.

Appropriate arrangements, such as hazard warning signs, controlled area notices and secure access were in place to restrict access to radiation areas. However, six monthly checks were required on warning lights and the information we reviewed during our inspection showed that warning lights had not been checked since February 2016. This was raised with staff during our inspection.

In nuclear medicine, the toilet which had been identified for patients who had been injected with radioactivity to use, to make sure the waste was measured and managed properly, was left open
and unlocked when not in use. This meant that non-nuclear medicine patients could use this toilet. Signage was in place to inform patients and other visitors that the toilet was for use by nuclear medicine patients. We raised concerns that other visitors to the department could inadvertently use this toilet as the waiting area for outpatient and GP referral imaging, which included a children’s play area, was adjacent to the nuclear medicine area. In response, the trust stated that the radiation protection advisor had confirmed that signage for the “hot toilet” was sufficient and would be considered low risk. The trust provided assurance that “Patients are directed into the specific nuclear medicine department on arrival and once the procedure has been completed, patients are clearly told which toilet facilities they are allowed to use. The toilet has contamination monitoring every evening. If there is no radioactivity present, a sign is displayed on the door for the cleaning staff indicating it is safe to clean and the door is left unlocked. If radioactivity is present, then a sign is displayed indicating radioactivity is present and is not safe to clean and the door remains locked. The “hot toilet” is not kept locked during the day to avoid patients undergoing nuclear medicine procedures who urgently need the toilet using other toilets within the department or having accidents which would then require decontamination in a less controlled manner. The nearby toilet in the ultrasound area of the department is clearly marked as for the use of ultrasound patients only. The “hot toilet” is not easily visible from the ultrasound waiting so it is felt unlikely that patients would wander into this area and use the toilet, which is clearly marked for nuclear medicine patients only.”

The radiology department had an on-site engineer, who kept an equipment log which showed the dates that each piece of equipment required servicing. Equipment servicing records were checked during our inspection and were mostly up-to-date. Whilst the majority of equipment checked during our inspection was in date for servicing, MRI safe accessories (equipment specifically marked as safe for use in MRI) such as chairs and a trolley had not been serviced. This was raised with staff during our inspection, who said that they would discuss the servicing of this equipment with the biomedical engineering department. A maintenance contract was in place with an external company for some imaging equipment. Staff spoke positively about the responsiveness of this company in addressing any equipment failures. The service had an equipment quality assurance programme in place. Equipment within MRI had been labelled appropriately to show whether it was safe, conditional or unsafe for the area.

Equipment training records were available for staff. This has been reported further under the effective domain.

Concerns regarding equipment were not always resolved or addressed in a timely manner. The 2017 radiation protection advisor’s report stated that there were three units which had the same remedial actions recommended over a number of years without any apparent action being taken or discussion as to why this could not be corrected. For example, one issue related to the intra-oral unit in the dental room, where the need for rectangular collimation to be available and used clinically to reduce the amount of radiation patients were exposed to had been raised every year since 2011. This meant that the service had not taking action, despite prompts from the radiation protection advisor, to ensure that the dose patients were exposed to when undergoing imaging with this piece of equipment was as low as possible.

Appropriate systems and processes were not in place for the management of consumable stock. We checked a range of consumables during our inspection. In the emergency diagnostic imaging area we found a large box of high pressure syringes that had expired in April 2018. In the recovery area of fluoroscopy, seven consumables had expired between April and June 2018. In nuclear medicine, over 20 needles had expired in April 2018. Consumables that were found to be past their expiry date during our inspection were passed to a member of staff to dispose of. The diagnostic imaging service did not have a dedicated member of staff responsible for the management of consumable stock. Radiology assistants had some time allocated in the rota for the management of stock, but could be required to undertake other tasks during this time.
Specialised personal protective equipment was available for use by staff and carers when needed but lead aprons were not consistently checked for damage by screening and visual checks. The trust’s policy stated that checks should be carried out on an annual basis. We checked the records for lead apron checks as part of our inspection; records included all applicable locations across the trust. Some lead aprons were in date for checks, including in the pain clinic, cardiac, and in CT. However, in some areas, such as orthopaedic theatres, burns and plastics, and at the St Peters community location, lead coats were overdue for checks by around four months at the time of our inspection. In other locations lead aprons were overdue for checks by a number of years. For example, lead aprons in mobile imaging locations and at Braintree Hospital had last been checked in 2014 and were therefore three years overdue. Lead coats in fluoroscopy, the emergency department, and general theatres had last been checked in 2015 and 2016. Records indicated that there were some lead coats in main radiology that had last been checked in 2010 and 2012. Concerns regarding overdue checks on lead aprons were raised with staff during our inspection.

The service did not monitor all staff for radiation exposure. Dose monitoring only took place in areas where higher doses were received, including fluoroscopy and nuclear medicine. In addition, pregnant radiographers would receive dose monitoring and would be risk assessed. Dose badges were no longer in use in general CT or x-ray and instead, environmental monitoring was carried out. Environmental monitoring is undertaken to ensure that the levels of ionising radiation in areas adjacent to designated areas do not exceed the annual dose constraint. The last environmental audit was carried out in 2012. The radiation protection service’s policy was to monitor the environment initially at commissioning and at five yearly intervals thereafter. Monitoring was also undertaken if the type of work changes or the workload increases significantly. A further review was due in January 2017 but this had not been carried out. This therefore meant that the service did not have up to date information about environmental radiation exposure. The 2017 radiation protection advisor report included recommendations for 2018, one of which was to carry out environmental monitoring. Following our inspection, the trust stated that their radiation protection advisor had advised that “the level of associate risk is very, very low. The workload has not changed significantly over this time but also the original lead specifications for all rooms was high. In addition, staff wear dosimetry badges at all times and there has never been any readings recorded on these”. However, as has been reported above, staff did not wear dosimetry badges in all areas.

Resuscitation equipment was readily available in the majority of diagnostic imaging areas. In the outpatient imaging area, resuscitation equipment was shared between nuclear medicine, ultrasound, x-ray and fluoroscopy. The resuscitation equipment had been regularly checked in line with the trust policy and resuscitation council guidelines. However, the resuscitation equipment in the emergency diagnostic imaging area did not contain paediatric defibrillation pads. This was raised with staff during our inspection. Staff said that children would normally be escorted to the area and that they would contact the crash team if necessary. However, staff were not able to confirm that the crash team would have all the necessary paediatric resuscitation equipment.

The imaging service carried out risk assessments for new or modified use of radiation. The risk assessments reviewed during our inspection were up-to-date. However, risk assessments in nuclear medicine held basic information and there was no evidence of these being shared with nuclear medicine staff.

Staff had assembled, stored and maintained sharps boxes correctly. Clinical waste was separated and dealt with appropriately.

In nuclear medicine, the histology radioactive waste store log showed that whilst records were completed from the 6th of July 2018 to the 17th of August 2018, there was poor record keeping prior to that date.
Assessing and responding to patient risk

The service did not always have systems in place to ensure that staff were able to identify and respond appropriately to changing risks to people who used services.

Staff in the radiology department were trained to basic life support level. However, as has been reported in the mandatory training section, compliance rates were low. During our inspection staff said that no radiographers or radiologists were trained to immediate life support or paediatric life support. Information provided after our inspection stated that five radiologists were trained to adult immediate life support level. Staff said that patients would be escorted to radiology by clinical staff from other areas of the hospital when required. For example, if a patient was on oxygen or had an early warning score of one or more, then the patient would be escorted by a registered nurse who would be able to respond appropriately if the patient deteriorated. However, the June 2018 transfer form audit showed that out of 19 patients requiring an escort, 12 patients had escorts and seven patients needed an escort but one did not come. This amounted to 36.8% of patients, and demonstrates that a member of staff with the skills to respond to a deteriorating patient may not always be available in diagnostic imaging areas when necessary. Staff in diagnostic imaging said that they would also phone the hospital crash team if required. Information with contact details for the hospital crash team was displayed in diagnostic imaging areas. Patients would be transferred to the emergency department for further observation and treatment as required.

There were separate procedures for the collapse of a patient in MRI, and staff were aware of these. However, service leaders said that the procedures for the collapse of a patient were not regularly practiced by staff in diagnostic imaging.

Staff said that they did not carry out patient observations or calculate early warning scores when patients attended the department for imaging. A patient transfer form was in place which required ward or emergency department staff to record the most recent patient observations. However, the transfer form had been shortened in an attempt to improve completion by ward staff and as the June 2018 audit report noted, the new forms “miss a lot of important information”, including resuscitation status of the patient, infection status, requirement of oxygen, allergies and medications. Staff said that patients would be escorted to the department if a patient was at risk of deterioration. However, as has been detailed above, the most recent audit showed that over a third of patients who required an escort did not receive one. Radiology staff would not have access to a patient’s full records in this event.

Patient call bells were not always working or accessible to patients in diagnostic imaging areas, which meant that staff may not be able to promptly assess and respond to patient risk. A changing cubicle in the inpatient imaging area had a panic buzzer rather than a pull cord and staff acknowledged that this meant patients may not be able to access the buzzer if they had collapsed or fallen. Staff said that they waited outside of the cubicles whilst patients changed in order to mitigate this risk. In the outpatient imaging area, there were seven cubicles, two of these cubicles had emergency pull cords but neither were working at the time of our inspection. Staff stated that they had been out of order for several months due to building works. Concerns had been escalated to the estates department in the hospital but they had not yet been resolved. The lack of functioning emergency pull cords meant that there could be a delay in staff identifying and responding to patients who had deteriorated or fallen. A risk assessment completed in March 2018 stated ‘Patients which are assessed as requiring assistance are changed in the disabled cubicles which have alarms. All the other main wait cubicles are curtained and therefore patients can shout for help if necessary.’ Staff said that they had been made aware to provide support when patients were using the cubicles. In the emergency imaging area, call bells were available in the trolley waiting area. However, a member of staff raised concerns that trolleys were often parked away from the wall and that this meant patients could not easily access the call bells. The reason for this was not clear; there was sufficient space for patients to be parked next to the wall. The member of staff felt that this was of particular concern out of hours when there were less staff working in the department. We did not observe this in practice during our inspection. There was a risk on the risk register from January 2011 regarding the monitoring of patients in this area,
as the emergency trolley waiting area was not routinely monitored and the walking wait area was not routinely monitored out of hours. CCTV had been installed in September 2013 to help minimise the risk, and patients should attend the department with a nurse escort when required. Local audits were undertaken to measure adherence to the patient transfer policy. However, as has been detailed above, the most recent audit showed that over a third of patients who required an escort did not receive one.

An unexpected and urgent findings policy was in place to ensure that findings were communicated and escalated appropriately. Staff were aware of the policy and the actions that should be taken.

The radiology information system (RIS) allowed staff to organise the list of referrals waiting to be reviewed by the number of days waiting or by urgency, which allowed staff to prioritise patients based on risk.

The service did not have a formal policy in place for carrying out harm reviews when patients had experienced significant delays in their imaging or the reporting of their imaging. During our inspection, staff stated that if information came to light which indicated that delays within diagnostic imaging may have led to patient harm, then a further review of events would be carried out. Information provided after our inspection stated “Once reporters are aware of the discrepancy, the referring clinician is informed to assess the degree of harm and possible changes to patient management. This also triggers an incident report to be completed which would be reviewed at (executive review group) ERG. If this is escalated to a serious incident, this would include a Duty of Candour meeting with the patient following discussion with the referring clinician to assess degree of harm. There are plans in place to formalise this process in a SOP (standard operating procedure). If there has been a delay in the pathway - this will also trigger the same process.”

We requested information about the number of ‘harm reviews’ that had been carried out in the year prior to our inspection but this was not provided.

There was no specific training for non-radiology clinicians who were reporting images, known as auto-reporting. In addition, the service did not audit the reports these staff produced. Staff said that the duty radiologist was available for advice if required. However, CQC’s Radiology review: A national review of radiology reporting within the NHS in England (2018) stated that “there is a potential risk of harm to patients associated with this (auto-reporting)” and trusts needed to assure themselves that non-radiology staff who were responsible for reporting images “…are competent to perform the task. Trusts also need to make sure that audits are performed to make sure that reports are documented and accurate.” This is also supported by Royal College of Radiology (RCR) guidance. The trust had a Procedure For Reporting of Radiological Examinations which set out the process for images evaluated by non-radiology clinicians, including the type of images that could be evaluated, and this stated that an annual audit should be completed by radiology. The service was therefore not following their documented process.

Staff checked the recent results of a patient’s kidney function test before administering contrast media. Contrast media are substances which increase the contrast of structures or fluids within the body used in certain types of radiological investigations. The trust also had a guideline for the risk assessment and prevention of contrast-induced nephropathy (CIN) and this was linked to national guidance. CIN is a form of kidney damage which can occur within 48 hours of exposure to contrast media. Staff were aware of the policy and the actions that should be taken.

The diagnostic imaging service had a policy in place to ensure that women (including patients and staff) who are or may be pregnant always informed a member of staff before they were exposed to any radiation, in accordance with IR(ME)R. We requested evidence of any audits carried out to review this process but this was not provided. The Royal College of Radiologists states that “As part of risk management within a department, a regular audit of the effectiveness of the local processes for avoiding irradiation of the pregnant woman is essential.” Signs were displayed throughout diagnostic imaging areas advising female patients to inform staff if they were or could potentially be pregnant.
The diagnostic imaging service had a process in place to ensure that the 'requesting' of an X-ray, MRI, nuclear medicine or other radiation diagnostic test, e.g. by GP’s or others is only made by staff in accordance with IR(ME)R. Radiation protection supervisors delivered regular training to medical staff and had adopted referral criteria. Non-medical referrers were required to provide a scope of practice and an IR(ME)R certificate to the radiation protection supervisor before they were able to make referrals. Radiation protection supervisors maintained a spreadsheet of all approved non-medical referrers. Non-medical referrers were contacted to educate and advise if they made referrals outside of their scope of practice.

There was appropriate accessibility to the radiation protection advisor (RPA) and medical physics expert (MPE), which were provided by an external provider. Staff provided positive feedback about the support provided. The external provider who supplied the RPA and MPE was due to change shortly after our inspection. The service had appointed radiation protection supervisors in each clinical area.

Local rules and employers procedures had been reviewed and were appropriately displayed in diagnostic imaging areas. Ionising Radiation Regulations (2017) require the employer to provide written local rules to ensure that the risk of radiation exposure in particular radiation work areas is restricted. Local rules are normally written by the radiation protection supervisor (RPS) with support from the radiation protection advisor (RPA) and should cover normal work and also details of any contingency plans in the event of a radiation accident.

In MRI the list of authorised person details was incorrect and staff confirmed that this needed updating.

Staff had not always received appropriate training to respond to aggressive or violent incidents as conflict resolution training was optional. However, staff said that they would phone security if necessary and said that patients who were aggressive or violent normally arrived in the radiology department with an escort. Staff said that they did receive a debrief or were given other support after aggressive or violent incidents. A protective glass screen and a panic buzzer had been added to the reception area of emergency diagnostic imaging as staff worked on their own at night. Reception staff had a ‘red phone’ for access to fire, security, or in the event of a cardiac arrest. Some staff raised concerns about safety when working out of hours on their own. Risk assessments had been carried out to minimise risks associated with lone working.

**Medical staffing**

_We found that the trust had a shortage of medical staffing in diagnostic imaging._ This was supported by the data supplied by the trust and we confirmed this at the time of our inspection.

**Broomfield Hospital**

The trust reported the following medical staffing numbers in diagnostics at Broomfield Hospital as of March and May 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTE)</td>
<td>Planned staff (WTE)</td>
</tr>
<tr>
<td>Broomfield Hospital</td>
<td>19.3</td>
<td>21.7</td>
</tr>
</tbody>
</table>

The medical staffing level within diagnostics decreased slightly from 88.8% in March 2018 to 84.5% in May 2018.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)
Consultant radiologist cover was provided on site in emergency radiology from 8am to 8pm Monday to Friday and 9am to 5pm at weekends. Outside of these hours, remote support for advice and reports was available through an outsourced teleradiology company.

Registrars had been introduced into the department in the 12 months prior to our inspection. Staff spoke positively about the introduction of registrars and felt that this improved retention of these staff in the longer term.

Some radiologists said that there was insufficient capacity to prepare for and attend all of the multi-disciplinary meetings that they were required to cover. They said that there were occasions where radiologists could be pulled out of a reporting session to attend multidisciplinary meetings.

Service leaders said that staffing requirements were assessed on an annual basis or when changes were made to the service. As part of our inspection we requested documentation from the last staffing assessment that had been carried out. This was not provided but in response the trust stated that “The directorate review staffing model with the finance manager and this is next scheduled for October 2018. The model is revised with the changes in banding of staffing due to completion of advanced practice courses. Also, when we make any changes to extended hours / increased weekend working, we review the admin and ancillary staff structure and numbers to ensure we have the right level of cover.” The lack of documentation provided meant that we did not receive assurance that the service effectively planned and reviewed their staffing requirements on a regular basis.

Vacancy rates

Broomfield Hospital

From June 2017 to May 2018, the trust reported a vacancy rate of 13.3% for medical staff in diagnostics at Broomfield Hospital. This was lower than the trust target of 15.4%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Information provided after our inspection indicated that the vacancy rate for radiologists was 17%. The service had recently appointed four additional radiologists. However, one of the four new appointments had already been working in the service as a locum radiologist. It was anticipated that the new radiologists would commence their posts by the end of 2018. However, there remained radiologist vacancies in the service and the service leaders planned to continue recruitment, with two further consultant interviews being held in October 2018.

Turnover rates

Broomfield Hospital

From June 2017 to May 2018, the trust reported no turnover among medical staff in diagnostics at Broomfield Hospital. The trust has a target turnover rate of 18.05%.

Within the RPIR, the trust noted that there was an issue with their turnover data. The process used in ESR when staff leave and retain a staff bank contract means that they are not counted in ESR as a leaver. As a result, the turnover figures reported from ESR are lower than they actually are. The trust’s internal reports and the Joint Working Board report are adjusted to reflect the additional leavers, so that the correct turnover figures are reported. However, due to the manual recording of this data, and its limitations, it was not possible for the trust to analyse it to the level of detail required for the RPIR.

The trust reported that this process was changing and, in the future, all of their leavers would be
included in reports from ESR.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

Broomfield Hospital

From May 2017 to April 2018, the trust reported a sickness rate of 1.8% for medical staff in diagnostics at Broomfield Hospital. This was lower than the trust target of 4.24%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

Although the trust provided the total numbers of shifts worked by medical bank and locum staff over the most recent year as requested in the Routine Provider Information Request (RPIR), they were unable to supply the total number of shifts worked by all medical staff, including permanent medical staff. This meant that the proportions of shifts worked by medical bank and locum staff could not be calculated.

However, the trust was able to supply the number of WTE medical staff budgeted for, the number of WTE permanent medical staff contracted and the number of WTE locum medical staff employed. These figures were used to calculate the proportions below.

In May 2018, the trust reported that medical locum staff made up 8.4% of budgeted WTE medical staff in diagnostics. Over the same period 4.1% of budget WTE medical posts in medical care were left unfilled. The site at which the shifts occurred was not specified.

The table below shows a breakdown by shift type:

<table>
<thead>
<tr>
<th>Bank/locum</th>
<th>Number of shifts</th>
<th>Percentage usage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locum</td>
<td>1.6</td>
<td>8.4%</td>
</tr>
<tr>
<td>Not filled</td>
<td>0.8</td>
<td>4.1%</td>
</tr>
<tr>
<td>Total budgeted shifts</td>
<td>19.4 shifts</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical locum tab)

Qualified allied health professionals staffing

We found that the trust had a shortage of allied health professional staffing in diagnostic imaging. This was supported by the data supplied by the trust and we confirmed this at the time of our inspection.

Broomfield Hospital

The trust reported the following qualified allied health professionals numbers in diagnostics at Broomfield Hospital as of March 2018 and May 2018:

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTE)</td>
<td>Planned staff (WTE)</td>
</tr>
<tr>
<td>Broomfield Hospital</td>
<td>62.0</td>
<td>80.8</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Qualified allied health professionals tab)
The numbers of actual and planned qualified allied health professionals within diagnostics were the same in March and May 2018. The fill rate was quite low at 76.8%.

(Source: Routine Provider Information Request (RPIR) – Total staff tab)

Service leaders said that staffing requirements were assessed on an annual basis or when changes were made to the service. As part of our inspection we requested documentation from the last staffing assessment that had been carried out. Documentation was not provided but the trust’s response is detailed in the medical staffing subheading. The lack of documentation provided meant that we did not receive assurance that the service effectively planned and reviewed their staffing requirements on a regular basis.

Service leaders felt that the diagnostic imaging service was staffed safely, with enough senior support. There was a more experienced radiographer (band six) on duty at all times and senior radiographers (band seven) were in all areas during normal working hours.

We requested data on shift fill rates for radiographers as part of our inspection. In response, the trust did not provide data but stated “If somebody is off sick, we do not backfill with agency / bank at short notice – the work is covered by the rest of the staff.” It was therefore not clear that the service had an oversight of the number of shifts that were not filled.

Vacancy rates

Broomfield Hospital

From June 2017 to May 2018, the trust reported a vacancy rate of 21.1% for qualified allied health professionals in diagnostics at Broomfield Hospital. This was higher than the trust target of 15.4%. The vacancy rate was particularly high in ultrasound: 38.9%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Radiographers described one of the main challenges in their department as staffing shortages. Staff said that three further sonographers had recently left the trust and this had further increased vacancy rates in ultrasound. However, staff also stated that three radiographers had recently been appointed. Data provided by the trust after our inspection showed that there was a 45% vacancy rate for sonographers, and a 16% vacancy rate for radiographers. The service was undertaking work to improve vacancy rates. This included overseas recruitment, training programmes for staff to become sonographers, and the service had recently changed the university from which they received student placements to improve retention rates. Several staff that had worked in the department as radiology assistants had either started or completed training to become radiographers.

Turnover rates

Broomfield Hospital

From June 2017 to May 2018, the trust reported a turnover rate of 2.1% for qualified allied health professionals in diagnostics at Broomfield Hospital. The trust target is 18.05%.

Within the RPIR, the trust noted that there was an issue with their turnover data. The process used in ESR when staff leave and retain a staff bank contract means that they are not counted in ESR as a leaver. As a result, the turnover figures reported from ESR are lower than they actually are. The trust’s internal reports and the Joint Working Board report are adjusted to reflect the additional leavers, so that the correct turnover figures are reported. However, due to the manual recording of this data, and its limitations, it was not possible for the trust to analyse it to the level...
of detail required for the RPIR.

The trust reported that this process was changing and, in the future, all of their leavers would be included in reports from ESR.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

Broomfield Hospital

From May 2017 to April 2018, the trust reported a sickness rate of 4.3% for qualified allied health professionals in diagnostics at Broomfield Hospital. This was higher than the trust target of 4.24%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

Bank and agency staff usage for qualified allied health professionals is not included in the RPIR.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

We requested data on bank and agency radiographer usage after our inspection. The data provided by the trust showed that between August 2017 and August 2018, an average of 0.9% of shifts were filled by bank staff and an average of 5.6% of shifts were filled by agency staff. The amount of agency staff being used had increased in the five months prior to our inspection, from 3.42% in April 2018 to 9.68% in August 2018.

Staff said that there were difficulties in attracting agency staff to work in the department due to competition from trusts in London. Appropriate induction arrangements were in place for bank and agency staff.

Records

People’s individual care records were written and managed in a way that kept people safe. The diagnostic imaging service used electronic records systems, including a radiology information system (RIS), a picture archiving and communication system (PACS) and the trust’s electronic patient record system, which had been introduced in April 2017.

Trust staff used the electronic patient record system to refer patients for imaging. Referrals automatically transferred onto the radiology information system. Referrals from GPs came mainly via email but in some cases by post. When paper referrals were received, these were date stamped and scanned onto the system.

The service had a process to ensure that transport of patients to radiology included relevant clinical information, but this was not always followed. Referrers were prompted to answer additional questions dependent on the imaging they had selected, such as an infection assessment and a mobility and transport assessment. Transfer forms were used for ward staff to record relevant information for radiology staff, such as most recent observations and whether an escort was required. An ongoing audit was in place to review the quality of transfer form completion as there had been ongoing concerns in this area. The most recent audit had been completed in June 2018 and this showed that “In most cases the forms are not being fully/correctly filled in”. For example, out of 39 forms audited, seven were clearly filled in regarding resuscitation status of the patient and 32 were unclear. In 15 out of the 32 unclear cases the resuscitation status had not been completed at all. Work had already been carried out with ward staff to discuss
the concerns regarding transfer form completion and to shorten the transfer forms. However, we were not provided with details of any further actions that would be taken as a result of the June 2018 audit.

The radiology records system did not contain flags or alerts regarding patients’ mental health needs, learning disability needs, autism needs, or dementia needs and the service no longer specifically asked for this information as part of the referral process. However, staff stated that referrers would include this information in the clinical details section if necessary.

The RIS system kept a log of all letters sent to the patient, kept an audit trail of events, and staff could upload any relevant documentation, such as safety questionnaires, onto the system. The system also gave staff access to discharge letters, which allowed radiology staff to look at patient history and find out further details.

The service provided electronic access to diagnostic results. Internal referrers received reports via the electronic patient record system. Daily emails were sent to staff to make them aware that reports were available for review. Reports were sent to GPs electronically via a separate computer system, or by secure email for the small number of GPs who did not have access to this system. Results were sent to GPs three times per day.

The PACS system, a digital imaging display and storage system, enabled images to be viewed anywhere in the hospital. In addition, it meant that staff working away from the hospital could also view images. The trust had begun using a new PACS system in June 2017 in order to use the same system as two local trusts, with whom they were working towards a potential merger. This meant that images could be more easily shared between the trusts. The trust had 24 hours a day, seven days a week support for their PACS system, with service level agreements for the resolution of issues based on urgency. Plans were in place in the event of systems failures. The service was also working towards a combined radiology information system with the two local trusts, and had recently gone out to tender for a system. Staff were required to complete e-learning modules for PACS and the radiology information system (RIS) prior to passwords being issued. An introductory overview was also provided during the doctor's induction programme.

The service was not regularly reviewing the quality of documentation within radiology. We requested evidence of documentation audits being carried out in diagnostic imaging areas. The only audit results provided were for the patient transfer form, which reviewed the quality of documentation by ward staff rather than radiology staff. Staff stated that audits of the radiology information system were not possible to carry out, as these could only be carried out by the RIS supplier. However, the records we reviewed during our inspection had been completed appropriately. Staff were observed entering dose and identification checks appropriately onto the radiology information system as part of the imaging process.

**Medicines**

**Medicines, including contrast media used to enhance imaging, were stored appropriately but documentation relating to the administration of medicines was not always kept up to date.**

During our last inspection we raised concerns about contrast storage, as contrast was found to be stored in an unlocked cupboard. During this inspection, we found that these concerns had been rectified as contrast was stored appropriately. The contrast warmer temperature log was signed and completed daily. All contrast checked during our inspection was within expiry date. All other medicines checked during our inspection were within their expiry date and stored appropriately.

Patient group directions (PGDs) were in use in diagnostic imaging. PGDs provide a legal framework which allows some registered health professionals to supply and/or administer specified medicines, such as painkillers, to a predefined group of patients without them having to
see a doctor. However, we checked five PGDs in MRI and they had not been reviewed since 2012. This was raised with staff, who said that they were currently in the processes of being reviewed through liaison with pharmacy.

Radiologists held appropriate certificates for administration of radioactive medicinal products and the delegation of injecting was clearly documented. A list of Administration of Radioactive Substances Advisory Committee (ARSAC) holders, practitioners and operators was available. However, the modality lead for nuclear medicine advised us that the details on the list were out of date and that they would be updating this list. Processes were in place to ensure that the right radiopharmaceutical was injected. Isotopes were stored in a locked room.

Incidents

Staff spoken to on inspection showed an understanding of the use of the incident reporting system and the type of incidents they should report. However, staff were not always aware of serious incidents that had occurred in the department and the service was not ensuring that learning from discrepancies was shared and discussed in a timely manner.

Staff reported incidents through an electronic incident reporting system. All grades of staff could access the incident reporting system. Staff indicated that they could request feedback for incidents that they had reported through a tick box on the electronic incident reporting system. Staff said that learning from incidents was shared through a radiology newsletter. We reviewed the two most recent copies of the radiology newsletter and saw evidence that learning from incidents was shared, as well as an overview of recent incidents. However, staff were not always aware of serious incidents that had occurred in the department and were limited in examples that they could provide of changes to practice that had occurred as a result of incidents.

The service had a governance lead who had oversight of all incidents that occurred in radiology. This ensured that radiation incidents were fed into risk management and for accidental and unintended exposures, notified to CQC under IR(ME)R or to HSE under IRR requirements. The governance lead ensured that any immediate actions had been completed and worked with modality leads during the investigation process. The governance lead met regularly with the department’s clinical lead and service manager to review incidents that had occurred in the department.

We requested data on the incidents reported in diagnostic imaging between January and September 2018 as part of our inspection. Data provided by the trust showed that the total number of incidents reported in radiology had increased from 265 in 2015 and 331 in 2016 to 394 in 2017. The number of radiation incidents reported in 2017 was 41, which was a decrease from the 70 incidents reported in 2016 and 54 incidents reported in 2015.

There was evidence of changes to practice as a result of incidents. For example, In CT, a safety questionnaire had been introduced to help prevent radiation incidents. The form was completed when patients booked in and included patient identification, checking for previous CT images and the length of time since imaging last occurred, as well as information about pacemakers and allergies. The service had also taken a range of actions to address referrer errors, including the introduction of a safety questionnaire for all invasive ionising radiation procedures, a review of standard operating procedures, and additional induction and training courses. As a result, the number of referrer errors had reduced from 65 in 2012 to 21 in 2017.

There was evidence of adherence to duty of candour regulations, including a process for and evidence of written apologies. Information provided by the trust prior to inspection noted that duty of candour had been applied five times in diagnostics between June 2017 and May 2018. This amounted to 5.4% of all duty of candour applications within the trust. A mandatory section was triggered on the incident form if the recorded level of harm was moderate, severe or a fatality, or if the incident was recorded as a serious incident to ensure that duty of candour was discharged. The radiology governance lead took responsibility for undertaking the formal duty of candour process with patients and relatives. Staff were aware of the principles of the duty of candour and said that they were encouraged to be open and honest. The governance lead felt that there had
been an improvement in the candour of staff since the time of our last inspection, with a lessening of blame culture.

Never Events

Broomfield Hospital

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

From August 2017 to July 2018, the trust reported no incidents classified as never events in diagnostics at Broomfield Hospital.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

Broomfield Hospital

In accordance with the Serious Incident Framework 2015, the trust reported five serious incidents (SI) in diagnostic imaging at Broomfield Hospital which met the reporting criteria set by NHS England from August 2017 to July 2018.

Three of these serious incidents were classified as diagnostic incidents including delays (including failures to act on test results). The remaining two serious incidents were categorised as a medical equipment/devices/disposables incident and a treatment delay.

(Source: Strategic Executive Information System (STEIS))

We reviewed copies of three serious incident root cause analysis investigation reports as part of our inspection. Reporting discrepancies were identified as the root cause of each serious incident that we reviewed. A reporting discrepancy occurs when a retrospective review, or subsequent information about patient outcome, leads to an opinion different from that expressed in the original report. In each case, the reporting discrepancy was to be discussed at a discrepancy meeting, and in two cases the staff involved were asked to review their imaging and the incident as a whole, so that this could be used as evidence of audited practice in their appraisal/revalidation portfolio. However, in the third incident there was no indication that this had occurred. Two out of the three serious incident reports had been triggered by a patient complaint as staff had failed to submit an incident report when the reporting discrepancy was identified. This demonstrated that staff did not always recognise that reporting discrepancies should be reported as incidents. Actions were put in place to remind staff to consider the need to report an incident when a reporting discrepancy was identified.

Each serious incident investigation included a detailed review of events, including a timeline and a review of a range of potential contributory factors. All investigation reports included an action plan to implement identified learning. There was evidence that changes to practice had been made as a result of the serious incidents that had occurred and there was evidence that duty of candour had been implemented in each case. Action plans within the serious incident reports we initially received did not always have due dates for each action. However, we were provided with updated action plans after our inspection which showed that actions had due dates and persons responsible identified. In addition, the action plans had been updated when actions had been completed. The action plans showed that the majority of actions had been completed, although in some cases there had been a delay of one to two months after the original due date. Two actions had not been marked as complete at the time of our inspection and these both related to the discussion of reporting discrepancies at discrepancy meetings. One case should have been
discussed by November 2017 and another by May 2018. The service was therefore not ensuring that learning from discrepancies was shared and discussed in a timely manner.

Modality leads had not always completed route cause analysis training. However, the governance lead had completed route cause analysis training and worked alongside modality leads when route cause analysis investigations were being carried out in order to provide support. Human factors training had been completed by leads and radiologists in the diagnostic imaging service.

The governance lead had worked with the patient who was the subject of a serious incident to share learning with diagnostic imaging staff via a PowerPoint presentation.

Processes were in place to ensure that the right person received the right radiological scan at the right time. The service used the Society of Radiographer’s “pause and check” checklist. However, we requested evidence of any audits carried out to review the completion of identification checks and these were not provided.

Is the service effective?

Evidence-based care and treatment

The diagnostic imaging service worked to national regulations and guidelines, although there was historical poor compliance with ionising radiation regulations in areas outside of radiology which had not been resolved in a timely manner.

The radiology department staff worked to the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) and guidelines from the National Institute for Health and Care Excellence (NICE), the Royal College of Radiologists, the Society of Radiographers and other national bodies. The majority of policies, procedures and protocols referred to by staff were in date for review and in line with legislation, standards and evidence based guidance. Staff in radiology were aware of new Ionising Radiations Regulations which came into force in January 2018 and work was being carried out to ensure that practice within the department was in line with these new regulations.

There was a risk on risk register regarding historical poor compliance with IR(ME)R in areas outside of radiology, including dose documentation, radiation protection supervisor involvement, demonstration of operator certificates, equipment competency records and compliant referring for procedures. A radiation protection supervisor was overseeing this risk, including carrying out a weekly audit of compliance. Training and practical demonstrations had also been carried out, and meetings were being held with relevant areas to address this risk. The weekly audit reviewed a range of metrics to determine whether processes had been followed correctly. Weekly audits had been completed for 305 weeks, the equivalent of over five years, but data from the audit showed that maintaining ongoing compliance in some areas remained a concern, particularly in ensuring that images had been correctly annotated and the completion of a mini c-arm form for the procedure. There were also issues with patients that did not attend before examination start time and documentation of which operators undertook the process. Data provided after our inspection showed that compliance had been 0% at the time of the first audit. Compliance over the last six weekly audits prior to our inspection averaged at 69.5%, but compliance over these weeks had fluctuated between a low of 54% and a high of 84%. Contingency measures had been put in place to highlight any issues with documentation and add this information retrospectively. The service kept a log of all images awaiting annotation corrections; the log contained 51 images at the time of our inspection and 36 of these were dated between six and eight months prior to our inspection. This therefore demonstrated that there were delays in rectifying concerns once these had been identified. There was no formal action plan in place to address the audit findings.

The Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) state that local diagnostic reference levels (LDRLs) should be established and reviewed on a regular basis to ensure that patient doses are optimised. Diagnostic reference levels are dose levels for typical examinations for groups of standard-sized patients for broadly defined types of equipment. The trust had developed local diagnostic reference levels for some examinations and procedure types and we saw that these were displayed in scanning areas for staff information. Staff audited DRLs
annually to ensure patients received the correct dose. The service did not have LDRLs for paediatrics at the time of our inspection but they were planning to develop these.

A trust-wide process was in place to ensure that compliance with new or updated National Institute of Health and Care Excellence (NICE) guidance was regularly reviewed. The trust had a team who were responsible for identifying new or updated guidance on a monthly basis; this was then directed to the relevant department, who carried out a self-assessment about the relevance of the guidance to their area. A gap analysis tool was then completed and compliance was recorded on a central system. If there were gaps identified, a timeline and an action plan were completed. Staff said that new or updated national guidance was discussed at joint divisional meetings. We requested evidence of any self-assessments, gap analysis tools, action plans or timelines at the time of our inspection. In response, the trust stated that ‘There is currently nothing outstanding in Radiology in regards to NICE guidance’. Most pieces of guidance specifically for Radiology are not applicable to the Trust. However, the radiology department does contribute to the review of recommendations for guidance that sits within other areas. Any guidance that is relevant to Radiology is fully implemented.’ After our inspection, the trust provided us with evidence that there was a process in place in line with the trust process.

**Nutrition and hydration**

**Patients had access to hydration in order to meet their needs while in the department.** Patients attending the department were not routinely provided with food or drinks. The majority of patients only attended the department for a short period. However, if patients were in the department for an extended period, staff could arrange for sandwiches to be made available if required.

If patients had fasted prior to a procedure, staff said that they would provide tea and biscuits after their procedure. This was observed during our inspection.

Patients had access to fresh water in each waiting area. In addition, there were a range of cafes, coffee shops, vending machines and other shops located throughout the hospital.

**Pain relief**

Staff did not routinely use pain relief in radiology as the majority of patients using the diagnostic imaging service did not require pain relief as part of their scan. Staff stated that pain was not formally assessed through pain assessment tools whilst patients were undergoing imaging. However, we observed staff checking whether patients were in any discomfort where this was appropriate. Staff could provide patients with paracetamol if necessary. If a patient indicated that they were in significant pain then staff would take the patient to the emergency department or back to their ward to arrange for pain relief to be provided before the patient underwent imaging.

**Patient outcomes**

The service did not always appropriately monitor the effectiveness of care and treatment.

The service’s audit programme demonstrated that some audits were being carried out to review the effectiveness of care and treatment. The radiology department had four audits planned for 2018, as well as three rolling audits which were carried out on an ongoing basis. Two audits were focused on image quality, one was a review of imaging requests and another audit reviewed complications after CT-guided percutaneous lung biopsies. The rolling audits reviewed radiology transfer form completion, World Health Organisation checklist completion and an audit of compliance with IR(ME)R in areas outside of radiology. However, two of the four planned audits were marked as overdue at the time of our inspection in September 2018; these audits were both planned to start in April 2018, with a report due in June 2018. In addition, the audit programme showed that only one audit was carried out in 2017.

The service had carried out an audit on complications after CT lung biopsies. The primary aim of the audit was to compare the service’s complications with the national survey and assess compliance with the British Thoracic Society (BTS) *Guidelines for radiologically guided lung biopsy*
(2003). The audit results were in line with the national survey and British Thoracic Society (BTS) guideline data for pneumothorax, drain insertion, and fatality. However, it was noted that whilst results for pneumothorax (39%) were within the broad range (0 to 61%) provided by BTS, it was higher than the given target of 20%. In addition, the service’s haemoptysis complication rate (8%) was higher than the reported national average (1.25 to 5%). The service planned to repeat the audit and to review ways to reduce complication rates further.

The service had a radiologist audit lead. Staff said that the service held regular audit meetings to learn and feedback, and both radiologists and radiographers attended meetings. Staff said that presentations from audit meetings would be sent out by email for staff who were not able to attend and information about audits was shared with staff via the radiology newsletter. Staff said that audit activity had increased since the time of our last inspection due to the introduction of registrars into the department, as well as audit activity undertaken by radiographers as part of a progression scheme. However, we requested minutes from audit meetings as part of our inspection and these were not provided. This meant that we could not review the content of meetings or be assured that meetings were documented so that learning could also be shared with staff not in attendance. In addition, we requested evidence of any action plans to implement learning identified from audits but these were not provided and we therefore did not have assurance that learning was effectively implemented.

There was evidence that the service had changed in response to audit findings. For example, the service had carried out an audit of patient transfer forms which found that the required information was not always provided by ward staff. Transfer forms were used to record a range of information, including resuscitation status and most recent observations. The service had met with ward staff to discuss the findings of the audit and had then worked to alter and simplify the form. However, the most recent audit results in June 2018 raised concerns that this had resulted in the form missing out “a lot of important information”, including resuscitation status of the patient, infection status, requirement of oxygen, allergies and medications. It was therefore not clear in this case that the change to practice that had been implemented was appropriate or effective. There were further examples of changes to practice as a result of audits, including a change to the angle that CT scans were performed at after an audit of CT eye doses and a change to when paediatric protection gonads were used.

The service undertook discrepancy meetings, but not always at the frequency or level of attendance rates set out in the Royal College of Radiologist (RCR) guidance. The purpose of discrepancy meetings is to promote learning from radiology discrepancies and errors. All radiologists were asked to notify the reporting radiographer responsible for collating the discrepancy report of all examinations which had required an addendum to be added once a discrepancy had been highlighted and these were then discussed at the meeting. However, RCR guidance states that “the minimum frequency of meetings should be every two months”. Only two discrepancy meetings had been held in 2018, one in February and one in June, at the time of our inspection in September 2018. In 2017, five meetings had been held, and there was a four-month gap where no meetings took place. The frequency of meetings was therefore not in line with RCR guidance. RCR guidance also states that radiologists “should achieve at least a 50% attendance rate”. Data from November 2015 to September 2018 showed that, of the radiologists that had been employed over the complete time period, the average attendance rate was 43.2% and eight out of 13 radiologists had not met the 50% attendance rate. The service said that a report with attendance rates would be sent to the clinical lead and attendance records could be discussed at appraisal. The report stated that “The department is short staffed and this may lead to clinical commitment prioritisation.” The RCR state that the recording of the outcome of discrepancy meetings should include any action points where appropriate. Whilst learning was identified in the discrepancy meeting minutes we reviewed, appropriate actions were not always identified. In addition, in cases where actions had been identified, such as “Invest in latest versions of VR software/equipment to reduce error”, there was no indication of who was responsible for carrying out the action or the timescale for completion. A summary of cases discussed was available to radiologists as minutes were taken during meetings; minutes were held by the convener for distribution if requested. In addition, cases were saved onto PACS in a specific, anonymized folder which could be reviewed by staff.
Images and reports were reviewed as part of the multi-disciplinary meeting process, as the previous findings were peer reviewed for the meeting. This provided an opportunity for any discrepancies to be identified. The service said that whilst they would aspire to provide a 1% discrepancy audit for all imaging modalities, this was not possible at the time of our inspection due to the demand on services. The service did provide double reporting for advanced practitioners in 5% of plain film images as per the Royal College of Radiology guidelines. The radiology interface automatically pulled 5% of all of the advanced practitioners’ plain film reports for audit every month. This was audited on an ad hoc basis.

The service did not hold Imaging Service Accreditation Scheme (ISAS) accreditation. The service had been working towards ISAS accreditation at the time of our last inspection. Service leaders said that there had been limited progress in working towards accreditation due to capacity within the department. However, the service was working closely with two local trusts due to a potential upcoming merger and they had plans to work towards accreditation once the merger had been completed. The three trusts had visited a local trust with ISAS accreditation in preparation for this, in order to understand the preparatory work that was required.

The trust participated in NHS radiology benchmarking, which meant that the service had information about how they compared to other trusts in metrics such as average cost per examination, numbers of outsourced examinations, waiting times and staffing numbers. Staff spoke positively about participation in this programme as it provided the opportunity to benchmark their practices and performance against other departments. Information provided after our inspection showed that benchmarking data had been used to support cases for new equipment and increased staffing.

**Competent staff**

Appraisal rates for radiographers and radiology assistants were low and equipment competency was not regularly reviewed. There was no specific training for non-radiology clinicians who were reporting images and the service did not audit the reports these staff produced.

The majority of staff who administered radiation were appropriately trained and staff who were not formally trained in radiation administration were adequately supervised in accordance with legislation set out under IR(ME)R. However, there was a risk on risk register regarding historical poor compliance with IR(ME)R in areas outside of radiology, including demonstration of operator certificates and equipment competency records. The service carried out a weekly audit, which included a review of whether operator certificates were stored on the electronic system for the examinations being audited. The service kept a log of any operators with three or more examinations that were not compliant with mini c-arm procedures to identify any particular concerns that needed to be highlighted. Training and practical demonstrations had also been carried out, and an agreement had been made with the relevant team directors that no operators were to use equipment without training.

Equipment training records were available for radiographers and sonographers who operated imaging equipment. Staff said and documentation confirmed that a self-assessment of competence to use equipment was undertaken on a one-off basis and this was then reviewed annually at appraisal. A spreadsheet was maintained with every piece of equipment within diagnostic imaging and all radiographers and sonographers, indicating whether staff had self-assessed as competent, not competent or in training on each piece of equipment. However, the spreadsheet that we were provided indicated that annual reviews of equipment competency had not been carried out. The spreadsheet showed that the records of 37 out of 78 radiographers and sonographers had been updated to show that competency had been re-reviewed after we requested the data. Out of these 37 members of staff, there was a three-year gap since the last review for nine staff, a two year gap since last review for seven staff and a five year gap for one member of staff. Of the records that had not been updated after our request, there had been a two-year gap since the last review for 14 staff, a three year gap for nine staff and a five year gap for five staff. The date of the last review was not recorded for 12 staff. We were not provided with
equipment training records for radiologists or surgeons and therefore did not receive assurance that equipment competencies for these staff were monitored.

The trust stated that ‘If a staff member highlights that they do not feel competent within an area they are expected to work, they will be fully supervised until deemed competent.’ Not all staff would rotate into all areas and they would therefore not be expected to have competencies in all modalities. The trust also stated that ‘Each time a new piece of equipment is introduced into the department a full training programme is implemented for staff required to work within that area.’.

The imaging service had referral guidance, which was available electronically. In addition, training was provided on the electronic requesting system as part of the induction for doctors and other referrers. The training highlighted recent incidents and referrer errors. Radiation protection supervisors or radiation protection advisors delivered training. There was no specific training for non-radiology clinicians who were reporting images, known as auto-reporting. In addition, the service did not audit the reports these staff produced. This has been reported further under the safe domain.

Reporting, vetting and authorising radiographers were working in the diagnostic imaging service. Radiographers undertaking extended roles had learning agreements and a scope of practice. In addition, mentor radiologists were identified. Guidelines were in place to support the extended work radiographers carried out.

Senior staff in diagnostic imaging said that support would be provided for any staff selected for the Health and Care Professions Council (HCPC) random sampling. The HCPC audit a random sample of 2.5 per cent of registrants at every renewal and ask these individuals to send information and evidence that they have met the continuing professional development (CPD) standards.

**Appraisal rates**

**Broomfield Hospital**

From June 2017 to May 2018, 76.6% of staff in diagnostics at Broomfield Hospital received an appraisal, which was lower than the trust’s target of 79%. The 79% appraisal target was met for the majority of staff groups with the exceptions of qualified healthcare scientists, doctor and nurse support staff and qualified allied health professionals.

A breakdown of appraisal completion by staff group is shown in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>June 2017 to May 2018</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Appraisals completed</td>
<td>Individuals required</td>
<td>Completion rate</td>
<td></td>
</tr>
<tr>
<td>NHS infrastructure support staff</td>
<td>30</td>
<td>30</td>
<td></td>
<td>100.0%</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic, technician staff</td>
<td>3</td>
<td>3</td>
<td></td>
<td>100.0%</td>
</tr>
<tr>
<td>Medical staff</td>
<td>16</td>
<td>17</td>
<td></td>
<td>94.1%</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>4</td>
<td>5</td>
<td></td>
<td>80.0%</td>
</tr>
<tr>
<td>Qualified healthcare scientists</td>
<td>3</td>
<td>4</td>
<td></td>
<td>75.0%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>12</td>
<td>17</td>
<td></td>
<td>70.6%</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>37</td>
<td>61</td>
<td></td>
<td>60.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>105</strong></td>
<td><strong>137</strong></td>
<td></td>
<td><strong>76.6%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Some staff said that there was limited time available to complete appraisals and in some cases staff felt that it did not always support development. For example, some staff felt that they had requested additional training as part of their appraisal and this had not been followed up.
The trust introduced a temporary worker checklist in May 2018 to ensure that temporary staff were orientated to the clinical areas at the beginning of their shift. It also ensured that the clinical area was made aware of their clinical competencies. All bank staff undertook the trust induction day, which covered trust policies and practices for providing care. All agency staff completed mandatory training prior to working in the trust. All locum doctors had to have a pre-employment checklist completed to ensure compliance in all areas including mandatory training, General Medical Council (GMC) fitness to practice, and appraisal. Within diagnostic imaging, temporary staff received a short introduction which covered computer systems and equipment.

The induction and competence assessment documents we reviewed during our inspection were appropriate. Mentors were allocated to new staff to offer support. The service had an induction pack for new starters, and induction lasted for 10 to 12 weeks. The pack included checklists for each area within diagnostic imaging, including competencies for the equipment in each area. New staff would not be allocated to complete a shift in an area until the checklist for that area had been signed off. We spoke to one radiographer who had recently started working at the trust, they confirmed that they were completing the induction booklet and had completed a trust induction, although they had not had a mentor assigned to them yet. The member of staff had read the local rules and signed them, and said that they had been shadowing another radiographer to understand the systems and equipment used in the department. The member of staff said that they had only undertaken imaging when they felt confident and that they had felt well supported by colleagues.

The majority of staff spoke positively about the opportunity for development and progression. Two radiographers had completed a postgraduate qualification in forensic radiography, several radiology assistants were in the process of or had completed training to become radiographers, and a programme was in place for newly qualified radiographers to progress (from band five to six) within two years. One or two trainees were supported through training to become sonographers every year. The service held 'lunchtime lectures', covering a range of topics including film viewing, image interpretation, and moving and handling. Practical sessions were included and staff who had attended courses were encouraged to share their learning as part of these sessions.

Staff did not always have the skills to recognise and treat a deteriorating child. This has been reported on further in the safe domain.

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients.

Staff told us that the majority of team working and multidisciplinary working in diagnostic imaging areas was effective. Radiologists and radiographers worked well together. The service supported extended roles for radiographers, such as reporting, and these activities were supported by radiologists.

Staff described positive relations with staff in other areas of the hospital and felt that radiology had become more integrated with the organisation as a whole since the time of our last inspection. Radiologists were included in multidisciplinary meetings. In addition, one-stop clinics were available, involving diagnostic imaging staff working in conjunction with other departments in the hospital to ensure that diagnostic tests could be performed on the same day that patients had been reviewed by medical staff. The radiology governance lead regularly coordinated with other departments and staff in the trust as part of incident investigations, managing risk and other governance work.

There was evidence of effective working with external organisations. The trust worked closely with two local trusts, with whom they were potentially merging with, and significant work had been carried out to streamline processes and systems. There were weekly and monthly meetings between the diagnostic imaging departments at the three trusts to review performance, share
learning and highlight any issues that had arisen, so that there could be coordination between the trusts. Although there was a lead radiologist for all three trusts, staff felt that there was opportunity for increased communication between radiologists across the three trusts.

As part of the justification process to carry out exposure to radiation, the imaging service attempted to make use of previous images of the same persons requiring the test, even if these have been taken elsewhere. The picture archiving and communication system (PACS) used by the trust was also used by two other local trusts, which meant that staff were able to access images from these hospitals if required. We observed staff checking for previous imaging during our inspection.

**Seven-day services**

The service did not fully meet national standards for scheduled seven-day access to diagnostic services but was working towards this.

NHS England *Seven Day Services Clinical Standards* state that hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), and magnetic resonance imaging (MRI). The service was not fully meeting these standards but was working towards this through a trust-wide seven-day services strategy. There was 24 hours a day, seven days a week access to emergency CT and x-rays. MRI scans were available from 8am to 8pm on weekdays and 9am to 4pm on weekends. There was scheduled seven day access to ultrasound. On weekends and bank holidays there was a scheduled inpatient ultrasound session from 9am to 1pm which was covered by the duty radiologist. The trust told us that ad hoc additional outpatient ultrasound lists were carried out by sonographers and consultants as required. Nuclear medicine was provided Monday to Friday only, based on the level of demand and isotope supplier availability.

Staffing levels had impacted on the ability to provide seven-day services, with a reliance on overtime and staff volunteering to undertake additional work. Service leads recognised that a sustainable solution was required and two new senior radiographers (band seven) had been recruited with a view towards seven day working.

**Health Promotion**

Due to the short length of time that staff spent with patients attending imaging procedures, staff had limited opportunity to support or promote healthier lifestyles. However, national priorities to improve the population’s health were supported through information leaflets and posters displayed in diagnostic imaging waiting areas. This included leaflets from the British Heart Foundation and leaflets about smoking cessation.

The service also supported national priorities to improve the population’s health through the provision of screening programmes.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**

Staff understood their roles and responsibilities under the Mental Capacity Act 2005. Staff knew how to support patients who lacked the capacity to make decisions about their care. However, completion rates for Mental Capacity Act level two training were low.

The Mental Capacity Act (MCA) provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The Deprivation of Liberty Safeguards are part of the MCA and they aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.

Staff were able to provide examples of how they had responded to patients who lacked capacity
to consent to imaging. If a patient lacked the capacity to consent to imaging, this was normally communicated to staff in radiology by the referring clinician, along with details of mental capacity assessment documentation that had been completed. If this was not the case and diagnostic imaging staff were concerned about a patient’s capacity to consent to imaging, staff would liaise with the referring clinician for more information, as well as attempting to support the patient to make a decision about their care. Appointments and imaging would be delayed or re-arranged if necessary to address any concerns about consent and capacity. All documentation within diagnostic imaging prompted staff to check whether a mental capacity assessment had been carried out.

Mental Capacity Act and Deprivation of Liberty Safeguard training was delivered on induction and was available for all staff. All patient facing staff were required to update this training every three years. Level two training was also available to all staff.

**Mental Capacity Act and Deprivation of Liberty training completion**

**Broomfield Hospital**

The trust reported that from June 2017 to May 2018 Mental Capacity Act (MCA) level 1 training was completed by 89.2% of all staff in diagnostics at Broomfield Hospital, compared to the trust target of 90%.

This included 76.5% of medical staff and 89.2% of qualified allied health professionals. Therefore the 90% target was not met by medical staff or allied health professionals.

The breakdown by staff group for medical staff and qualified allied health professionals is shown in the table below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2017 to May 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Medical staff</td>
<td>13</td>
<td>17</td>
<td>76.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>58</td>
<td>65</td>
<td>89.2%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust reported that from June 2017 to May 2018 Mental Capacity Act (MCA) level 2 training was completed by 15.7% of all staff in diagnostics at Broomfield Hospital, compared to the trust target of 90%.

This included 11.1% of medical staff and 12.3% of qualified allied health professionals. Therefore the 90% target was not met for these staff groups.

The breakdown by staff group for medical staff and qualified allied health professionals is shown in the table below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2017 to May 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Medical staff</td>
<td>2</td>
<td>18</td>
<td>11.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>8</td>
<td>65</td>
<td>12.3%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
Deprivation of Liberty Safeguards training is covered under the MCA levels 1 and 2 training modules.

(Source: Routine Provider Information Request (RPIR) – Training tab)

We requested details of any consent or Mental Capacity Act audits as part of our inspection. As part of a patient transfer form audit in June 2018, the service had reviewed whether mental capacity assessment documentation was required and had come with the patient to diagnostic imaging. The audit found that only one out of 39 patients had required an MCA form and this had not come with the patient.

The service had undertaken an audit of the consent procedure on a weekly basis for minimally invasive ultrasound procedures. The audit reviewed whether consent had been completed and documented in the clinical notes, and whether this information had been scanned onto the electronic system. The audit results showed 100% compliance with the consent process in the 21 weeks prior to our inspection; compliance had not fallen below 94% in 2018.

Some staff said that although they were aware of the trust’s translation and interpreting services, they preferred to use family members to translate, including for consenting to a procedure. This is not in line with national guidance, such as the Department of Health’s Reference guide to consent for examination or treatment (2009), which states “To be valid, consent must be given voluntarily and freely, without pressure or undue influence being exerted on the person either to accept or refuse treatment. Such pressure can come from partners or family members, as well as health or care practitioners. Practitioners should be alert to this possibility and where appropriate should arrange to see the person on their own in order to establish that the decision is truly their own.”

Staff said that they would contact security for aggressive or violent patients, which may require restraint. Staff had not received any training on conflict resolution but did not raise concerns about their ability to respond to aggressive or violent patients. Staff spoke positively about the responsiveness of the security team. We did not observe any restraint or staff responding to aggressive patients during our inspection.
Is the service caring?

**Compassionate care**

**Staff cared for patients with compassion.** Patients gave consistently positive feedback about the care provided by staff, who they described as kind and caring. One patient described staff as “very professional”. Another patient said that the treatment they had received was “truly amazing”, and stated that they had chosen to travel a significant distance to attend the hospital due to the high-quality care that they received.

We observed kind and caring interactions between patients and staff. Reception staff were observed to be friendly, informative and helpful when speaking to patients. They were observed to provide clear directions and support to a patient. Clinical staff were also observed to be caring and attentive to patients’ needs.

Staff members displayed understanding and a non-judgemental attitude when talking about patients who had mental health concerns or learning disability, autism and living with dementia diagnoses.

We requested Friends and Family Test data for diagnostic imaging as part of our inspection but this was not provided. Friends and Family Test feedback boxes were available in diagnostic imaging waiting areas. There was also information on display about the Friends and Family Test, which encouraged patients to complete feedback.

The environment within the diagnostic imaging department meant that patients’ privacy and dignity could not always be maintained. Limited space meant that patients checked in in-front of other people waiting, which meant that they were not always able to speak to a receptionist without being overheard. Changing areas were not always separated into male and female areas. However, the service had put measures in place to mitigate the impact on privacy and dignity.

Patients in the outpatient radiology area were asked to wait inside their cubicle until a member of staff came to collect them, so that they did not have to share a waiting area with other people in hospital gowns. Screens were used to protect the privacy and dignity of patients who had changed into hospital gowns. In both the emergency radiology area and the inpatient radiology area, the waiting area for patients on trolleys was not separated into male and female areas. In the emergency area, a screen was used to separate the waiting area into two. This was not possible in the inpatient area due to the positioning of the CCTV camera. However, staff arranged the timing of imaging to see men and women at separate times of day as much as possible. Staff showed an awareness of the importance of maintaining the privacy and dignity of patients.

Arrangements were in place to provide chaperones where required. This was normally undertaken by either a radiology assistant or a radiographer, depending on availability. There was the potential that a chaperone of the same gender as the service user may not be available, and the imaging could therefore potentially have to be delayed or re-arranged.

Staff responded appropriately to patients who might be frightened, confused, phobic about medical procedures or any aspect of their care. For example, patients could come to see imaging equipment before their procedure if they informed staff that they felt apprehensive.

**Emotional support**

**Staff provided emotional support to patients to minimise their distress.** Patients said that they felt able to discuss any concerns or worries with staff. One patient said that staff were “always on the end of the phone if you are unsure” and another patient said, “I know I can just pick up the phone if I have any worries”.

Staff were observed providing appropriate support to patients. For example, a radiographer in MRI was observed using a voice link to regularly check on a patient’s welfare and to reassure the patient whilst they were in the scanner.
Quiet rooms were available in the radiology department, which staff said they could use to provide emotional support, for example if a patient became distressed in an open environment.

A chaplaincy team was available at the hospital, providing a 24 hours a day, seven days a week on call system. The chaplaincy team were based at a multi-faith centre, which could be used as a quiet space to sit, or for prayer or meditation. The centre was also used as a safe space for supportive conversations with a chaplain.

**Understanding and involvement of patients and those close to them**

**Staff involved patients and those close to them in decisions about their care and treatment.** The majority of patients said that staff communicated with them so that they understood their care and treatment. Patients said that they felt listened to by staff and that their views were considered. Patients said that staff regularly updated them about their care and treatment. Patients understood how and when they would receive test results or their next appointment date, and who to contact if they were worried about their condition or treatment after they left the hospital. Patients said that staff introduced themselves and we observed this in practice.

Staff were observed giving forecasts about what would be happening with patients' treatment, explaining post procedure information, providing after care advice, and answering patient questions. Staff checked that patients knew why they were attending the department. In MRI, staff were observed regularly updating a patient, including regarding the length of scanning time left.

People’s carers, advocates and representatives, including family members and friends, were welcomed and treated as important partners in the delivery of their care. For example, one relative said that they had always been allowed to accompany their relative into appointments on request and had felt involved in the process.
Is the service responsive?

Service delivery to meet the needs of local people

The service generally planned and provided services in a way that met the needs of local people.

The environment within diagnostic imaging was generally appropriate and patient centred, although aging in some areas. There was generally sufficient seating in waiting areas, with toilets, reading materials, and a water machine. WIFI internet access and televisions were available in some waiting areas. A range of leaflets were available for patient information. A separate play area was available for children in the outpatient area of radiology, but this was not available in the emergency or inpatient area due to space limitations. The waiting area for nuclear medicine was relatively small, with only 10 seats, and patients sat facing one another. The trust stated, ‘Patient experience is not as we would like in respect of the waiting room, and should an opportunity arise to revamp the area, consideration of an improved waiting area would be included.’ In addition, a desk and computer was located within one of the nuclear medicine scanning rooms, which meant that a radiographer may be present in the room undertaking administrative work while a scan was in progress. This was observed in practice during our inspection. The trust stated ‘The radiographers will use the computer to undertake admin tasks while the scan is underway to make best use of their time… As with the waiting area, if the area is revamped when it is time for equipment replacement, the choice of equipment is likely to be different, requiring a separate control room with view onto the scanner which will remove this concern.’

Patients said that there was not always sufficient car parking available. However, there was a dedicated park and ride shuttle bus available and a range of other bus services to Broomfield Hospital.

Signage was generally clear enough to be understood by people unfamiliar with the environment, and volunteers were based at entrances to aid visitors. The hospital was split into five zones, each delineated with a colour scheme. Information was provided to service users before appointments with contact details, a hospital map and directions, and information about any tests, samples or fasting required.

All the patients we spoke with in the radiology department told us their appointments generally ran to time. However, waiting times were not displayed in waiting areas. Reception staff said that they would inform patients of delays on an individual basis.

Quiet rooms were available in the radiology department, which staff could arrange for patients to wait in if they found busy environments distressing. Alternatively, arrangements could be made for patients to be brought straight through to avoid the waiting area, if this was highlighted prior to an appointment.

A broad range of CDs were available in MRI for patients to choose from and in the new MRI scanner, patients could pick from a variety of scenes or settings to view whilst they were being scanned, including Asia, South America, cartoons for children, or a theme colour. The scene or setting was projected on to a screen, then a mirror, positioned above the patient's head, which enabled them to see it. This meant that the service had put measures in place to improve patient experience during an MRI scan, especially those who may be claustrophobic.

Patients requiring diagnostic imaging services had access to some one-stop services. For example, ultrasound was provided as part of one-stop clinics. The one-stop services were responsive to patient needs as they reduced the number of separate attendances to the hospital, saving patients both time and money. Several of the patients spoken to during our inspection said that their imaging appointments had been coordinated with their other appointments to reduce the number of separate attendances to the hospital. Out of hours services were also available, offering flexibility and choice for patients. Staff said that they tried to be as flexible as possible to accommodate patients and we observed this during our inspection. For example, a patient...
presented for an x-ray which they should have booked for but had not and staff made arrangements for the patient to be seen immediately.

The appointment letter sent to patients asked them to contact the hospital if the appointment that they had been provided was not convenient. Patients said that the service was accommodating when changes to appointments were required, to allow them to choose a more suitable time. The service had introduced a partial booking system for ultrasound, which meant that patients phoned the department to arrange an appointment date and time. Staff said that this was working well as it provided an opportunity to find out additional information about the patient such as any transport requirements or information about carers that accompanied the patient. The service felt that partial booking led to a better patient experience and was therefore working towards expanding partial booking to other modalities in the future.

Some diagnostic imaging was outsourced, such as ultrasound, but this offered patients increased choice, including a location which was in the middle of Chelmsford, with free parking and evening appointments.

The diagnostic imaging service was working closely with the diagnostic imaging services at two local trusts ahead of a potential merger. The three trusts were working on plans to improve service delivery for patients, including longer term plans for a single booking system across the three trusts to promote cross site load sharing, and the potential for a community hub facility to increase capacity.

Meeting people’s individual needs

The service generally took into consideration the individual needs of patients attending the hospital for diagnostic imaging, although information about individual needs was not always gathered and recorded appropriately and the service did not always meet the information and communication needs of people whose first language was not English.

The trust electronic patient record system had a flagging mechanism in place to alert staff to patients with learning disabilities or mental health concerns, to prompt that reasonable adjustments may be required. There was no electronic flagging system for people living with dementia or patients who are severely blind or deaf. This had been highlighted as a priority at the operational group for the new electronic patient record system. The radiology records system did not contain flags or alerts regarding patients’ mental health needs, learning disability needs, autism needs, or dementia needs and the service no longer specifically asked for this information as part of the referral process. Staff in diagnostic imaging said that information about individual needs would normally be communicated to them by the referrer in the background information provided if any adjustments were necessary. In addition, information was gathered from patients and relatives through the appointment booking process. However, there was a risk that the individual needs of some patients may not be identified in sufficient time to ensure that staff could make appropriate adjustments.

The service took account of the individual needs of people with complex needs, mental health conditions, learning disabilities, autism, or people living with dementia and ensured that extra support was available when required. Staff said that they would make adjustments to patients’ care on a case by case basis. For example, the service could allocate additional time for service user’s appointments if necessary or they could arrange an appointment at a specific time of day, such as at the start or end of the day. Staff could fast track patients through the department and ensure that patients could bypass queues at reception. Staff had recently received a thank you letter from the relative of a child with special needs. The relative had thanked them for responding appropriately to the patient’s individual needs; staff used minimal language and ensured that waiting times were kept to a minimum by having all equipment set up for the patient’s arrival. These adjustments had been arranged through consultation with the relative prior to the patient’s appointment.
Support with transport was available to service users with mobility issues. Wheelchair stations were available within the main entrance areas. Waiting areas were generally large enough to accommodate wheelchairs, except in nuclear medicine and space was limited in the emergency radiology seated waiting area. Disabled toilets and hearing induction loops were available in most diagnostic imaging waiting areas.

A bariatric trolley and a hoist were located in the emergency area of diagnostic imaging. Staff were aware of the size and weight limits of imaging equipment and said that if these limits were exceeded, alternative types of imaging or alternative imaging locations were considered.

Autism awareness training was available to all staff at the trust. There were three levels of training on dementia available to all staff; all staff accessed level one training as a minimum. Dementia champions were also appointed in each clinical department, who had accessed level three training, and cascaded learning to staff within their teams. Several members of staff in radiology had undertaken level three dementia training and confirmed that they had shared learning from this training with other staff in the department. Staff also had access to a care of patients with dementia policy to provide guidance on meeting the specific needs of patients living with dementia. All new trust employees undertook equality and diversity training and thereafter every three years.

The trust had one whole time equivalent dementia specialist nurse, although the post was vacant at the time of our inspection. There was no specialist nurse for patients that are severely blind or deaf. A learning disability liaison nurse was available to review all patients that presented with learning disabilities to ensure that their needs were met and that any assistance in planning reasonable adjustments to deliver care. The learning disability nurse was notified of the admission of patients with learning disabilities through contact from staff, carers and family members, or external organisations and staff. Staff within diagnostic imaging did not describe regularly liaising with specialist nurses when meeting people’s individual needs. In addition, there was limited evidence of the use of communication tools in radiology.

The trust had an accessible information web page which held easy read patient information; a section was available on mental health issues and was free to download.

The trust offered translation and interpreting services via an external provider, who provided a telephone translation service or face to face appointments where required. The service also offered Braille and sign language interpreting. Staff were aware of this service but some staff said that they preferred to use family members to translate, including for consenting to a procedure. In addition, there was no patient information displayed or leaflets available in any other language. However, the service had created multi-lingual posters with information for patients about notifying staff if they were or could be pregnant. These had not yet been displayed at the time of our inspection. The new MRI scanner could be programmed to speak to patients in a range of languages.

The service had a group of radiographers with an interest in establishing a child friendly experience in diagnostic imaging. They had recently raised funds through a bake sale to develop the paediatric waiting area. There was a children’s play area in the waiting area of the outpatient area of diagnostic imaging. This included a range of toys and books. However, separate children’s play areas were not available in other areas of diagnostic imaging, such as the emergency or inpatient areas. Staff said that this was due to space limitations. Play specialists were used in some areas of diagnostic imaging, including in nuclear medicine during monthly paediatric sessions and during non-accidental injury skeletal surveys. Some imaging rooms had child friendly decorations.

Access and flow

Patients did not always have timely access to diagnostic imaging and reporting.

Diagnostic waiting times (percent waiting 6+ weeks)

From September 2017 to June 2018 the percentage of patients waiting more than six weeks to
see a clinician was consistently higher than the England average. The trust did not submit data in either July or August 2017.

The England average is the mean value from NHS Trusts, NHS Foundation Trusts and Independent Sector Providers in England. The chart below shows 6+ weeks percentages over time.

![Chart showing 6+ weeks percentages over time](Source: NHS England – Diagnostic Waits)

Data for July 2018 showed that performance had significantly improved, with only 0.9% of patients waiting more than six weeks. This meant that the trust’s performance was better than the national average.

Service leads stated that waiting times performance had been impacted in late 2017 and early 2018 by a sharp increase in ultrasound demand in 2017. The backlog was being managed through outsourcing and extra lists, including at St Peters and Braintree locations. There were only four ultrasound rooms at Broomfield Hospital and the lack of space therefore limited the additional work that could be undertaken. By the time of our inspection, waiting lists for ultrasound scans had reduced to approximately five weeks.

Data on current waiting times for appointments for each modality was requested as part of our inspection but this was not provided. In information provided prior to our inspection, the trust noted radiology has some of the longest waiting times compared to other services. Inpatient referrals for ultrasound & MRI were only delivered within 48 hours for 79% of patients, whilst nuclear medicine had only 32% delivered within 72 hours. The service was working towards seven days working in MRI, CT and ultrasound and undertaking recruitment to address these waiting times.

The radiology bookings manager reviewed waiting lists on a daily basis. Weekly meetings were held with service leaders to review patients waiting, including a review at individual patient level of any patients that had or would wait for over six weeks. A daily report was produced from the radiology information system of patients that had been booked the previous day, in order to show whether any patients would breach the six week target based on the date of their booking.

The trust’s electronic patient record system allowed staff in diagnostic imaging to see the number of patients in the emergency department and information about their attendance. This meant that staff could determine the number of patients likely to attend diagnostic imaging and this allowed staff to plan ahead. Once patients were in the department awaiting imaging, staff could view a list of patients waiting, with names marked in red if patients had waited over 15 minutes and green if they had been waiting less than 15 minutes.
The service had taken part in a continuous improvement project with two other local trusts, which included pilots to improve performance and efficiency. Data showed that changeovers between scans could be reduced by implementing standard work and sharing best practices between the hospitals. As of July 2018, this work had led to a 33.5% increase in the number of patients scanned per hour in CT and a 12.8% increase in the number of patients scanned per hour in MRI, compared to July 2017.

Reporting took place normally from 8am to 8pm. Outside of these hours, reporting was outsourced to an external company. Urgent scans were sent direct from scanner to remote reporters. The service did not have local KPIs for report turnaround time, except a one hour “scan to report “time for CT and MRI referrals from the emergency department. The lack of KPIs may have impacted on the service’s ability to monitor and ensure the timely completion of reports.

At the time of our inspection there were 5690 outpatient plain film images, 2640 inpatient plain film images, 1580 GP plain film images, 732 emergency department plain film images, 295 CT images, and 72 MRI images that had not yet been reported. The oldest outpatient and inpatient plain film images had been unreported for 252 days, the oldest GP plain film for 27 days and the oldest emergency department plain film for 59 days. The oldest CT image had been unreported for 13 days and the oldest MRI image for 15 days. Staff said that the number of unreported images had increased from previous levels at the time of our inspection.

Data provided by the trust prior to our inspection for April 2018 showed that in MRI, reports were completed in an average of 4.6 days for routine images, 1.9 days for urgent images and 3.7 days for fast-track images; 10.9% of reports took more than seven days to be completed. In CT, reports were completed in an average of 4.9 days for routine images, one day for urgent images, and 3.4 days for fast-track images; 6.4% of reports took more than seven days to be completed. In plain film x-ray, reports were completed in an average of 4.7 days for routine images, 2.4 days for urgent images, and 12.3 days for fast-track images; 11.4% of reports took more than seven days to be completed. In nuclear medicine, reports were completed in an average of 7.3 days for routine images, 3.1 days for urgent images, and 3.3 days for fast-track images; 13.4% of reports took more than seven days to be completed. In fluoroscopy, reports for routine and fast-track images were completed in less than a day on average, and urgent images were reported in an average of 1.3 days. Images in ultrasound were all reported within a day on average. We requested up to date data regarding report turnaround times at the time of our inspection but this was not provided.

Reports were prioritised based on urgency; plain film chest, spine and pelvis images were prioritised, as well as cancer work. However, the images that were prioritised amounted to a large proportion of all imaging and there was a requirement for more specific prioritisation based on risk. In addition, the service did not have a clear process to review whether patients who had experienced delays in imaging or reporting had come to harm.

Reporting capacity for radiology images due to staffing levels and increased levels of activity had been added as a risk to the risk register. The service was outsourcing some reporting and the service had asked the external company to double the amount of reporting that they were undertaking shortly before our inspection. The service was also insourcing additional weekend sessions, and had recently recruited additional radiologists. Reporting radiographers were also working in the service. However, there was also a risk on the risk register from January 2017 regarding the lack of space to undertake reporting tasks within radiology, which led to reduced reporting capacity. Service leaders felt that the reporting backlogs had increased due to the increased focus on reducing ultrasound waiting times. However, service leaders were hopeful that the backlog could be addressed through the recent recruitment of additional staff. We requested recovery plans for diagnostic imaging as part of our inspection and these were not provided.

As part of our inspection, we requested data on how long people were kept waiting once they arrived in the department but the trust advised that this information was not recorded.
Departmental leads said that they did monitor this data. The waiting time at appointments was not communicated through notices in waiting areas. However, reception staff said that they communicated any delays on an individual basis. Patients spoken to during our inspection did not state that they had waited for excessive periods.

We requested information about ‘do not attend’ (DNA) rates for the diagnostic imaging service but this was not provided until after our inspection. Diagnostic imaging leaders said that they did monitor DNA rates through a combination of automated phone call and text message reminders in the week prior to appointments, as well as the increased use of partial booking.

Staff raised concerns about the shortage of portering staff for radiology and the impact on the flow of patients through the department as a result. These concerns had been added to the risk register in June 2017, stating ‘lack of cover during normal working hours, evenings and weekends is causing operational difficulties…This results in major inefficiencies and delays to patients.’ As a result, radiology clinical staff were resorting to collecting and taking patients back themselves. Staff were submitting incident reports to highlight this issue and concerns had been escalated to the portering manager.

**Learning from complaints and concerns**

Complaints were not always dealt with in a timely manner and there was limited evidence of changes implemented as a result of complaints.

**Summary of complaints**

**Broomfield Hospital**

From June 2017 to May 2018 the trust received nine complaints about diagnostics at Broomfield Hospital. The trust took an average of 38.0 working days to investigate and close these complaints. Their complaints policy states that complaints should be responded to within 25 working days, or 60 working days for more complex complaints.

There were three complaints open at the time of reporting and these had been ongoing for an average of 52.7 days. This was in line with the trust’s complaints policy of 60 working days for complex complaints; however, one of the three complaints had exceeded the 60 day target, having been open for 87 days at the time of reporting.

The breakdown of the nine complaints by subject is shown in the table below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
<th>Percentage of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>5</td>
<td>55.6%</td>
</tr>
<tr>
<td>Appointments</td>
<td>3</td>
<td>33.3%</td>
</tr>
<tr>
<td>Communications</td>
<td>1</td>
<td>11.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

**Number of compliments made to the trust**

**Broomfield Hospital**

From June 2017 to May 2018 the trust received 20 compliments relating to diagnostics at Broomfield Hospital.

The breakdown of compliments by ward/unit/team is shown in the table below:
<table>
<thead>
<tr>
<th>Ward/unit/team that the compliments related to</th>
<th>Number of compliments</th>
<th>Percentage of compliments</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-ray - main</td>
<td>7</td>
<td>35.0%</td>
</tr>
<tr>
<td>MRI</td>
<td>7</td>
<td>35.0%</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>3</td>
<td>15.0%</td>
</tr>
<tr>
<td>Radiology department</td>
<td>2</td>
<td>10.0%</td>
</tr>
<tr>
<td>E.E.G</td>
<td>1</td>
<td>5.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

In the RPIR the trust did not provide a breakdown of the compliments by either subject or theme.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Patients we spoke with had not needed to make a complaint but felt able to do so if necessary and were aware of how they could make a complaint.

Staff said that they would attempt to resolve any complaints or concerns informally in the first instance and would then escalate to a more senior member of staff or to the Patient Advice and Liaison Service (PALS). Leaflets were available in the department to inform patients about the complaints process and the PALS service. Some staff said that they dealt with complaints so infrequently that they were unsure where complaints information, such as leaflets for patients wishing to complain, were located but that they would be able to locate this via the trust intranet or by liaising with colleagues if necessary.

Staff said that information about complaints was shared with them through a radiology newsletter. The last two radiology newsletters prior to our inspection did not contain information about complaints. Staff said that the majority of complaints in radiology related to reporting backlogs. Staff were not able to provide specific examples of changes to practice as a result of complaints. However, leaders of the diagnostic imaging service said that if any complaints arose about staff communication, this would be discussed with the staff involved.

We reviewed three recent diagnostic imaging complaint responses as part of our inspection. The complaints related to concerns about potential reporting discrepancies and delays. There had been delays in the completion of complaint responses in two cases, where responses had taken 58 working days and 70 working days. In each complaint response, the trust offered an apology, offered the opportunity for the complainant to further discuss concerns with the complaint department if necessary, and provided details of the ombudsman if the complainant wished to escalate their concerns further. There was evidence that diagnostic imaging leaders discussed the concerns with the complainant informally via telephone, as well as providing a formal response letter. However, where applicable, there was a lack of information in complaint responses about what action would be taken as a result of the complaint, such as discussing concerns with the staff involved or reviewing the case at a discrepancy meeting.

**Is the service well-led?**

**Leadership**

Departmental leaders were limited in their availability and visibility, and modality leads were limited in their capacity to provide leadership due to being required to work clinically.

Diagnostic imaging was part of the cancer and clinical support services division. The division was led by a triumvirate of a divisional director, a clinical director and an associate director of nursing.
and operations. The leaders of the radiology department spoke positively about divisional leaders, whom they described as supportive.

The radiology department was led by a service manager and a clinical lead, who had both been in post since the time of our last inspection. Staff within diagnostic imaging described the leaders of the radiology department as approachable and supportive, and felt they could raise concerns with them. However, staff did not always feel that they received feedback or saw evidence of action being taken to address concerns that they raised. In addition, some staff felt that departmental leaders were somewhat limited in their availability and accessibility. The radiology service manager acknowledged that they had limited visibility due to their workload, although they made their contact number available to staff so that they could make contact when needed. The service manager was trying to increase the amount of time that they spent in clinical areas. They felt that the introduction of a business manager for the division would be beneficial to allow them to do this. The radiology service manager worked on a term time only basis and said that this was manageable through the support of a “good senior team”, including a deputy manager and modality leads, and through maintaining some contact whilst away from work. Some staff felt that progress within the department stalled or slowed whilst the service manager was away from work. There was some evidence to support this, for example there had been a delay in an action plan being developed regarding concerns raised through a staff comments box as the service manager was away from work.

Departmental leaders understood some of the challenges to quality and sustainability in the department and had identified some actions to address these challenges. For example, leaders identified the reporting backlog as one of the key challenges to quality and sustainability within diagnostic imaging. However, the actions that had been implemented had not been sufficient to address the challenge and leaders did not have a clear documented plan to reduce backlogs. The trust could not provide us with a recovery plan or trajectory to address backlogs in diagnostic imaging.

Each modality within radiology had a lead radiographer (band seven). Some modality leads said that they had limited time to provide leadership to staff in their area due to being required to work clinically. Modality leads said that they had escalated these concerns and felt that the concerns had been acknowledged. However, action could not be taken to address the concerns due to vacancy levels and demand within the department. Whilst some modality leads demonstrated a clear oversight of their area of the department, this was not the case in all areas.

Staff said that trust leaders were not visible in the diagnostic imaging service and staff were not able to name the majority of trust leaders. However, they said that trust leaders held regular update sessions which any member of staff could attend.

**Vision and Strategy**

There was no separate formal strategy for diagnostic imaging and staff were not aware of the trust’s strategy or values.

The leaders of the diagnostic imaging service said that there was no formal strategy for the diagnostic imaging service; their future plans for the department were focused on streamlining their systems and processes with two local trusts ahead of a potential upcoming merger. Regular meetings were held with the departmental leads of the other trusts to monitor progress and to monitor demand and capacity across the three trusts. We requested documentation regarding a strategy for the diagnostic imaging service as part of our inspection. The trust provided a draft document titled *Structuring a Radiology Programme for Mid and South Essex*, which had been created in January 2018. The document had identified clear objectives for the three trusts to work towards, which were using digital technology, improving resilience in the workforce, developing teaching/training/research, procuring the right equipment, standardising processes and procedures, and designing the leadership structure of the service. Twenty projects had been
identified to achieve the objectives; projects had a timeline for implementation, an assessment of priority, an assessment of the level of financial and clinical benefits, and an indication of the progress of each project as at January 2018. However, some longer term projects, such as Imaging Service Accreditation Scheme (ISAS) accreditation, allied health professional recruitment and retention, and MRI on-call projects, had not yet been fully developed. We were not provided with evidence that the strategy had been formalised after the draft document was created or that progress had been monitored since January 2018. The lack of a separate formal strategy for Mid Essex’s diagnostic imaging service could lead to a lack of focus on making improvements and developments within the service, outside of streamlining processes with the other trusts. For example, the service was working on ISAS accreditation at the time of our last inspection and had not made further progress towards this by the time of our current inspection. Departmental leaders said that work towards accreditation had been put on hold until the three trusts had merged and due to staff shortages and lack of capacity.

The trust’s strategic priorities were focused on achieving clinical and service excellence, providing quality leadership, building effective relationships and maintaining business excellence. Staff in radiology were not aware of these strategic priorities. When asked about the trust’s strategy, staff said that the trust was working towards a merger with two other local trusts. Staff were uncertain what impact the merger would have on the diagnostic imaging service.

The draft Structuring a Radiology Programme for Mid and South Essex document had set out a vision for the three radiology departments in Mid and South Essex. The vision was “To use the combined resources and talent in each department and come together to have a seamless department that has the capabilities, ethos, expertise to be able to deliver the highest standard of care to our patients and clinicians. The combined department should be an exemplar, and be able to challenge the regional leaders”. The trust’s vision was “To be a healthcare organisation that puts patient care first and whose reputation for excellence and innovation inspires our patients, staff and the population we serve.” This was translated in short to: “Patient care first… always”. The trust values were “at our best, we are a…kind, professional, positive team”. The values were developed from patient and staff feedback during a series of listening events and surveys in 2015. The trust stated that there was an ongoing programme of communications across the organisation to reiterate the values to all staff through screen savers, pop up signs and leaflets. Most staff spoken to on inspection were not aware of the trust values. However, staff did state that the values had been promoted and displayed around the trust on posters and on computers on an ongoing basis.

The service was planning ahead for staffing, in light of this staff group being classed within the national shortage list. The service had recently changed the university which provided student radiographers in an attempt to increase retention. The service was engaged in extended roles for radiographers. The service was focused on overseas recruitment. Several radiology assistants had either completed or were due to begin training to become radiographers, and ongoing training was made available to develop sonographers.

The service was using IT systems to actively monitor demand and activity in the diagnostic imaging service. Data was entered onto a performance dashboard which included data about the numbers exams completed per hour, the types of patient, and staffing hours. The trust’s data was compared to data from two local trusts.

The radiology department had plans for the replacement of high cost equipment. This was through a capital replacement programme. The programme was risk stratified so that equipment at highest risk of failure was prioritised for replacement. This could mean that the replacement of some equipment could be deferred if other pieces of equipment were deemed higher priority. The department had recently received a new MRI scanner through the equipment replacement programme.

Culture
There was a mostly positive culture throughout the diagnostic imaging service, which was centred on the needs and experiences of the people who used the service. However, the majority of staff said that morale was low in the diagnostic imaging service. Morale was being impacted by staffing levels and the ongoing increase in demand in the department. The service manager for diagnostic imaging had implemented an anonymous comments box for radiographers in summer 2018. Staff had made comments about the impact of staffing levels, the visibility of leaders and the work they undertook, as well as a lack of availability of additional training. The service manager had held a meeting with staff to discuss the comments, and planned to develop an action plan to address the concerns that were raised. The service manager felt that there was a need to increase the time that they spent in clinical areas and to raise awareness amongst staff about the work of leaders in the diagnostic imaging service, as well as raising awareness about the additional training opportunities that had been made available to staff. The service manager planned to introduce a comments box for radiology assistants and the administration team.

Staff mostly described cooperative, supportive and appreciative relationships with colleagues. Many staff members had been working for the trust for a significant number of years. None of the staff spoken to on this inspection raised concerns about bullying, harassment or intimidation. Staff described working in a friendly and welcoming team. Staff received praise and congratulations through a monthly radiology newsletter; the newsletter was also used to welcome new members of staff to the team. Staff said that they felt able to raise concerns when necessary. However, staff did not always feel that they received feedback or saw changes being brought about as a result of concerns that they had raised.

The culture encouraged openness and honesty, including with people who used services, in response to incidents. Staff understood the principles of duty of candour and were focused on being open and honest with all patients. Duty of candour was included on the corporate, healthcare assistant and registered nurse induction programmes for new staff to raise awareness. Duty of candour was also included in the trust's root cause analysis training for investigating officers. The trust had a Being Open and Duty of Candour Policy, which described the responsibilities of staff and the processes in place to ensure compliance.

The trust had schemes in place which focused on staff well-being, including a staff counselling service which was accessed by self-referral, and a 24-hour listening and support service through the chaplaincy service.

Governance

There were not always robust governance processes in place.

The diagnostic imaging service held monthly governance meetings in conjunction with other departments within the diagnostics and therapies division. We reviewed minutes for the last three governance meetings prior to our inspection. We were provided with minutes for April, June and July 2018. This therefore indicated that meetings were either not held in May and August or that minutes for these meetings were not available. Meeting minutes showed that the radiology manager and clinical lead had not attended any of the last three governance meetings. However, the governance lead for radiology had attended two out of the last three meetings. The trust told us that the deputy imaging services manager attended these meetings and the radiology manager and clinical lead received these minutes. We were told that the governance meeting minutes were discussed at weekly meetings.

A meeting template was used for governance meetings which prompted staff to discuss topics under the headings of risk & compliance, patient safety, workforce, and patient experience. Staff were provided with an ‘Incidents & Clinical Effectiveness Report’ for each meeting, with a range of data on incident numbers and themes, risks, national guidance implementation, patient safety alerts and audits. However, the report did not include data on workforce, such as mandatory...
training rates, appraisal rates and vacancy rates, data on patient experience, such as Friends and Family Test results, or any performance data. Within meeting minutes, whilst it was clear that the data in the report provided for the meeting was noted and reviewed, there was limited evidence that the data was subsequently used to generate discussion amongst attendees and to identify all areas where actions should be implemented to drive improvement. For example, when incident data was reviewed, there was no indication that any learning from incidents or emerging themes were discussed amongst attendees. Similarly, the numbers of patient complaints were noted at each meeting but the minutes did not show any discussion about the themes from complaints or any learning from complaints.

An action log was kept to monitor progress against actions that had been identified as part of governance meetings. However, actions did not always have a target completion date identified. The action log had the facility to RAG (red, amber, green) rate actions to indicate whether they were overdue (red), at risk of achieving by due date (amber) or complete (green), however this was not being utilised for the majority of actions. Meeting minutes did not provide evidence that the action log was regularly reviewed and discussed as part of meetings.

The governance meeting template included sections on matters for escalation to divisional board and matters for feedback to departments. No matters had been escalated to divisional board in the three sets of minutes that we reviewed. Matters had been fed back to departments on one occasion.

Diagnostic imaging clinical governance meetings fed up to monthly divisional board meetings. Following monthly divisional meeting, the triumvirate leaders attended a monthly performance and accountability meeting with the trust leaders, where performance across quality and safety, operational performance, and finance was reported on.

We requested team meeting minutes for staff working in diagnostic imaging, to review how governance related information was fed down to staff but no minutes were provided. Staff described team meetings as irregular and that meetings had been phased out over the summer months. Staff said that governance related information was fed down to them through a regular radiology newsletter. Senior radiographers held meetings on a fortnightly basis and staff said that they would cascade information to more junior staff verbally. Radiology assistants held meetings separately from the rest of the radiology department.

Leaders said that regular meetings were held to monitor service level agreements with third parties. We were not provided with evidence of this after our inspection. Whilst monthly reports were provided by the external company to which reporting was outsourced, there was no evidence of regular meetings to discuss any concerns or discuss performance. We were provided with meeting minutes from November 2017 between the trust and the external organisation that provided mobile CT and MRI scanners. The minutes indicated that bi-monthly meetings were to be set up from January 2018. However, we were not provided with evidence that meetings had taken place in 2018. This meant we did not have assurance that performance or any concerns were regularly discussed and reviewed.

The service held quarterly radiation protection committee meetings. We requested the latest minutes, which showed that staff regularly reviewed incidents, risks, and other matters related to compliance with IR(ME)R. An action log was kept to monitor progress against actions that had been identified as part of meetings; actions had a responsible officer and target date identified.

**Management of risk, issues and performance**

**There were not always robust arrangements for identifying, recording and managing risks.** Risks for diagnostic imaging were recorded electronically on a risk assurance framework. Senior staff in the department showed an awareness of the risks that were on the risk register. Risks were reviewed at monthly governance meetings but minutes did not demonstrate the discussions that were held about individual risks. For example, any discussions relating to the effectiveness of
actions being taken to mitigate risks or whether the nature of risks had changed. There were 11 risks on the risk register for diagnostic imaging in September 2018. The register included both clinical and service risks, and there was scoring and controls in place for each risk. However, four risks had been on the risk register for between five and eight years. Service leads confirmed that some risks remained on the register even when the risk had been addressed and no longer represented a risk. Staff indicated that some risks were left on the register ‘just in case’. In addition, not all risks identified during our inspection had been included on the risk register. For example, the lack of working emergency pull cords in changing cubicles in the outpatient imaging area. Whilst this had been identified as a risk on a security risk assessment carried out in March 2018, this did not ensure that the risk was regularly reviewed as it would have been if it had been included on the radiology risk register.

Leaders had not always taken appropriate action to address or mitigate identified risks. For example, leaders were aware that there had been no working emergency pull cords in the changing cubicles in the outpatient imaging area for several months prior to our inspection. Service leaders had escalated the need for this to be addressed, but had not taken timely action to ensure that this had been completed.

The service did not always have effective processes to manage performance as there was a lack of defined key performance indicators (KPIs) for report turnaround times. The only KPI in place was a one hour “scan to report” time for CT and MRI referrals from the emergency department. CQC’s Radiology review: A national review of radiology reporting within the NHS in England (2018) states “Having a defined set of key performance indicators (KPIs) is the foundation for a good radiology service as they allow for effective performance monitoring, appropriate escalation of backlogs to senior management and help drive improvements in the service.” Service leaders said that there was daily monitoring of report turnaround times and any concerns would be escalated. Leaders said that they were considering the introduction of KPI’s in conjunction with the other trusts in the group to ensure consistency.

There were other processes in place to give leaders oversight of performance in the department. The service had a performance dashboard which included a wide range of metrics and benchmarked performance against two local trusts. Staff said that weekly meetings were held in the diagnostic imaging service and monthly meetings were held with two local trusts to monitor performance. However, we were not provided with evidence of meeting minutes as part of our inspection and we could therefore not assess the way that performance data was used in meetings and how effectively performance was being reviewed.

The department was carrying out some audit activity to monitor quality, operational and financial processes. However, audit activity had been limited in 2017 as there was only one audit on the audit programme. There were limited audits carried out specifically to review compliance with national guidelines and standards. The service was not performing audits to ensure that reports by non-radiology staff, also known as auto-reporting, were documented and accurate. CQC’s Radiology review: A national review of radiology reporting within the NHS in England (2018) states that such audits should be carried out. In addition, the service was not carrying out a 1% discrepancy audit on reports due to the reporting backlog within the department. This reduced the ability for the service to review the quality of reports and identify any potential reporting discrepancies. Clinical audits of the quality of outsourced reports were carried out by the external company, who reviewed 5% of their reports and provided the service with a monthly report which flagged any discrepancies.

There was evidence that the service collected data on the performance of third parties, to which work was outsourced. A monthly report was provided by the external company to which image reporting was outsourced. The report included data on the numbers of examinations reported, discrepancy levels, turnaround times and financials. There was also a monthly dashboard to monitor key performance indicators for the external company that provided mobile CT and MRI scanners. The dashboard included metrics on the numbers of patients booked, average number of
patients per day, patients not scanned, numbers of patients who did not attend, as well as complaints and incident data. However, we were not provided with meeting minutes from 2018 to demonstrate that this performance data was being effectively used.

Information Management

The service did not always collect and use information well to support its activities.

The service did not have a holistic understanding of performance, which sufficiently covered and integrated people’s views with information on quality, operations and finances. Diagnostic imaging governance meetings did not review all relevant data on patient experience, or any performance data. Whilst a range of quality data was reviewed at governance meetings, sustainability did not receive the same coverage. There were not always clear and robust service performance measures in place as there was a lack of key performance indicators for report turnaround times.

A significant amount of information requested as part of our inspection was not provided or available. For example, the service did not record data on waiting times. We did not receive meeting minutes for audit meetings, performance meetings, or team meetings, despite staff stating that these meetings did take place. We therefore did not have assurance that the service collected, analysed and managed information appropriately.

Effective arrangements were in place to ensure that data or notifications were submitted to external bodies as required. The service had a governance lead who oversaw all incidents that occurred in radiology and ensured that radiation incidents were fed into risk management and for accidental and unintended exposures, notified to external bodies.

Information technology systems were being used to monitor and improve the quality of care. Leaders used the radiology information system to provide a range of reports and spreadsheets, including a weekly report regarding reporting backlogs, a daily report of booked patients which highlighted any patient that would breach waiting time targets, and spreadsheets which highlighted any patients which had not completed blood tests ahead of their appointment. The radiology information system highlighted patients in the department who had waited over 15 minutes and allowed staff to filter lists of patients awaiting review by urgency or length of time waiting.

The trust deployed a new electronic patient record system in May 2017. This had resulted in some data quality issues with information held on the systems, particularly relating to waiting times. The diagnostic imaging service had added a risk to the risk register regarding potential delays in the radiology service due to implementation of electronic systems. The service had implemented actions to mitigate the majority of risks identified as part of the implementation of the new system, including weekly monitoring and changes to forms and processes.

Staff in the radiology department could access policies and patient records electronically. Staff were aware of how to locate policies and all policies and guidelines held electronically were found to be in date for review. However, paper copies of cleaning related policies held in cleaning folders were all found to be significantly out of date for review during our inspection.

There were arrangements in place to maintain the integrity and confidentiality of identifiable data, records and data management systems. The majority of staff locked and secured computer terminals when not in use.

Engagement

There was some evidence that the service engaged with patients and staff to plan and manage appropriate services, but this was somewhat limited. However, the service engaged well with external partners.

There was some limited evidence that people’s views and experiences were gathered to shape and improve the diagnostic imaging services and culture. For example, patient representatives
were asked to review the new MRI unit to provide feedback from a patient perspective. The service also took part in the Friends and Family Test to gain patient feedback. The trust had placed post boxes and cards in most of the modality waiting areas so patients could leave suggestions and comments. However, diagnostic imaging leaders recognised that there was the potential for increased patient engagement within the service.

The trust had been engaging and consulting patients, public and key stakeholders regarding proposals to reconfigure a number of acute services through a potential merger with two local trusts. There had been a public consultation document, online questionnaire, discussion events, workshops at community meetings, social media and local media coverage, and a telephone survey.

The diagnostic imaging service had recently gathered the views of radiographers through an anonymous comment box to provide an opportunity for staff to provide feedback and comments. A meeting had been held to discuss the comments that had been made, and the service manager planned to complete an action plan to address the concerns that had been raised. Some staff felt that there had been a delay in actions being taken to address the concerns raised through the comment box. The service manager also planned to introduce a comment box for radiology assistants and administration staff.

Staff said that the trust used various methods of communication to engage with them. There were regular staff briefing sessions held by members of the senior leadership team, which staff said were an opportunity to receive updates and an opportunity to ask questions. One member of staff from the department may be nominated to attend and update other staff on the content of the briefing session. The trust also had a monthly staff message from the chief executive, and a range of publications, including an ‘our time to shine’ publication which celebrated success and improvement. There were a range of staff awards available at the trust, including annual staff outstanding service and care awards, employee of the month, department of the month and long service awards. One member of staff spoken to on inspection had recently received a long service award.

The trust had undertaken a Health and Wellbeing Survey between March and April 2018; 4.8% of respondents worked in radiology. The survey included the topics of smoking cessation, nutrition and hydration, physical activities, mental wellbeing, and an opportunity to provide any additional feedback. Actions had been identified as a result of the feedback provided by staff. The trust had also undertaken a number of listening events, enabling staff to speak about their experience working for the trust.

There were examples of collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. The diagnostic imaging service was working closely with two local trusts ahead of a potential merger. There was weekly and monthly communication and meetings to review performance and to streamline processes across the three trusts. There was transparency and openness about performance across the three trusts, as performance data across a range of metrics was benchmarked on a regular basis.

Learning, continuous improvement and innovation

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

The service had taken part in a continuous improvement project with two other local trusts. The project had engaged the support of a consulting group to consider the variation in processes and procedures of the three sites and whether there were any actions that could be taken to improve performance and efficiency. NHS National Benchmarking data had been used to highlight areas to focus on. Workshops had also been undertaken with staff to discuss areas of opportunity. For example, data showed that changeovers between scans could be reduced by implementing
standard work and sharing best practices between the hospitals. A number of pilots were launched as a result of the recommendations made by the consulting group and as of July 2018, this had led to a 33.5% increase in the number of patients scanned per hour in CT and a 12.8% increase in the number of patients scanned per hour in MRI, compared to July 2017.

Staff within the diagnostic imaging service were focused on continuous improvement through developing patient pathways. For example, staff had identified that there was a requirement to improve patient flow on the cancer biopsies pathway. As a result, there was an aspiration to increase the number of beds available from five to eight.

A diagnostic radiographer in the radiology department had become the president of the Society of Radiographers in July 2018. This member of staff regularly networked with diagnostic imaging staff from across the country as part of this role, which allowed them to share best practice and innovations with the diagnostic imaging service at Broomfield Hospital. For example, this member of staff was involved in work looking at the terminology used with distressed patients and the potential introduction of hypnosis.

However, the service had been working towards ISAS (Imaging Services Accreditation Scheme) accreditation at the time of our last inspection and limited progress had been made by the time of this inspection. The service was waiting for a potential merger with two local trusts before progressing further with ISAS accreditation work.