

Colchester Hospital University NHS Foundation Trust

Quality Report


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

Ratings

Overall rating for this trust

Inadequate 

Are services at this trust safe?

Inadequate 

Are services at this trust effective?

Inadequate 

Are services at this trust caring?

Requires improvement 

Are services at this trust responsive?

Inadequate 

Are services at this trust well-led?

Inadequate 

Summary of findings

Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) carried out a comprehensive inspection between the 15th and 18th September 2015. We carried out this comprehensive inspection as part of our regular inspection programme to follow up on previous inspections of trusts in special measures where further improvements were required. Colchester Hospital University NHS Foundation Trust was placed into special measures in November 2013 and was fully inspected in May 2014 where it was provided with an overall rating at the trust wide leadership level of inadequate. Further inspections of the trust's primary location Colchester General Hospital were undertaken in response to concerns in November, December 2014 and July 2015 where urgent enforcement action was taken to protect patients from the risk of harm. Following the November and December inspection the rating for the location Colchester General Hospital was changed from requires improvement to inadequate.

Prior to this inspection the trust was identified as having seven elevated risks and twelve risks on the Care Quality Commission's (CQC) Intelligent Monitoring system in May 2015. The overall percentage score of risk, which is how these reports and organisational risk is calculated, increased from 4.8% in March 2014 to 11.5% in May 2015.

Colchester Hospital University NHS Foundation Trust is comprised of two main hospital sites which are Colchester General hospital and Essex County Hospital. The Essex County Hospital is scheduled to close during 2016 and the only services currently provided on site are outpatient services and ophthalmic eye surgery under local anaesthesia. Colchester General hospital has 560 beds and provides district general hospital care to 370,000 people in North Essex. For this inspection we inspected both sites but have reported on both in the one main location report.

During this inspection we found that the trust had capacity issues and were having to reassess bed capacity at least three times a day. We found that staff shortages meant that there was a high use of agency staff which did impact on the quality of care provided to patients. We found that required improvements, identified at previous inspections since May 2014, had not been undertaken, this included the service, maintenance and repair of

equipment which was found to be poorly undertaken throughout the trust. Outpatient service provision had deteriorated and the trust had lost grip on the number of patients who required treatment through outpatients. End of life care provision had also deteriorated since it was last inspected in May 2014 with patients not receiving safe or effective care at the end of their life.

We have rated Colchester Hospital University NHS foundation Trust as inadequate overall, the location Colchester General Hospital as inadequate although we found that the trust employed staff were highly motivated and were working through many issues to drive improvements locally, they were however impacted by the high use of agency, some of whom were poor in quality of care, which caused them real frustration. We have rated the overall trust as inadequate as there was a lack of management oversight and robust governance systems in place to highlight the concerns we found during this inspection.

Our key findings were:

- There was a significant and substantial shortfalls in registered nursing staff in a number of areas. Overall the trust had a shortfall of 244 (20%) registered nurse vacancies from Band 5 to Band 7 in May 2015.
- There were wards throughout the trust which had very high agency usage noted with staffing on five wards ranging between 80-100% agency use at weekends and at night time. A further 6 wards had agency use above 30% continuously.
- There were significant medical staffing vacancies with a shortfall of 81 WTE (15.8%), which meant that there was a high use of locum medical staff. The shortages of junior, trainee and middle grades was especially notable across medical and surgical specialties during the inspection.
- We found the executive leaders in the trust were not always aware of the risks or significant issues within the trust and required inspections to identify these for them. Where risks were identified they had they either did not consider them to be significant or follow them through to completion.

Summary of findings

- The trust was reactive to risk when it was identified, such as taking action to improve services that were previously inspected however the high level of focus on one area was not always proportionate and worked to the detriment of other areas in the trust with risk.
- Concerns with the equipment not being electrical safety tested, serviced, maintained or calibrated was identified during previous inspections in May, November, December 2014. During this inspection we identified that the equipment within critical ward and departments such as A&E, critical care, theatres and maternity was out of date. The trust was aware of this issue but failed to take appropriate action in a timely way. We raised this with the trust during the inspection and they provided us with a plan to ensure the equipment concerns were resolved by 31 March 2016.
- Pressure on surgical services meant routine operations were frequently cancelled and patients were waiting longer than the 18-week referral to treatment target for operations. The reasons provided for cancellations were linked to bed availability and administration reasons but in many cases patients were not being rebooked quickly.
- Pressure on the cancer services meant that there were many reported incidents of patients who had gone more than 100 days without treatment for their cancers. Cancer performance on the RTT was also poor and showed a downward trend noted between July 2014 and May 2015, though some improvement was noted between May and September 2015.
- The disjointed approach to the management and booking of outpatients placed pressure on the service with some bookings going through the division and some going through the central booking team. The trust executive team were not clear on what their risks within outpatients were without the numbers for each service. There was also a real lack of understanding at the trust board level of what was required for the monitoring and management of admitted and non admitted referral to treatment times.
- The trust was not aware of the current patient backlogs and active patient waiting lists in outpatient services. Following the inspection we were informed about the issues with validating outpatient data and the backlog of pathways. It was subsequently found that there were in the region of 370,791 open patient referrals that required review of which around 149,000 were high risk. This backlog and pressure meant that there were long and in some cases severe delays for some specialties and not all patients being followed up appropriately.
- The longest wait noted on the 18 week pathway was in the region of 116 weeks.
- As of January 2016 the trust confirmed that they had commenced the validation of the open referrals on their system to assess if there had been any adverse impact of this issue on patients, and ensure patients receive appropriate treatment.
- We observed several examples of patients who should have been receiving dedicated end of life care who were not because staff had not identified that they were at the end of their life. Due to the lack of identification of patients at the end of their life the standard procedures for end of life care plans were not given priority or utilised when needed.
- Operational management of the beds, capacity, and flow was not organised well by the leaders of the services and did not provide effective outcomes which delivered support to services in need to capacity including the emergency department and intensive care.
- The approach from the trust the monitoring of mortality including the undertaking of mortality and morbidity meetings to review trends and improve patient care was inconsistent. There were areas where these meetings and reviews were not taking place.
- The trust has seen a steady increase in mortality over the last six months. At the time of the inspection the last Hospital Standardised Mortality Ratio (HSMR) for the trust was 103 and their Summary Hospital-level Mortality Indicator (SHMI) was 106.7 however their weekend mortality ratio was 113.6.
- The way in which responses to complaints and concerns were handled by the trust was not consistent, with some poorly investigated and non-

Summary of findings

supportive responses being issued, which resulted in further complaints being raised about the complaints process. This was evident with the trust being highlighted as one of the top reported trusts in England where complaints management and responses are referred to the Parliamentary Health Service Ombudsman.

- The four hour standard was only being achieved for around 80% of patients, with significant numbers of patients waiting more than 4-12 hours for admission.
- Overall there had been some improvement in the care delivered on the medical wards. However, Safety was rated as inadequate.
- Care on some medical and surgical wards as well as the postnatal ward was poor with patients not being treated with sufficient dignity and respect and call bells not always being answered promptly.
- There was improvement in the culture of being open in some areas of the hospital, however staff in many areas still felt unable to speak up about concerns they had regarding services and care.

However, we also found examples of innovation and good practice including:

- There was notable desire from the staff to make the changes needed to improve their departments and services to ultimately provide good care to patients. The enthusiasm of staff to deliver this was positive.
- The core permanent employed trust staff working on the frontline were, in the majority, dedicated professionals who wanted to provide the best care possible to their patients and were caring, however they felt let down because the agency staff employed did not all show the same commitment to values of good care.
- There were areas where good and innovative practice was taking place particularly in maternity with hypnobirthing and in critical care with staff being involved in research, which has led to national and international publication of their research.
- The mortuary team worked exceptionally well to provide a service when capacity for patients was limited and were innovative and resourceful to cope with demand.

- The creation of the role of the pharmacy intern was innovative and an area of outstanding practice.

There were areas of poor practice where the trust needs to make improvements.

Importantly, the trust must ensure that:

- Ensure that mandatory and statutory training rates through the trust are improved.
- Ensure that staff are assessed and signed off as competent to use equipment which is used to deliver patient care.
- Ensure that appraisal rates in surgery improves and that clinical supervision rates improve throughout the trust.
- Ensure that equipment is service, maintained and calibrated so that it is safe to use on patients.
- Ensure that the culture within the organisation of poor staff morale, staff not being willing to raise concerns openly and concerns around bullying are given sufficient priority by the board with.
- Ensure that all staff in operational roles within the trust are educated in understanding the requirements and fundamentals of referral to treatment times.
- Ensure that improvements are made to the classification of incidents to ensure that they are reported, escalated and graded appropriately.
- Ensure that the conditions imposed by the Commission on the Emergency Assessment Unit are effectively implemented.

The trust should also:

- Review the process for mortality and morbidity in the trust to make the process more robust so that trends are identified and lessons are shared and learned.
- Review the process for the management and response to complaints received from patients and members of the public to address and respond to the concerns they raise appropriately.
- Review the process for the board assurance framework and the links between the divisions and ensure that the top risks are fully discussed and addressed at board meetings.

Summary of findings

- Review the operation management arrangements for the trust to ensure that the operational support functions effectively in supporting wards, departments and services.

Following our inspection at Colchester Hospitals University NHS Foundation Trust a new chief executive was appointed and a new action plan drawn up against the feedback provided at the inspection. We note that since our inspection there has been some limited progress against our areas of concern. I am therefore recommending that the trust remain in special measures

for a period of three months during which time they will submit a weekly dashboard of key improvement indicators to relevant stakeholders in order that we continue to monitor improvements. Based on the findings of this inspection I have recommended that further regulatory action be taken and required the trust to make significant improvements on the care and service they provide to patients.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Colchester Hospital University NHS Foundation Trust

Sites and locations

Colchester Hospital University NHS Foundation Trust comprises of two locations registered with CQC. However all acute activity takes place on the Colchester General Hospital site with primary care including ophthalmology and outpatient services provided at Essex Count Hospital.

The trust has a scheduled plan to close the Essex County Hospital site during 2016 with all services moving to the Colchester General Hospital site.

Population served:

Patients predominantly come from north Essex and the hospital serves a population of approximately 370,000 and provides oncology and radiotherapy cancer services

to approximately 750,000 people across North and mid Essex. The town is expected to see the fastest growth of any town in England over the next decade and has seen a 15% increase in population over the past 10 years.

Deprivation:

Deprivation in Colchester and Tendring is significantly better than England average, however about 16.3% (5,200) and 24.9% (5,800) of children live in poverty in Colchester and Tendring, respectively.

Life expectancy for both men and women in Colchester is similar to the England average while in Tendring it is lower than the England average.

Our inspection team

Our inspection team was led by:

Chair: Heidi Smoult, Deputy Chief Inspector of Hospitals, Care Quality Commission

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

The team included nine CQC inspectors and a variety of specialists including, a clinical fellow, a safeguarding

specialists, a pharmacist, two medical consultants, a consultant in emergency medicine, a consultant obstetrician, an intensive care consultant, a consultant paediatrician, a junior doctor, 12 nurses at a variety of levels across the core service specialities and two experts by experience. (Experts by experience have personal experience of using or caring for someone who uses the type of service that we were inspecting.)

How we carried out this inspection

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

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

The inspection took place between 15 and 18 September 2015.

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

We held a listening event on 7th September 2015, when people shared their views and experiences of

Summary of findings

Colchester General and Essex County Hospitals. Some people who were unable to attend the listening event shared their experiences with us via email or by telephone.

We carried out an announced inspection visit between 15th and 18th September 2015 and then on 8th October 2015. We carried out unannounced inspections at Essex County Hospital on 30th September and at Colchester General Hospital on 3rd October 2015.

We spoke with a range of staff in the hospital, including nurses, junior doctors, consultants, administrative and

clerical staff, radiologists, radiographers, pharmacy assistants, pharmacy technicians and pharmacists. We also spoke with staff individually as requested and held 'drop in' sessions.

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

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Colchester General and Essex County Hospitals.

What people who use the trust's services say

The experience of patients using Colchester General and Essex County Hospitals was mixed. The cancer patient's survey showed that patients were getting a service broadly in line with others in the country with four questions scoring in the top 20% of trusts in the country however four questions scored in the bottom 20% of the country. Patients did not have confidence in the doctors treating them and they were not always given a choice of treatment or were provided with the correct information about their treatment.

The NHS patient survey showed that the trust performed in line with other trusts surveyed across all areas and in most areas there were improvements to scores year on

year. The number of complaints received by the trust continued to fall. However, we heard from patients, who were not in receipt of a service at the time of inspection that the trust did not always respond to their complaints.

The listening event we held on 7th September 2015 was well attended by approximately 50 people. We heard mixed accounts of the care provided at the trust. Most people were very loyal to their local hospital but felt that they were not seeing enough improvements, there were delays in receiving their outpatient and surgery appointments. Patients and relatives also felt that the shortages of staff was impacting on the care being provided and how compassionate and caring staff were to patients.

Facts and data about this trust

Size and throughput

Beds: 640 (plus 86 day beds)

- 591 General and acute
- 34 Maternity
- 15 Critical care

Staff posts: 4,229

In post at the time of the inspection: 3,672

- 515 Medical

- 1,198 Nursing

- 2,516 Other

Vacancies as of May 2015:

- -81.58 WTE medical staff
- -243.86 WTE nursing staff
- -46.91 WTE on support staff

The overall staff deficit equated to 556.95 WTE staff.

Revenue: £267,576.000

Summary of findings

Full Cost: £289,894,000

Surplus (deficit): -£22,318,000 (Deficit)

Safety (trust wide)

- Never events in previous 12 months: 11 from June 2014 to May 2015
- Serious incidents (STEIS): 32 from June 2014 to May 2015
- C Diff: 35
- MRSA: 0
- MSSA: 17

Effective (trust wide)

HSMR Weekday 102.8 Weekend 113.6 Overall 103.0

SHMI Overall 106.7

Caring (trust wide)

CQC inpatient survey: No. of items in top 20% 0 No. of items 'average' 49 No. of items bottom 20% 0

Cancer patient experience survey:

No. of items in top 20% 4

No. of items 'average' 26

No. of items bottom 20% 4

Responsive (trust wide)

Number of complaints in 12 months: 1300 in 2014/15

RTT non admitted (12 months): 62.9%

RTT admitted (12 months) : 87.2%

Diagnostic 6 weeks wait: 4.0%

Cancer 2 week wait: 83.9%

Cancer 31 day wait: 90.5%

Cancer 62 day wait: 70.2%

The number of complaints received has more than doubled between 2012/13 and 2013/14. The complaints rates for 2014/15 has increased further with the trust being cited as in the top 10 of all trusts in England for referrals to the Parliamentary Health Service Ombudsman being made in respect of complaints at the trust.

Well led (trust wide)

Staff sickness 4.00%

Staff turnover 18.0%

Staff survey

The trust returned 1 positive finding and 25 negative findings from 32 questions in the 2014 staff survey. The 'Positive' in 2014 related to: The percentage of staff experiencing physical violence from staff in the last 12 months. The results of the staff survey place this trust within the top three worst results for a staff survey in England.

CQC Intelligent Monitoring

Elevated risks

- Never Event Incidence
- Monitor- Governance risk rating
- NHS Staff Survey – KF9. The proportion of staff reported receiving support from immediate managers
- NHS Staff Survey – KF15. The proportion of staff who stated that the incident reporting procedure was fair and effective
- NHS Staff Survey – KF21. The proportion of staff reporting good communication between senior management and staff.
- Whistleblowing alerts
- Provider complaints

Risks


- Proportion of ambulance journeys where the ambulance vehicle remained at the hospital for more than 60 minutes
- NHS Staff Survey – The proportion of staff who would recommend the trust as a place to work or receive treatment
- CQC complaints
- Monitor – continuity of service rating

Summary of findings

Colchester Hospital University NHS Trust has an increasing position in Intelligent Monitoring, with a greater number of indicators flagged as risk/elevated risk from March 2014 to May 2015.

Summary of findings

Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>We rated this key question as inadequate as the shortages of nursing staff and quality of some agency workers impacted upon the care being delivered to patients. Shortages of junior and training medical staff meant that there was limited on site cover out of hours and at weekends in both medical and surgical areas, without appropriate support in place, and they were required to cover multiple services. The provision for end of life care was poor with patients at the end of their life not being identified at the earliest opportunity; therefore we were not assured that the trust was responding to the needs of patients at the end of their life in a timely way. The provision for outpatient services was unsafe because the trust had lost grip on the number of patients who were waiting for an outpatient appointment and following a change over in their system it meant that patients were at risk of some significant delays in receiving care. At the time of the inspection there was a lack of clinical risk assessment and clinical prioritisation due to the volume of patients in the system. Equipment was identified as out of service, maintenance and electrical safety testing date during inspections in May, November and December 2014 however it was identified that the service and maintenance of equipment had not improved. Equipment was out of date, not serviced and we were not assured that it was safe to be used. There was a lack of oversight from the executive management team to manage this issue.</p> <p>Incidents</p> <ul style="list-style-type: none">• The trust has reported nine never events between May 2014 and April 2015. The trust has declared a further four never events between April 2015 and October 2015.• The trust had the highest reported never event rates of any trust in England for 2014 and currently has the highest declared rate of never event incidences in 2015 to date with 14 being declared since September 2014.• The incident reporting rate was in line with other trusts in the country with 6,941 being reported between May 2014 and April 2015.• There were high incident report rates for administration and clerical functions, such as clinical coding, and also from clinical areas such as Accident and Emergency and the Emergency Assessment Unit. However we noted overall lower than expected incident reporting rates in Maternity and Gynaecology and also surgical services.	<p>Inadequate </p>

Summary of findings

- Of the 6,941 incidents reported 98% were categorised with 'no harm' or 'low harm' as the impact. We reviewed the trust policy on incidents and identified that the incident reporting system for declaring levels of harm was not in line with national recommendations for the classification of harm.
- The majority of trusts in England calculate impact on variety of levels including, physical harm, emotional/ psychological harm, financial impact, staffing shortages, adverse publicity or reputational impact. Colchester Hospital University NHS Foundation Trust only categorises impact where there has been physical harm from an incident.
- For example we examined the incidents and found the following incidents which were categorised as 'no harm', a patient exceeded 100 days on the cancer pathway without treatment, shoulder dystocia to baby following delivery, grade two pressure ulcer, Sepsis not appropriately monitored and treated resulting in critical care admission.
- The trust executive team and senior management team hold meetings twice per week to review incidents graded with a moderate impact or higher to determine if a further investigation is required through the serious incident investigation route. We reviewed minutes of the discussions and found that the incidents reviewed were appropriately discussed.
- We reviewed the incidents reported between 01 January and 31 August 2015 and found that approximately 20% had not been graded correctly and therefore we are not assured that the trust is reviewing all the incidents required for serious incident investigation. We are also not assured that the trust is declaring all serious incidents in line with the 'Serious Incident Framework' published by NHS England in March 2015.
- We could not be assured all staff were raising incidents appropriately. Feedback from agency staff was mixed; some agency staff reported little or no access to the online incident reporting system.

Duty of Candour

- At executive level the management team were aware of the Duty of Candour regulations. The Trust had ensured wide awareness of this through staff leaflets and team briefings. Duty of Candour is concerned with openness and transparency and places a responsibility on NHS hospitals to inform patients when things have gone wrong and harm has been caused

Summary of findings

- In the wards and department areas the majority of staff were aware of the duty of candour requirements and we saw evidence of duty of candour discussions taking place and being recorded in the patient's records.
- The trust displayed information within ward and public areas explaining their responsibilities relating to being open (Duty of Candour) through the 'At our best' campaign.
- Senior staff were mostly aware of their responsibilities relating to Duty of Candour and were able to give us examples of when Duty of Candour would apply. However the trust does not recognise, through its incident reporting procedures and policies, the need to assess the psychological or emotional impact of an incident, which creates a risk of duty of candour not being undertaken.

Mortality and Morbidity

- The trust has a recoded history of high mortality and was reviewed as part of the Keogh review into 14 trusts across England with high mortality. The trust has since worked through some of the concerns identified on their Keogh mortality action plan, however the action plan has not yet been signed off fully due to changes on mortality and morbidity not yet being embedded.
- The trust has included mortality and morbidity in the overall trust improvement plan as item number nine. We have reviewed the minutes of the meeting for the improvement board and found that due to the number of issues being discussed, the subject of mortality and morbidity was not discussed regularly. We are therefore not assured that mortality and morbidity was being given sufficient priority through this route.
- During a risk summit in August 2015 NHS England stated in their report that the trust is a significant outlier for mortality in the East of England and that mortality rates remain significantly higher than expected. The Trust was recorded as an outlier on both SHMI and HSMR mortality indicators.
- At the time of the inspection the last Hospital Standardised Mortality Ratio (HSMR) for the trust was 103 and their Summary Hospital-level Mortality Indicator (SHMI) was 106.7 however their weekend mortality ratio was 113.6.
- Through the data we can see that the mortality ratios have seen an increase Summary Hospital-level Mortality Indicator (SHMI) for the six months up to March 2015.
- The Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at trust level across the NHS in England using a standard and transparent

Summary of findings

methodology. Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the number of deaths in hospital is higher or lower than expected. The guideline for trusts in England is to have a ratio of below 100.

- It was identified through inspection that within the divisions of medical care and surgery and urgent care that there was inconsistency with the format for which mortality and morbidity meetings and reviews were undertaken. There were notable gaps in the reviewing of mortality in urgent care, medical care and some sub specialties of surgery. This means that learning from mortality trends were not being identified.
- We spoke with the medical director about our concerns during a meeting held after the inspection, they acknowledged that further work was needed to ensure processes for learning on mortality through the divisions was robust.

Safeguarding

- The trust had safeguarding leads for adult and children's safeguarding teams.
- The trust, whilst it had a named lead for adult safeguarding at the time of the inspection, had gone through a number of staff changes in safeguarding including a staffing review. The staffing review had resulted in changes to the job description and roles of the team. When asked the team were not clear what additional work was required of them because this had not been explained to them by the trust leadership team.
- Whilst training databases demonstrated that staff received mandatory training in this area we noted that some services where training in safeguarding was low. For example safeguarding children training at level 3 in urgent and emergency services and on the acute medical wards.
- The adults and children's safeguarding policy were currently under review to reflect current national policy.
- There was a safeguarding action plan for the trust which was created to improve the safeguarding approach from the organisation. This was in response to concerns which had been raised through previous inspections. The plan identified items as complete and others that were still ongoing.
- Throughout the trust we observed that the staff would recognise the need to raise safeguarding concerns on risks associated with physical and financial abuse and would identify neglect from an individual or another provider if a person at risk arrived into their care.
- However we were concerned that there was a lack of recognition throughout the trust regarding neglect provided by the trust

Summary of findings

services, where poor care provided to patients was not identified by the trust as a form of neglect. We identified two cases during the inspection where neglect was a concern and we subsequently raised two safeguarding alerts to protect these patients.

Equipment

- Concerns with the equipment not being electrical safety tested, serviced or maintained was identified during previous inspections in May, November, December 2014. During this inspection we identified that the equipment within critical ward and departments such as A&E, critical care, theatres and maternity was out of date.
- We escalated the concerns regarding the equipment to the executive management team during the inspection who contracted engineers in to service the equipment in priority areas to ensure it was safe to use.
- Since the inspection we have met with the trust and we have been informed that a plan had been developed to ensure that the management of equipment was brought up to an acceptable standard by the end of March 2016. The trust provided us with an action plan of how they intended to complete this work.
- Concerns were also identified with processes relating to the moving and handling equipment and staff competencies in undertaking assessments and using the equipment to support patient care. This was identified as a concern during the May 2014 inspection and was investigated by the Health and Safety Executive in October 2014. Due to ongoing concerns with the equipment and moving and handling competencies we have referred our concerns back to the Health and Safety Executive for their consideration and action as appropriate.
- The Care Quality Commission is utilising its enforcement powers to review the ongoing breach of regulations in respect of the safety of equipment being used to provide patient care. A report of our action will be published once this action has been concluded.

Staffing

- The trust has a higher number than national average of consultants at 40% compared to the national average of 39% and middle grade doctors is also higher than the national average with 15% compared to the national average of 9%.
- The specialist trainee posts are not well staffed within the trust with a rate of 26% compared to the national average of 38%.

Summary of findings

- Junior doctor positions are higher than the national average at 19% compared to 15%.
- The trust has a problem recruiting nurses and currently has a high number of nursing vacancies. When asked the executive team members felt that the recruitment issues were associated with the trust being in special measures.
- The recruitment of permanent nurses was increasing throughout the trust with the employment of a large numbers of nursing from overseas however this was creating a greater risk regarding skill mix and competence with the workforce being so new.
- This shortfall is mitigated through the use of bank and agency staff and whilst this is below the national average at 5.3% as opposed to 6.1% there remain some shifts which are not filled.
- Throughout the inspection the quality of the agency staff being booked was continually raised as a concern with regards to how dedicated they were or how consistent care was not provided.
- There were notably high agency use on wards including Birch ward with 89%, Mersea Ward 44%, A&E with 42%, Emergency Assessment Unit (EAU) with 39%, D'Arcy ward 39%, Frail elderly unit 39%, Peldon ward 31% and Brightlingsea ward 30% on agency.

Medicines Management

- The hospital used a comprehensive prescription and medication administration record chart for patients which facilitated the safe administration of medicines.
- We saw that the records of administration were incomplete so we could not be sure that people always received their medicines as prescribed.
- The trust had carried out an audit of missed doses in August 2015 which showed that the 412 prescription charts reviewed included 63 occasions on which medicine was not given as prescribed.
- We saw minutes of meetings and posters on wards which showed that action was being taken to address the problem. Members of the pharmacy team told us that nursing staff were starting to work jointly with them to reduce the incidence of missed doses.
- We saw that pharmacy staff reviewed and confirmed the prescriptions for people on first admission to hospital. Members of the pharmacy team had recorded important interventions on the prescription charts to help guide staff in the safe administration of medicines.

Summary of findings

Are services at this trust effective?

The trust was rated as inadequate or being effective because clinical staff competency was not always monitored and appraisal rates in some areas, particularly surgery services, were very low for example the appraisal rate of Mersea ward was 4%. Where agency staff were used, they were not always able to access information about patients they were supporting. Whilst there were up-to-date evidence-based guidelines in place, we were concerned that these were not always being followed.

Outcomes of audits, both local and national, were mixed. Outcomes for patients in some care elements such as Acute Myocardial Infarction Audit (MINNAP) 2013 were significantly better than the England average however outcomes for patients with stroke, sepsis, septic shock and hip fractures were below expectations when compared with similar services.

The endoscopy unit was not currently accredited by the joint advisory group (JAG). This is a national award given to endoscopy departments that reach a gold standard in various aspects of their service, including patient experience, clinical quality, workforce and training. JAG accreditation was lost in June 2015. Three concerns were raised regarding the unit, two related to the environment which had since been addressed and a further concern related to diagnostic waiting times.

Competencies for staff on how they were safe to use items of equipment, including hoists and infusion pumps were not up to date and in some areas had not been completed. We were therefore not assured that staff were evidenced sufficiently as competent to safely use equipment.

We were concerned regarding the provision of end of life care not being effective. The trust had removed the Liverpool Care Pathway and replaced it with an 'individual care record for the last days of life', however not all staff were aware of this record, not all staff had been trained to use it and due to this lack of awareness opportunities to place people on the correct pathway of care at the end of their lives were missed.

Staff had limited knowledge of their responsibilities under the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards. Nursing and medical staff were unclear about the procedures to follow when reaching decisions in persons' best interests.

Evidence based care and treatment

Inadequate



Summary of findings

- Most specialties provided care and treatment in line with guidelines from the National Institute for Health and Care Excellence (NICE) and Royal College guidelines. Local policies were written in line with these guidelines.
- There were specific care pathways for certain conditions, in order to standardise the care given. Examples included stroke pathways, sepsis, acute kidney injury and non invasive ventilation and falls. However we did not see pathways in place for the management of those patients with long-term conditions for example Parkinson's or dementia.
- There were integrated care pathways in place for all patients admitted to the cardiac catheter laboratory. However, during our inspection we found that an intravenous iodine policy had been waiting for review since September 2009.
- The trust does not have a policy in place for end of life care. The trust end of life individualised care record was not being used consistently where patients were identified as end of life to ensure they receive evidence based end of life care. There was a lack of identification by staff at all levels, including the executive level, within the trust about when a patient was at the end of their life and when certain plans were required.
- There was no formal policy or procedure for transferring patients from a trolley onto a bed at any stage. With no clear process for the assessment of patients who were waiting on trolleys to be seen this meant that patients may be put at risk from pressure area damage developing by remaining on trolleys for lengthy periods on Copford ward the surgical assessment unit, the emergency department and the emergency assessment unit.
- In endoscopy we were not assured staff were following local and national guidance to ensure consistency of practice. At the time of our inspection local decontamination guidance dated March 2010 with a review date of 2012 and, British Society of Gastroenterology (BSG) Guidelines for decontamination dated February 2008 was available to staff in paper format.

Patient outcomes

- The trust participates in a number of national audits to benchmark itself against the national picture. The trust performed well in a number of audits including: the sentinel stroke national audit programme (SSNAP), the Acute Myocardial Infarction Audit (MINNAP) 2013, The College of Emergency Medicine audit of asthma and in the audit of

Summary of findings

paracetamol overdose, bowel and lung cancer audits, the Maternal Newborn and Infant Clinical Outcome Review Programme (MBRRACE) Report, and the Royal College of Obstetrics and Gynaecologists quality indicators.

- In some audits the trust was performing worse than in previous years. These included: the College of Emergency Medicine audit of severe sepsis and septic shock, the East of England neutropenic sepsis audit, the national emergency laparotomy audit and the National Neonatal Audit Programme (2013).
- The National Heart Failure Audit reported in 2013 / 2014, showed that the trust scored above the England average in all four in-patient care measures, but worse than the England average for 3 out of seven discharge measures. Access to the stroke unit was rated as level E in the most recent the sentinel stroke national audit programme (SSNAP),
- The maternity service does not currently monitor or submit the data for emergency maternal readmissions within 30 days of delivery or monitor women who had planned to have a vaginal birth after having a caesarean during a previous birth (VBAC).

Multidisciplinary working

- We saw some good examples of multidisciplinary working across the trust and into the community.
- Wards teams had access to the full range of allied health professionals and team members described good, collaborative working practices. There was generally a joined-up and thorough approach to assessing the range of people's needs, and a consistent approach to ensuring assessments were regularly reviewed and kept up to date.

Competent Staff

- Induction and competency assessments were in place for new, temporary and agency staff across all areas. There was an attempt to book regular agency staff as they were familiar with the areas, paperwork and systems at the trust, which reduced the risk of compromised patient safety.
- The majority of services and directorates were on track with appraisals with the exception of surgery which had appraisal rates below 60%. The worst areas for staff appraisal were Mersea ward at 4% and Brightlingsea ward at 6%.
- There were competency assessments in place for theatre equipment and a record of completion held by the training and development lead. There was a lack of competency assessments throughout all areas for the use of hoists, resuscitaires, CTG machines and infusion pumps.

Summary of findings

- We asked to see the competency assessments for the use of moving and handling equipment throughout the trust for permanent and bank and agency staff; however no competency data was available. We are therefore not assured that staff trustwide are fully competent in the use of moving and handling equipment.
- We asked to see training records and competency records for the staff using the syringe drivers and the trust provided a sample of information. Training information on these items was incomplete, and showed that 66% of staff on West Bergholt (an oncology specialty ward), 100% of staff on Birch and 89% of staff on Dedham ward had been trained to use McKinley syringe drivers by February 2012 which meant that competencies on key items of equipment used trustwide were not up to date.

Seven day working

- The pharmacy department provided a dispensing and supply service from 9 – 5 on weekdays and 10 – 4 on weekends and Bank Holidays. An on call pharmacist was available at other times. There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis.
- Radiology provided a service between Monday to Friday and some Saturday sessions. Emergency Radiology was available seven days per week.
- There was a lack of support services provided to clinical areas by physiotherapy and occupational therapies at weekends, which was predominantly linked to low staff numbers in post. This had a negative impact on outcomes for patients in services such as Stroke and respiratory care.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Mental capacity was not always assessed for patients who may lack capacity. Knowledge of staff was not consistent throughout the trust about the assessment and recording of mental capacity assessments.
- Deprivation of Liberty Safeguards were not always understood or recorded appropriately by staff, for example when urgent requests were made these were not always followed up with routine requests for ongoing care needs.
- We were not assured that the Mental Capacity Act and deprivation of liberty safeguards are always implemented for people who had do not attempt cardio pulmonary resuscitation (DNACPR) documentation.

Summary of findings

- Almost one third of all DNACPR forms reviewed as part of this inspection were not completed in accordance with Resuscitation Council UK guidelines.

Are services at this trust caring?

Care at this trust required improvement. The care provided to patients in medical care, surgery, end of life and maternity services required improvement because there were times when patients did not feel well supported or cared for. Some patients and their relatives had concerns about the way staff treated them and felt they were not always treated with kindness or respect or in a timely way when receiving care and treatment.

Within maternity services the attitude and approach of staff in post natal services was raised as a concern to us through a dedicated focus group for women who used the service. For patients receiving end of life care we observed mixed levels of compassionate care to patients and families and we also received feedback from families which was mixed about the care and support provided, particularly in relation to how messages of bad news was given. Within medical and surgical ward we observed the ward handovers which were undertaken in a manner which was not dignified, private or respectful to patients who were present during the discussions.

Within Surgery services patients from three wards, Mersea, Great Tey and Brightlingsea, provided information that suggested nurses at night were less caring, seemed fed up and could be rude. One patient referred to a “nasty nurse” overnight and another had reported to the ward sister that the agency nurse at night “had been frightening” They said that the sister had dealt with the situation and informed the patient that the nurse would not be booked again.

Within surgery and medicine services patient confidentiality was compromised during the nursing handover, which took place beside the patient’s beds. Handover included a full description of past medical history and the summary of current care. This was loud enough for other patients in the bays to overhear.

For end of life care we received several concerns about the way patients were treated including examples of delays in receiving pain relief, and a lack of information provided at the end of the patient’s life about what to expect and patients and relatives did not feel well supported or cared for.

Patients throughout the trust reported that in a majority of cases they were given the information they needed at a level they understood to enable them to be involved in their care. Families and those close to patients, in the majority, were kept up to date with

Requires improvement



Summary of findings

patients' progress and their views on care and treatment sought to enhance care given. Emotional support was offered through the chaplaincy service and a part time bereavement specialist however staff were also supportive to both patients they knew well and those who were admitted for the first time.

Compassionate care

- In the Cancer Patient Experience Survey, the trust achieved mixed results. Scoring well for the nursing staff, being helped with the side effects of chemotherapy and being given information about support groups.
- The trust scored in the lowest 20% of trusts for questions relating to choice of treatment, information about their condition and confidence and trust in all doctors treating them.
- The trust scored 'About the same as other trusts' in all questions in the CQC Inpatient Survey.
- The Trust scored about the same as others in 16 indicators and better than other trusts in one indicator in the CQC Maternity survey 2013.
- The maternity service Friends and Family test was based on a response rate of 11.2%, which was significantly lower than the England average of 22.4%. The results showed that overall 96% of women would recommend the service.
- We held a dedicated focus group for 30 women in the community who were first time mothers/mothers nearing due date to share their experience of using services with us within the last year. The feedback received from the women was mixed about their experience with the majority reporting negative experiences of their care, predominantly during post natal care and the key concern raised was the attitude of staff.

Understanding and involvement of patients and those close to them

- The trust used the NHS Friends and Family Test (FFT) to obtain feedback from patients. This was a single question survey which asked patients whether they would recommend the NHS service they had received to friends and family who needed similar care or treatment.
- The average FFT response rate for the trust was 28% in July against an average of 27%, In June it was 35% against an average of 27%, In May it was 26% against an average of 27%.
- Latest scores for Colchester General Hospital recorded that 95% of people would recommend using the service to friends and family.

Summary of findings

- In quarter 1 of 2015/16 (01 April to 30 June) 68% of staff would recommend the service to their friends or family with 11% saying they would not recommend the care at this hospital to friends or family. The response rate for this survey was 14%
- The Patient Led Assessment of the Care Environment (PLACE) survey results showed that the trust had slightly higher or very similar scores to the England average for cleanliness and food, however scored much better for privacy, dignity and wellbeing, and facilities.

Emotional support

- Patients could access a range of specialist nurses, for example in stroke and cardiac services. We saw that staff offered appropriate support to patients and those who were close to them in relation to their psychological needs.
- There was a trust wide spiritual care and chaplaincy team available to patients, families and staff of all faiths and none. This was available 24 hours a day 7 days per week.
- There was a bereavement support team of specialist midwives available
- A counselling service offered specialist counselling at the trust to individuals affected by cancer. This was a collaborative service between a local hospice, the trust, a local clinical commissioning group and, cancer support organisation.
- Within medical services most patients we spoke with were not aware of any emotional support services available to them. However, patients and relatives told us that they felt supported emotionally by the nursing staff.

Are services at this trust responsive?

We rated this domain as inadequate because the number of routine operations being cancelled by the trust was continually increasing over the previous six months. There was limited assurance provided by the trust to recover this. The waiting lists and referral to treatment times for cancer services were also not meeting the national standards. There were 112 reported episodes of patients going for more than 100 days without treatment for their cancers.

We also found that there was a significant back log of patients waiting for initial and follow up appointments with in the outpatients service. Whilst the trust is not exactly sure of the total numbers of patients waiting for appointments they have assessed that there are 161,750 patients who represent 370,716 pathways on the system. Of the total the trust is unclear as to the status of 243,543 pathways and what impact this may have on patients. There are 34,149 awaiting test results, 15,253 with missing data and 20,274

Inadequate



Summary of findings

with an open appointment still needing to be seen. Governance systems in outpatients were not in place to address the responsiveness of the department. The executive team were not aware of the scale of the backlog or the risk this presented to patients.

For patients who were receiving care at the end of their life rapid discharge back to their home or into the community for their preferred place of death was not rapid and delays were noted. The mortuary capacity was not sufficient for the size of the hospital and provided real challenges to cope with increased demand for space during busy periods.

Within Children's services concerns were noted with children under the age of 15 years being placed on adult wards for their admissions without appropriate risk assessments in place. This was not responsive to their needs. Within maternity services women reported being discharged during the night with their newborn child. The trust did not monitor out of hours discharges from the service so data was not available.

Service planning and delivery to meet the needs of local people

- The service was trying to work with key stakeholders to ensure that health and social services met the changing needs of the local area. However the trust is working further to build better relationships with these stakeholders to deliver the service plans.
- The North East Essex Clinical Commissioning Group has an end of life care strategy for 2013-2017 and the purpose of this was to join care at the end of life to make it integrated between home, primary care and hospital care. The trust is not an active member in participating in this strategy because attendance at meetings has been poor.
- There was a lack of service planning from the trust in respect of the mortuary service provision. The population of Colchester and North Essex is forecasted to increase by 37.6% between 2012-2032 and there was no strategy in place for forward plan for this service.
- Between July 2014 and May 2015 cancer waiting time standards for the cancer 62 day standard had not been achieved for every month. The 31 Day standard was only achieved in December 2014 and the two week wait standard had not been achieved for June to August 2015. Cancer waiting times standards monitor the length of time that patients with cancer or suspected cancer wait to be seen and treated in England.

Summary of findings

- Data for May 2015 showed waiting time standards for the 62 day standard to be 70% against a target of 85%, 31 day standard to be 90% against a target of 96% and, two week standard to be 84% against a target of 93%.
- Following discussions with the service leads for medicine we were told the division planned to be compliant with the 62 day standard by January 2016. Data for August 2015 showed an improvement in all areas, with the exception of dermatology, however this was the first month in 12 this had been achieved and there was no evidence of sustainability.
- Following the inspection we received information from the trust which updated us that they planned to be performing better on their referral to treatment times and meeting the requirements by 31 March 2015. However the action plan provided which states this was not fit for purpose as the detail on how the improvements would be achieved were not realistic given current capacity and demand concerns.

Meeting people's individual needs

- The chaplaincy team were highlighted as being responsive to the needs of the patients and the staff on the wards throughout the hospitals seven days per week. Their response and support was raised by several areas in the trust as positive.
- There was trustwide access to language line and translation services for those whose first language was not English.
- There was a lack of identification and recognition of specific types of dementia's and how the needs of those with Dementia would be met outside of the trust's dedicated care of the elderly wards.

Access and flow

- At the time of our inspection the bed occupancy across the trust was 93%. This was worse than the England average. We looked at information provided by the trust and saw that bed occupancy rates were consistently between 87% and 95% which was slightly higher than the England average.
- Delayed transfer of care rates for the trust were noted to be good with an average of 2-% recorded over the previous 8 months.
- The trusts performance cross all surgical and non surgical referral to treatment times has showed a downward trend over the previous six months in terms of performance which has ultimately had a negative impact with cancelled elective surgeries and delayed treatment for cancer care.

Learning from complaints and concerns

Summary of findings

- The trust board received data about complaints and complaints were discussed at the local governance and audit meetings. All complaints were seen and signed off by the interim Chief Executive Officer (CEO).
- Literature and posters were displayed within the wards, advising patients and their relatives how they could raise a concern or complaint, both formally and informally.
- Although staff told us that learning from complaints took place at a ward level, we were not assured that learning from complaints was shared across the divisions.
- The way in which responses to complaints and concerns were handled by the trust was not consistent. Some poorly investigated and non-supportive responses were being issued by the trust. This resulted in further complaints being raised about the complaints process. This was supported with the trust being highlighted as one of the top reported trusts in England where complaints management and responses are referred to the Parliamentary Health Service Ombudsman.

Are services at this trust well-led?

Well led at trust level has been rated as inadequate. Whilst the vision and values are well developed they were not well known to members of staff in all areas of the trust. The trust does not have a clinical strategy or quality programme established for the future delivery and improvement of the service.

We found that the arrangements for governance and performance management did not always operate effectively. An example of this is the lack of action on concerns previously raised through inspections on items elements such as the service and maintenance of equipment. Whilst the trust was aware that there were ongoing issues with regards to the service and maintenance of equipment in high risk areas they had not sufficiently prioritized the issue or kept oversight of the matter on the trust board's agenda, despite it being highlighted as a significant risk on the trust's board assurance framework.

There was a disconnect between what was happening on the front line and the senior management team. This was evident through the different core services we reviewed, for example the trust board were completely unaware of significant backlogs and patient safety concerns across outpatient services. Frontline staff could evidence business cases which had been presented at a divisional level but had not been accepted that the senior leadership team were not

Inadequate



Summary of findings

aware of, for example the trust board were completely unaware of the pressure for capacity within the mortuary where the team have been requesting for support to increase service functions for ten years without success.

Staff morale throughout the organisation was low and the multiple changes in leadership and direction they felt had significantly impacted their chances to make sustainable changes. The NHS staff survey results of the trust were in the top three worst results of any trust in England which was consistent with the feedback we received from staff about how they perceived the trust. However staff permanently employed by the trust were taking real ownership of the issues previously identified through inspection and were wanting to drive improvements through locally.

The culture of the organisation remains a concern, and there was no clear strategy regarding staff being able to openly raise concerns to the executive team which is evidenced by the CQC receiving 35 whistleblowing concerns in the 11 months prior to the 01 September 2015 and a further 14 whistleblowing concerns raised to date through the inspection process.

The trust has been found to be reactive when issues have been raised by regulators but a lack of effective governance systems meant that the trust were not proactive in the identification and resolution of issues raised.

Vision and strategy

- The trust has a vision and values called 'At our Best', which revolved around staff values and behaviours in how care would be delivered.
- The trust does not have a strategy for the future service delivery and there was no clinical strategy for the prioritisation of services.
- We heard examples of where services had put business cases forward for the expansion or increase in their service functions however they did not feel listened to and their business cases were rejected. This included the increase in therapies supports to provide a seven day service, increased provision of palliative care and an increase in capacity for the mortuary. There was a clear lack of investment in the provision of support services, end of life care through palliative care and the mortuary by the trust.

Summary of findings

- The trust was not clear on its trajectory for improvement going forward. There was one main action plan in place however the plan was large and aligned to a few members of the board only which meant that there was a risk that these actions would not be delivered by the time provided for the action completion.

Governance, risk management and quality measurement

- The governance system within the trust was not fit for purpose and requires immediate review to ensure that risks are identified, monitored and managed appropriately. There was a real disconnect between the divisions and the senior leadership team particularly in relation to governance and risk management. Items from the divisional risk registers, despite being high risk were not always captured through the board assurance framework or discussed at board level.
- At board level there was a lack of understanding and management of risk, which meant that risks stayed on the risk register for some time without movement to resolve those concerns where possible. For example the concerns regarding the equipment was identified on the trust risk register as a significant risk with potential consequences highlighted including patient harm and the receipt of regulatory action, yet no action from the trust was taken to deal with this risk despite the matter being one that could be resolved swiftly.
- The trust is quick to react when a concern is raised with them by the regulators, however the trust cannot prove a track record of sustained improvements in the areas of previously identified concerns. For example in July 2014 the Care Quality Commission identified significant concerns regarding safeguarding, culture and patient safety on Brightlingsea ward and during the inspection the ward had noticeably improved. However we identified similar themed concerns on another surgical ward named Aldham which the trust had failed to identify. Following the inspection after the attention had been removed from Brightlingsea further safeguarding concerns were reported for the ward which demonstrates that improvements are not being maintained.
- The trust had nine reported never events over the period covered by the inspection, however there have been 14 over the previous 18 months which is more than any other acute hospital in England. We saw that there was no shared learning of never events across each of the divisions.
- As part of our intelligence gathering prior to the inspection we were aware that the level of harm from incidents reported by the trust was declared to be very low in contrast to their serious incident and never event levels which remained high.

Summary of findings

- During the inspection we reviewed incidents reported in the divisions between 1 June and 31 August 2015 and identified that approximately 15% had been incorrectly graded with 'no harm' or 'low harm'. For example a delay in a patient's treatment with the patient suffering a cardiac arrest was graded as 'no harm'. Another incident where a safeguarding concern was raised about an agency nurse who forced medicines into a patient's mouth was graded as 'no harm'. Another incident where a patient was given four times the dose of a beta blocker, which affects the heart and circulation, resulting in the patient needing medical help was graded as 'no harm'. The processes for the classification and grading of incidents were therefore not robust.
- Within outpatients the our inspectors had to educate staff within the trust on the processes and differences of referral to treatment times for admitted and non-admitted patients and the parameters for which the trust should be monitoring trajectories, risks and backlogs which was not taking place prior to our inspection. This showed a lack of good governance as concerns should have been identified and managed through the trust's own processes.
- The senior management team were unaware of the backlogs and risks they had associated with delayed cancer care, outpatient appointment and diagnostic service delays and the poor provision for end of life care within the hospital. This demonstrated that governance and risk management systems were not as robust as they could have been.

Leadership of the trust

- The senior team were made up of relatively new members of the team with the Chief Executive and Human Resources roles were covered by interim staff members. At the time of the inspection the longest serving person in post was the interim Chief Executive who had been in post for 18 months. A new permanent Chief Executive, Human Resources Director and Finance Director had been appointed.
- The multiple changes in leadership had created a feeling of instability within the trust and meant that the direction and leadership approach to the organisation was not clear. The team were learning to work together and build a team working dynamic and relationship which was not yet well established.
- The Non-Executive Directors mostly had backgrounds unrelated to healthcare. There were two Non-Executive

Summary of findings

vacancies at the time of the visit, which were being recruited to, and two other positions had been filled within the last 18 months which meant that the non-executive team were still becoming established.

- Staff felt well supported by their local manager but reported that they did not see the senior management team, apart from the Director of Nursing in ward and frontline areas. The Director of Nursing's name was raised throughout the trust as the one board member they knew of and the one they felt supported by.
- We were not assured following our interviews with the trust board members that the team were cohesive and had sufficient experience in the acute sector to be able to understand the tasks ahead, the risks they faced and could articulate a way of driving delivery at a pace that would show improvements to patient care.

Culture within the trust

- The trust returned one positive, six similar to expected and 25 negative findings from 32 questions in the 2014 staff survey. The positive related to the percentage of staff experiencing physical violence from other staff in the last 12 months which had improved. Four of the negatives have been identified as 'Risks' and Elevated Risks' in the Intelligent Monitoring report for NHS Trusts. This survey result is one of the top three worst survey results of the 138 hospitals in England that took part.
- Due to the number of vacancies within the trust the majority of vacant shifts were filled by agency staff. Several trust staff throughout the trust expressed their disappointment to us about the quality of care provided by some agency staff and the impact that this had on the service and the staff who were working to try and keep patients safe. Staff who worked for the trust, in the majority, were passionate about providing safe high quality care but felt that this was hindered by staff who showed a lack of care which they told us was "upsetting".
- Concerns were also raised regarding the lack of action taken towards some agency staff who continue to get booked for shifts when concerns were raised about their practice. We discussed this with the director of nursing who said action would be taken where these concerns were raised however more action was needed to improve this process.
- The trust's policy on whistleblowing had been reviewed however there was a lack of direction to drive forward the agenda of culture through the organisation.

Summary of findings

- The trust took whistleblowing concerns to the board when raised, however these were limited in number and did not show to the trust what actions would be taken to support individuals who raised concern, the feeling amongst staff was that there remained a 'blame culture' within the organisation.
- Unions also raised concerns with us regarding the culture of the organisation. They believed that there continues to be a culture of bullying & harassment in specific areas within the organisation as well as 'an unhealthy culture within management resulting in staff either suffering detriment for raising concerns or staff feeling unable to raise concerns'.
- Within the emergency department the trust has seen an improvement since the trust began to review several raised allegations of bullying within the department in early 2015. These concerns were raised to us and we raised the matter with the trust to request that interventions took place to protect staff and improve the service.

Fit and Proper Persons

- The trust had discussed the trusts response to the fit and proper person test at a board meeting in February 2015.
- The trust has a system in place for senior staff to make a declaration of fitness. Where there are gaps in recruitment files the HR department contact the person for an explanation or to provide the appropriate documentation.
- We reviewed the files of those employed by the trust since the regulation came into force and the trust was meeting the requirements of the regulations.

Public and staff engagement

- The trust was actively seeking to increase the number of responses to the friends and family test.
- Senior members of the trust have started to hold meetings with patients and relatives to better understand the issues of poor patient experience. There was no evidence of how this was used to inform further service planning or delivery.
- Staff through the out the trust provided us with mixed feedback on how engaged they were with the trust board and the future of the organisation. Many reported that the multiple changes in management meant that they were not sure what was going to change next and this was unsettling for them.

Innovation, improvement and sustainability

- The trust had created new roles known as 'ward internship pharmacists'. These new posts had been created to improve medicines management support to the wards. Four

Summary of findings

pharmacists were completing their training as interns to enable them to administer IV drugs as well as attending consultant ward rounds and supporting patients to take their own medicines.

Enforcement Action taken by the Care Quality Commission

- In December 2014, following an inspection, two urgent notices of decision were issued to impose conditions on the trust's registration under Section 31 (1) (2) (a) of the Health and Social Care Act 2008. The first was to ensure that there was an effective process for streaming in the emergency department and the second was specifically around the configuration and set up of the Emergency Assessment Unit to ensure that patients at risk of deterioration were monitored appropriately and that there were sufficient levels of staff on duty at all times.
- We assessed the compliance of the trust against the conditions set out in the notice for the emergency department and found that streaming of patients was now taking place effectively. We have therefore removed these conditions from the trust's registration.
- The second notice issued in respect of the configuration of the Emergency Assessment Unit was also assessed as part of this inspection. We identified that there remained challenges with the staffing levels though they had improved since December 2014. We were informed that staff were told not to report incidents where the conditions imposed by the Care Quality Commission were breached. Between January and April 2015 three incidents form were reported by staff which stated that the imposed conditions were breached due to capacity issues. At this stage we are therefore not assured that these conditions have been effectively implemented and further improvements are still required.
- In July 2015, following an inspection, we served an urgent notice of decision to impose conditions on the trust's registration under Section 31 (1) (2) (a) of the Health and Social Care Act 2008 in respect of the induction and competency of agency staff. During our inspection all areas we saw where the trust was using agency staff the trust was meeting the conditions of this notice. We have therefore removed these conditions from the trust's registration.

Overview of ratings

Our ratings for Colchester General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Medical care	Inadequate	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Surgery	Inadequate	Inadequate	Requires improvement	Inadequate	Requires improvement	Inadequate
Critical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Good	Requires improvement	Good	Good	Requires improvement
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate
Outpatients and diagnostic imaging	Inadequate	Not rated	Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Requires improvement	Inadequate	Inadequate	Inadequate

Our ratings for Colchester Hospital University NHS Foundation Trust

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

Notes

Outstanding practice and areas for improvement

Outstanding practice

The creation of the role of the pharmacy intern was innovative and an area of outstanding practice.

Areas for improvement

Action the trust **MUST** take to improve

- Ensure that mandatory and statutory training rates through the trust are improved.
- Ensure that staff are assessed and signed off as competent to use equipment which is used to deliver patient care.
- Ensure that appraisal rates in surgery improves and that clinical supervision rates improve throughout the trust.
- Ensure that equipment is service, maintained and calibrated so that it is safe to use on patients.
- Ensure that the culture within the organisation of poor staff morale, staff not being willing to raise concerns openly and concerns around bullying are given sufficient priority by the board with.
- Ensure that all staff in operational roles within the trust are educated in understanding the requirements and fundamentals of referral to treatment times.
- Ensure that improvements are made to the classification of incidents to ensure that they are reported, escalated and graded appropriately.

- Ensure that the conditions imposed by the Commission on the Emergency Assessment Unit are effectively implemented.

Action the trust **SHOULD** take to improve

- Review the process for mortality and morbidity in the trust to make the process more robust so that trends are identified and lessons are shared and learned.
- Review the process for the management and response to complaints received from patients and members of the public to address and respond to the concerns they raise appropriately.
- Review the process for the board assurance framework and the links between the divisions and ensure that the top risks are fully discussed and addressed at board meetings.
- Review the operation management arrangements for the trust to ensure that the operational support functions effectively in supporting wards, departments and services.