

Colchester Hospital University NHS Foundation
Trust

Essex County Hospital

Quality Report

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

Ratings

Overall rating for this hospital

Requires improvement



Surgery

Good



Outpatients

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

Essex County Hospital is part of the Colchester University Hospital NHS Foundation Trust. This is a much smaller hospital than the main Colchester hospital, with only two oncology wards. This site provides day surgical services for ophthalmology and orthodontic services with minor operations only for other services and outpatients. As part of the CQC new inspection regime, we inspected both the surgical and outpatients services.

We carried out this comprehensive inspection as a follow up to the inspection that was undertaken last year as part of the Keogh Mortality Review.

The team of included CQC inspectors and analysts, doctors, nurses, patients and public representatives, experts by experience and senior NHS managers. The inspection took place between 6 and 8 May 2014, with an unannounced visit on 16 and 19 May.

Overall, we rated this hospital as 'requires improvement'. We rated it 'good' for providing caring and effective care, but it required improvement for safe, responsive and well-led care. We rated surgery services as 'good' but outpatient services 'required improvement'. There were areas of poor practice where the trust needs to make improvements.

Importantly, the hospital must:

- Review the decontamination procedures within the orthodontic clinic to ensure that these comply with the required national standards.
- Ensure that the use of the World Health Organisation (WHO) checklist is fully embedded in surgical practice, including the 'sign out' and debrief.
- Ensure that all staff have appropriate supervision and appraisal.
- Ensure that staff have access to training and development opportunities to ensure that they maintain the necessary skill for their role, this is to include management, leadership and professional development training.
- Ensure that there is a robust incident and accident reporting system in place and that lessons learnt from investigations of reports are shared with staff to improve patient safety and experience.
- Ensure that there are appropriate waste disposal procedures in place and these are implemented, particularly in the outpatients department.
- Ensure that all cleaning products are stored in accordance with manufacturing guidance and complies with legislative requirements.
- Ensure that all sterile equipment and products are appropriately stored to ensure that there sterility is maintained, including an adherence to expiry dates.
- Review the numbers and skill mix in the outpatients department to ensure that there are sufficient qualified and skilled staff to meet patient needs.
- Review the cancellation of outpatient appointments and take the necessary steps to ensure that issues identified are addressed and cancellations are kept to a minimum.
- Review waiting times in outpatients' clinics and take the necessary steps to ensure that issues identified are addressed.
- Review access into clinics to ensure that they are suitable for people with mobility problems.
- Ensure that information on how to complain is accessible to patients in all patient areas within the hospital.
- Review the involvement of staff in trust-wide issues to ensure that staff are fully conversant with the trust vision, strategies and objectives and can contribute to the development of services.
- Review the information provided to staff regarding future development of services and how staff can be involved and engaged in this process.

Summary of findings

We would normally take enforcement action in these instances, however, as the trust is already in special measures we have informed Monitor of these breaches, who will make sure they are appropriately addressed and that progress is monitored through the special measures action plan.

In addition, the hospital should:

- Review the waste disposal bins in toilets designated for people with disabilities.
- Review issues identified and associated with transport problems when accessing outpatient appointments.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Surgery

Rating

Good



Why have we given this rating?

The environment on the surgical wards and theatres was clean and there was evidence of learning from incidents in most areas. There was adequate equipment to ensure safe care. However, we witnessed that the 'five steps to safer surgery' was not undertaken consistently and that not all patients were seen daily by a consultant at weekends. Surgical services at this hospital used evidence-based care and treatment and had a clinical audit programme in place. There was evidence of multidisciplinary working. Effective pain relief and nutritional arrangements were in place. Patients received care and treatment from competent staff.

The surgical services provided at this hospital were caring. All patients and relatives, the results of the NHS Family and Friends Test and patient surveys supported our observations that patients received care and treatment given by staff with dignity and respect.

Staff reported good leadership at all levels within the directorate and improvements in staffing levels. Governance, risk and quality systems were in place.

Outpatients

Requires improvement



Although the outpatient environment was clean, we found poorly stored waste bins and lack of clarity regarding clinical waste disposal. We also found disposable equipment, such as needles and swabs, which had passed their expiry date. Staff were noted to be busy. There were no vacancies in the service and agency staff were rarely used. Staff told us their mandatory training was up to date.

Outpatient services were caring and most patients spoke positively about the care and treatment they received and felt they were involved in their care plan. We witnessed staff being polite and welcoming.

Although the trust had a work stream to monitor outpatient efficiency and to improve do not attend (DNA) rates, we were concerned to find a large number of cancelled outpatient appointments. Up to 9% of these occurred within one week of the original appointment time.

Summary of findings

We saw written information about the complaints procedure and the Patient Advice and Liaison Service, but none of the patients we asked had been given any information about complaints or knew how to make a complaint. We received consistently negative feedback from patients and staff about the patient transport service and patient parking. We found senior staff each had visions for the service at local-level, yet there seemed to be a lack of combined objectives and strategy to achieve an improved service. Issues had been identified within the service, but there were delays in resolving these. We were provided with minutes from divisional governance meetings which appeared to demonstrate that outpatient services were discussed in relevant speciality meetings rather than as a separate service and within these outpatients was discussed at any length. There was no discussions minuted relating to delays in appointments or cancellations. Staff we spoke with were not aware of key performance indicator targets or results for the service and therefore were not proactively managing the situation at clinic-level.

Requires improvement

Essex County Hospital

Detailed findings

Services we looked at

Surgery and Outpatients

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Detailed findings

Background to Essex County Hospital

Essex County Hospital is part of the Colchester University Hospital NHS Foundation Trust. This is a much smaller

hospital than the main Colchester hospital, with only two oncology wards. This site provides day surgical services for ophthalmology and orthodontic services with minor operations only for other services and outpatients.

Our inspection team

The inspection team was led by:

Chair: Ellen Armistead, Deputy Chief Inspector of Hospitals, CQC

Head of Hospital Inspections: Julie Walton, CQC

Inspection Manager: Carolyn Jenkinson, CQC

The team included CQC inspectors and a variety of specialists. There were nine CQC experienced inspectors,

six medical clinicians from a range of backgrounds, including children's, medicine, surgery and anaesthetics, eight nurses from a range of backgrounds that included cancer care, infection control, maternity, children and critical care.

The team was further enhanced by two experts by experience, who brought a service-user perspective into the teams.

How we carried out this inspection

Pre-inspection:

The on-site element of the inspection was preceded by a comprehensive information-gathering process. This phase involves collating data held by the CQC as part of our ongoing monitoring of the trust. In addition to this, the trust was asked to submit a significant number of documents as evidence of their performance around quality and service delivery.

Public involvement:

During the on-site inspection, we held two public listening events, where members of the public were invited to share their experiences of the trust. This involved small group discussion, as well as the offer of individual interviews with the inspection team. Attendees could submit comments via comment cards and we shared the website address where comments could be submitted.

While on site, we spoke to service users in clinical areas.

During the inspection, the CQC left post boxes where comment cards could be submitted by patients, relatives and members of the public.

Internal stakeholders:

We held a number of focus groups that included: junior doctors, student nurses, nursing staff, consultant medical staff and administrative and clerical staff.

During the inspection, we talked to staff from all staff groups, allowing them to share their views and experiences with us.

Inspection

The comprehensive inspection involved an on-site review of:

- A&E
- Medical care
- Surgery
- Critical care
- Maternity
- Children and Young Peoples Services
- End of life care
- Outpatients.

The on-site element of the inspection involved a team of experts by experience (service users), clinical associates (experienced healthcare professionals) and CQC inspectors. The team was divided into subteams, each of which looked at one the service lines described above.

Detailed findings

The subteams were led by an experienced inspector, supported by clinical experts as well as expert by experience. The teams undertook a number of methods of inspections from interviews to direct observations of care.

Members of the trust board were interviewed, as were members of the council of governors.

External stakeholders:

We invited a range of external stakeholders to share their experiences of the trust. This included Monitor, commissioners, local authority and MPs.

Post inspection

The comprehensive inspection programme included the option of carrying out an unannounced inspection. This took place on the 16 and 19 May, where we visited A&E, Nayland Ward, children's services and the outpatient department.

Detailed findings







Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires improvement	Good	Good	Good	Good	Good
Outpatients	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Notes

Surgery

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

Information about the service

Essex County Hospital provides a range of day surgical services, including orthodontics, oral surgery, ophthalmology, age-related macular degeneration and ear, nose and throat procedures. There four theatre suites and a day unit which provide surgical services.

We visited all areas in the surgical directorate. We talked with eight patients and 12 members of staff, including matrons, ward managers, nursing staff (qualified and unqualified), medical staff (both senior and junior grades), and managers. We also observed care and treatment and looked at care records for seven people.

Summary of findings

The environment on the surgical wards and theatres was clean and there was evidence of learning from incidents in most areas. There was adequate equipment to ensure safe care. However, we witnessed that the 'five steps to safer surgery' – the NHS Patient Safety First campaign adaptation of the World Health Organization (WHO) surgical safety checklist – was not undertaken consistently and that not all patients were seen daily by a consultant at weekends.

Surgical services at this hospital used evidence-based care and treatment and had a clinical audit programme in place. There was evidence of multidisciplinary working and effective pain relief and nutritional arrangements were in place.

The surgical services provided at this hospital were caring. All patients and relatives, the results of the NHS Family and Friends Test and patient surveys supported our observations that patients received care and treatment given by staff with dignity and respect.

Staff reported good leadership at all levels in the directorate and improvements in staffing levels. Governance, risk and quality systems were in place.

Surgery

Are surgery services safe?

Requires improvement



The environment on the surgical wards and theatres was clean and there was evidence of learning from incidents in most areas. There was adequate equipment to ensure safe care. However, we witnessed that the 'five steps to safer surgery' was not undertaken.

Incidents

- There had not been a surgical error Never Event (serious harm that is largely preventable) at the hospital in the previous year.
- The reporting of patient safety incidents was in line with that expected for the size of the trust.
- Staff said they were encouraged to report incidents and were aware how to complete this. Feedback was given to ward managers who confirmed that themes from incidents were discussed at staff meetings and displayed in staff rooms.
- Incidents were discussed at ward and clinic manager meetings and the surgical matron attended a monthly matron forum which had attendance from across the trust and promoted shared learning. However, staff were unable to identify improvements instigated as a result.

Safety thermometer

- Safety Thermometer (a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care) information was clearly displayed and included information about all new harms, falls with harm, and new pressure ulcers. The trust was performing within expected for these measures.
- Risk assessments for the conditions listed above were appropriately completed on admission.

Cleanliness, infection control and hygiene

- All patient areas appeared to be clean and we saw staff regularly wash their hands and use hand gel in between seeing patients.
- 'Bare below the elbows' policies were adhered to in line with national guidance on hygiene.
- Infection control information was visible in all ward and patient areas, with each ward having an infection prevention and control information board. MRSA and Clostridium difficile rates were within an acceptable range for the size of the trust.

- Infection control audits were completed every month and monitored compliance with key trust policies such as hand hygiene. Most areas in surgery demonstrated full compliance.
- The consultant managing the orthodontic clinic expressed concern over the adequacy of decontamination procedures in the clinic. He informed us that these were non-compliant with national standards.

Environment and equipment

- Equipment was appropriately checked and cleaned regularly. There was adequate equipment in the clinics and on the wards to ensure safe care.

Medicines

- Medicines were stored correctly, including in locked cupboards or fridges, where necessary.
- Fridge temperatures were checked.

Records

- All records were in paper format and kept securely when not in use. Nursing and healthcare professionals kept documented records in the same place. Record-keeping standards were audited annually and the most current audit report identified that no significant issues in surgery had been reported (Governance Meeting, March 2014).
- Documentation audits were undertaken by the wards annually and the results fed back to clinicians.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients' consent was obtained appropriately and correctly. We saw procedures in place for patients who did not have capacity to consent to their procedure.
- Staff were able to discuss the Mental Capacity Act 2005 appropriately and we saw that the Act's associated deprivation of liberty safeguards were applied, where appropriate

Mandatory training

- We looked at staff training records and confirmed that staff were up to date with their mandatory training.

Nursing staffing

- Nursing numbers were assessed using a recognised staffing tool. Ideal and actual staffing numbers were

Surgery

displayed on every ward and clinic. Staff reported that they were only rarely understaffed and we checked rotas and saw that any vacancies were filled with agency staff when required.

- We were told that staffing levels had been reviewed recently and 'uplifted' to provide more staff on the wards and clinics.
- We observed nursing handovers. Staffing for the shift was discussed, as well as any high-risk patients or potential issues.

Medical staffing

- Surgical consultants from all specialities were on call for a 24-hour period, during which they were free from other clinical duties.
- Junior doctors told us there were adequate numbers of junior doctors on the wards out of hours and that consultants were contactable by phone if they needed support.
- Ward rounds were not undertaken by consultants at set times, and although they would attend to any unwell patients at the weekend.

Assessing and responding to patient risk

- Pre-assessment of patients was in accordance with British Association of Day Surgery guidelines.
- We were told that day surgery patients were given a dedicated telephone number to call in the evenings (up to 8pm) if they experienced difficulty. After that, they had to go to accident and emergency, and may be directed to hospital services in London.
- Ward and clinic managers undertook regular audits (hand hygiene, records, falls). We saw that action was taken where issues were identified, for example, increased staffing and introducing link nursing roles. Local policies were written in line with this and were updated every two years or if national guidance changed.

Five steps to safer surgery

- Use of the 'five steps to safer surgery' checklist was not fully embedded in surgical practice. We did not observe compliance with all procedures in the checklist, particularly 'sign out' and 'debriefing'.
- All surgical wards and clinics completed appropriate risk assessments for falls, pressure ulcers and malnutrition. Risk assessments we reviewed were comprehensively completed.

Are surgery services effective?

Good



Surgical services at this hospital used evidence-based care and treatment and had a clinical audit programme in place. There was evidence of multidisciplinary working. Effective pain relief and nutritional arrangements were in place.

Evidence-based care and treatment

- The trust's quality and audit department completed audits to assess compliance with policies and procedure.

Pain relief

- Patients were assessed pre-operatively for their preferred pain relief.

Nutrition and hydration

- Patients were able to access suitable nutrition and hydration including special diets
- Nutrition and hydration assessments were completed on all appropriate patients in the care records reviewed. These assessments were detailed and used the malnutrition universal screening tool. Care pathways for nutrition and hydration were in place and had been comprehensively completed. Dietitian advice and support were available if a patient was at risk of malnutrition.

Patient outcomes

- The directorate participated in all the national audits that it was eligible for and, overall, performance was satisfactory.
- Patient readmission rates were not currently collected by location but by division and therefore monitoring was in place.

Competent staff

- We were unable to locate centrally held medical and nursing staff appraisal records. Some nursing and support staff told us they had not received an appraisal within the last 12 months and none were planned.
- Revalidation processes for nursing and medical staff were in place and up to date

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Multidisciplinary working

- Physiotherapists and occupational therapists worked closely with the nursing teams on each ward and clinic where appropriate. Daily handovers were carried out with members of the multidisciplinary team.
- There was pharmacy input on each ward and clinic during weekdays.

Are surgery services caring?

Good



The surgical services provided at this hospital were caring.

All patients and relatives, the results of the NHS Family and Friends Test and patient surveys supported our observations that patients received care and treatment given by staff with dignity and respect.

Compassionate care

- Throughout our inspection at this hospital we observed patients being treated with compassion, dignity and respect. We saw that patients were spoken to and listened to promptly; patients told us staff had "... been very good, reassuring and answered questions well. There are no issues'. Staff were very attentive to the comfort needs of patients.
- All patients we spoke with commented positively on the dedication and professionalism of staff and the high quality of care and treatment received.
- We observed patients being kept informed throughout their time in the anaesthetic room and theatres.
- We saw that doctors introduced themselves appropriately and curtains were drawn to maintain patients' dignity.
- The trust's NHS Friends and Family Test rating was higher than the England average between November 2013 and February 2014. One surgical ward at this hospital scored less than the trust's average.

Patient understanding and involvement

- Patients and relatives said they felt involved in their care and they had been given the opportunity to speak with the consultant looking after them.
- We saw that ward and clinic managers were visible on the wards and clinics so that relatives and patients could speak with them.

- Ward information boards identified who was in charge of wards for any given shift and who to contact if there were any problems.

Emotional support

- Patients said that they felt able to talk to ward staff about any concerns they had, either about their care or in general. Patients did not raise any concerns during our inspection.
- There was information in the care plans to highlight whether people had emotional or mental health problems.
- Patients were able to access counselling services, psychologists and the mental health team.

Are surgery services responsive?

Good



Services were responsive. Access and flow arrangements were in place and the hospital was mostly meeting people's individual needs. Discharge procedures were clear and understood by staff.

Service planning and delivery to meet the needs of local people

- Support was available for patients with dementia and learning disabilities.
- Clinics and wards inspected had designated champions responsible for highlighting the needs of patients with dementia and learning disabilities.
- A translation service was in place and advertised throughout the hospital.
- Policies were in place to ensure that patients with different religious faiths were treated with respect to their beliefs.

Access and flow

- The target for referral-to-treatment times was under 18 weeks and was being met by the trust.
- The Department of Health monitored the proportion of cancelled elective operations. The trust scored similar to that expected on the number of patients not treated within 28 days of last-minute cancellation due to non-clinical reason.
- Every ward had identified staff to undertake discharge planning and this process started as soon as patients were admitted.

Surgery

- A discharge summary was sent to the patient's GP on discharge from the wards and clinics. This detailed the reason for admission and any investigation results and treatment undertaken.

Learning from complaints and concerns

- Complaints were handled in line with the trust's policy.
- Patients or relatives making an informal complaint were able to speak to individual members of staff, the ward or clinic manager.
- Staff were able to describe complaint escalation procedures, the role of the Patient Advice and Liaison Service and the mechanisms for making a formal complaint. We saw leaflets available throughout the hospital informing patients and relatives about this process.
- Themes from both formal and informal complaints were collected and discussed in staff meetings when appropriate, although some staff were unable to identify improvements made.

Are surgery services well-led?

Good



Staff reported good leadership at all levels in the directorate and improvements in staffing levels. Governance, risk and quality systems were in place. Quality of service and patient experience were seen as priorities. Staff we spoke with were aware of the trust's vision.

Vision and strategy for this service

- The trust's vision was visible throughout the hospital in wards, clinics and corridors.
- Staff in the surgical directorate were able to repeat the vision and discuss its meaning with us at focus groups and during individual conversations.

Governance, risk management and quality measurement

- Quarterly governance meetings were held in the directorate and all staff were encouraged to attend, including junior members of staff.
- Complaints, incidents, audits and quality improvement projects were discussed at regular staff meetings and we saw 'quality' boards displayed throughout the hospital.

- Managers could provide examples of where they had identified issues and had taken action to address these.
- Where wards were consistently falling below the expected levels of performance, action was taken to improve performance. We saw the Quality Improvement Bulletin (April 2014) which detailed actions identified through the quality dashboard (a performance reporting and tracking system) to reduce incidences of Clostridium difficile, MRSA, falls, pressure ulcers and to enhance the patient experience.
- A surgical risk register was in place. This had controls and assurances in place to mitigate risk and we saw that it was regularly reviewed. We saw minutes (March 2014) of governance meetings informing staff of risks on the register.

Leadership of service

- There was a divisional lead for surgery and each of the surgical specialities had a clinical lead.

Culture within the service

- Staff spoke positively about the service they provided for patients and emphasised that quality service and patient experience were priorities and everyone's responsibility.
- Staff worked well together and there was respect between the specialities and also across disciplines.
- Staff were engaged with the rest of the hospital.
- Nursing staff stated that they were well-supported by their managers, although we were told that one-to-one meetings and appraisals were irregular.
- Medical staff stated that they were supported by their consultants and confirmed they received feedback from governance and action planning meetings.
- We saw good team working on the wards and clinics between staff of different disciplines and grades.

Public and staff engagement

- The Meridian computerised patient tracker was widely used on wards to capture patient feedback. We saw 'You said, we did' noticeboards throughout the hospital, wards and clinics identifying issues raised by patients and the trust's response.
- There was information about the Patient Advice and Liaison Service throughout the hospital.







Innovation, improvement and sustainability

- Managers and staff told us that they were supported to try new ways of working to improve the effectiveness and efficiency of the wards and clinics.

Surgery

- A quality team noticeboard in each theatre displayed patient experience data, safety, staff welfare and theatre utilisation.
- The Surgical Division Newsletter (April 2014) explained the governance structure within the division and highlighted themes from incidents, complaints and plaudits.

Outpatients

Safe	Requires improvement	
Effective	Not sufficient evidence to rate	
Caring	Good	
Responsive	Requires improvement	
Well-led	Requires improvement	
Overall	Requires improvement	

Information about the service

Colchester Hospital University NHS Foundation Trust offers outpatient services at Essex County Hospital and Colchester General Hospital. There were 504,963 patients who had an outpatient appointment in the trust between April 2012 and March 2013; this was an increase of 25,000 on the previous year.

Essex County Hospital has a main outpatient department providing an outpatient service with a variety of specialties, including ophthalmology, oncology, dermatology and ear, nose and throat (ENT). Minor procedures are carried out in the ENT department. We visited the radiology department as part of this inspection.

We inspected the outpatient department at Essex County Hospital over two days. We talked with nine patients, one relative and 12 staff. We also reviewed the trust's outpatients performance data.

Summary of findings

Although the outpatient environment was clean, we found poorly stored waste bins and lack of clarity regarding clinical waste disposal. We also found disposable equipment, such as needles and swabs, which had passed their expiry date. Staff were noted to be busy. There were no vacancies in the service and agency staff were rarely used. Staff told us their mandatory training was up to date.

Outpatient services were caring and most patients spoke positively about the care and treatment they received and felt they were involved in their care plan. We witnessed staff being polite and welcoming.

Although the trust had a work stream to monitor outpatient efficiency and to improve do not attend (DNA) rates, we were concerned to find a large number of cancelled outpatient appointments. Up to 9% of these occurred within one week of the original appointment time.

We saw written information about the complaints procedure and the Patient Advice and Liaison Service, but none of the patients we asked had been given any information about complaints or knew how to make a complaint. We received consistently negative feedback from patients and staff about the patient transport service and patient parking.

We found senior staff each had visions for the service at local-level, yet there seemed to be a lack of combined objectives and strategy to achieve an improved service.

Outpatients

Issues had been identified within the service, but there were delays in resolving these. We were provided with minutes from divisional governance meetings which appeared to demonstrate that outpatient services were discussed in relevant speciality meetings rather than as a separate service and within these outpatients was discussed at any length. There was no discussions minuted relating to delays in appointments or cancellations. Staff we spoke with were not aware of key performance indicator targets or results for the service and therefore were not proactively managing the situation at clinic-level.

Are outpatients services safe?

Requires improvement



Although the outpatient environment was clean, we found poorly stored waste bins and lack of clarity regarding clinical waste disposal. We also found disposable equipment, such as needles and swabs, which had passed their expiry date. Staff were noted to be busy. There were no vacancies in the service and agency staff were rarely used. Staff told us their mandatory training was up to date.

Incidents

- We spoke to two senior nurses in outpatients who told us that incident reports used to be completed for clinics that were delayed, overbooked or cancelled at the last minute. However, due to the high number of incidents, the staff no longer completed reports.
- We spoke with a nurse who felt that completing incident reports did help but staff did not get feedback from these, and so were not encouraged to complete these reports.

Cleanliness, infection control and hygiene

- On entering the main outpatient foyer, we found rubbish in black bags and broken-down cardboard that had been left on the floor.
- There were hand-washing facilities in all the clinic treatment and consultation rooms we inspected, along with liquid soap, paper towels and alcohol gel dispensers. We saw documentation to support daily clinic room checks, where staff ensured clinic rooms were clean and had the required cleaning facilities, such as alcohol gel.
- All staff we saw adhered to the 'bare below the elbows' policy for hygiene.
- We saw a variety of different coloured bins. It was not clear what they were used for as they were not labelled. This meant that there was a risk of clinical waste being disposed of in general wastage.
- We found cleaning products not stored securely. We observed that one storeroom for cleaning equipment, which contained cleaning products, was left open and accessible to patients.

Outpatients

Environment and equipment

- Senior outpatient staff told us that there were monthly environmental audits to ensure the environment was safe.
- In the main reception area, there were a variety of coloured lines on the floor that corresponded to the different outpatient clinics. We saw patients being advised by the receptionists to follow the relevant coloured line to get to their desired clinic. This system helped patients to get to their destination effectively.
- We saw equipment that had been cleaned had a green label; this system made it clear for users to see the date equipment had been cleaned.
- Resuscitation trolleys in outpatients were centrally located. We inspected two trolleys. We saw that they were clean, the defibrillators had been serviced and that staff documented equipment testing on days clinics took place to ensure equipment was fit for purpose. On both of the trolleys the packaging had been opened on non-rebreathable masks, this meant that the masks were not appropriately sealed but remained on the trolley, despite checks.
- We looked in four clinic rooms across ENT and ultrasound; three rooms were unlocked when they were not in use. We found equipment, including needles, surgical packs and swabs, had expired and two pieces of endoscopic apparatus expired in September 2011. We reported this to a nurse and the sister in charge. They told us that staff checked equipment in clinic rooms weekly but that there were no recorded audits to ensure that all equipment was within its expiry date. This meant that patients were at risk of being treated with out-of-date equipment and that equipment was not stored safely and securely to prevent theft, damage or misuse. This needed to be addressed.

Records

- Staff told us that they usually had a full set of patients' paper records in the clinic.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff reported that there was an e-learning module they could complete to learn about mental capacity.

Mandatory training

- Staff told us that their mandatory training was up to date. We were unable to identify training data to show staff compliance within outpatients, as this was included in the clinical specialities information as a whole.

Nursing staffing

- We saw that staff were busy. Two of the patients made comments about staffing levels; one person said, "They need more staff", and the other, "They need more funding as staff are very busy."
- An outpatient sister told us that there were currently no vacancies and the department used no agency staff in the service. If staffing was low, they used bank (overtime) staff who already knew the service.
- However, a nurse concerned about staffing told us that "a skill mix [assessment] has taken place and now I'm the only qualified nurse in the area".

Are outpatients services effective?

Not sufficient evidence to rate



Are outpatients services caring?

Good



Outpatient services were caring. Most patients spoke positively about the care and treatment they received and felt that they were involved in their care plan. We witnessed staff being polite and welcoming.

Compassionate care

- During our inspection we saw that staff were polite and welcoming to patients and visitors. We saw receptionists greeting patients and asking if they could help. We saw nurses greet patients with, "Hello I'm X and I'll be looking after you this afternoon".
- We spoke with one patient after their oncology appointment who told us that their care and treatment had been very good; they felt the appointment had been helpful to discuss all treatment options and they understood what was going to happen.
- Another patient in the oncology clinic commented, "I've had help and attention from everybody", "... the breast care nurse can't be praised enough", and, "You get real

Outpatients

care, not just feeling like a number". They told us that they found the consultant easy to talk to and had explained everything well. Although the clinic ran late, the consultants still gave them enough time and they didn't feel rushed.

- We spoke with one patient in the ophthalmology clinic who told us that their care and treatment had been good.

Patient understanding and involvement

- Four patients in the oncology clinic told us that they felt involved in all the decisions about care so far. One patient in the dermatology clinic commented that they felt involved in their care and listened to by staff.

Are outpatients services responsive?

Requires improvement



There were a significant number of outpatient clinics that were cancelled, some at very late notice (within a week of the appointment). In addition, patients regularly were kept waiting once they arrived at the department, and not all patients were kept informed of the potential delays.

There was an active Macmillan volunteer service for patients with cancer. A good range of patient information leaflets were available.

Service planning and delivery to meet the needs of local people

- The service manager told us that the booking of outpatient appointments was currently semi-centralised and that the trust was investigating if further centralisation would improve the patient experience.
- The booking centre was open Monday to Saturday, 8am to 8pm. During the appointment booking calls, patients had the opportunity to receive a confirmation text message with their appointment details. Patients could choose to have the text message sent to the mobile number held by the trust on the patient administration system or patients could provide a new mobile number. New mobile numbers were sent back to the trust to update the patient records and improve data quality. In February 2014, around 24% of patients chose to receive a confirmation text message with their appointment details.

- All patients we spoke with in outpatients told us that the reception check in procedure was quick and easy and that follow-up appointments were made in a timely fashion.
- A nurse working in ophthalmology told us that the service provided emergency appointments for patients who urgently needed assistance and that there was always a consultant on call. They told us that the service had extended working hours until 8pm on weekdays and 11am to 5pm at weekends and bank holidays to meet patients' needs.

Access and flow

- We were concerned about the number of outpatient appointments cancelled by the hospital. Data showed that the overall trust rates were 14.17%, 14.66% and 15.29% for February, March and April 2014 respectively. A total of 77,670 appointments were cancelled between April 2013 and March 2014.
- Reasons for hospital cancellations showed that 19.4% were due to rescheduled clinics, 12.1% were booking errors and 6% were when patients were offered an earlier appointment. We were concerned to see that 42.8% of hospital cancellations were due to consultant requests; the data showed that this was due to unknown reasons, study leave, illness, and the consultant being on call.
- Patient cancellation rates were also high, 14.63%, 14.73% and 15.53% for February, March and April 2014 respectively. However, there was no data to explain this.
- The trust had a work stream to look at outpatient efficiency. Data on the number of patients who did not attend their booked appointment showed that the overall trust rate was 7.5% for 2012/13, which was the average for the east of England. A target was set to deliver a reduction to 6.5% by the end of 2013/14 and further reduction to 5.5% by the end of 2014/15. We saw evidence that presented the patient non-attendance rates for February, March and April 2014 as 6.22%, 6.4% and 7.02% respectively.
- Senior staff told us that the trust operated a 'one strike policy' – that is, if a patient did not attend, they would be discharged from the service unless they were categorised as vulnerable, had cancer or were a paediatric patient.
- The trust had managed to reduce non-attendance rates for first appointments by contacting patients to agree the first appointment date and a call reminder service,

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which also gave patients the opportunity to rearrange or cancel appointments. These appointments could then be reallocated to another patient quickly to reduce waiting times. The forward plan was to contact follow-up patients to deliver the further reduction in patient non-attendance to meet the 5.5 % target.

- We identified pockets of excellent practice where some clinics had managed to get their rates down from 20% to 0%, such as interventional radiology, and clinics that were consistently below the target rates such as clinical oncology and dermatology.
- One patient in the oncology clinic told us that their previous appointment had been cancelled at the last minute because all the information had not been gathered for the appointment and that this had caused some anxiety for them. Another patient told us that three of their appointments had been cancelled and that, if this happened again, they would complain, although they did not know how to do this.

Meeting people's individual needs

- In the main reception, there was a dedicated area for Macmillan cancer support that displayed a vast range of information about their service and the support available for patients and relatives.
- We spoke with volunteers working for the service who told us that the service had assisted 5,000 people in the past year, providing support to patients and their friends and relatives. We saw a poster encouraging patients with cancer to join the user group to develop and improve patient services. The service relied on volunteers and ran Monday to Friday, 9am to 5pm.
- There were leaflets and posters throughout outpatient services that provided information about diagnoses, treatments and the support available for patients and relatives.
- We were told that there was no outpatient policy to highlight and protect the needs of vulnerable patients.
- There was one wheelchair and one Zimmer frame in the reception area for patients to use.
- We inspected two toilets marked for people with physical disabilities to use. Both had foot pedal waste bins inappropriate for people unable to use their feet.
- Nursing staff told us that a translator telephone service was available during clinics. They commented that patients who required sign language interpreters were often not identified prior to clinic and patients would attend only to have their appointment rearranged once this had been recognised.
- The matron for outpatients told us that there was a specialist nurse for learning disabilities who informed outpatient staff if a patient with learning disabilities had an appointment so that appropriate arrangements could be implemented. They commented that this system worked well. Yet a similar system was not in place for patients with dementia. The matron told us that staff often were unaware a patient had dementia until they arrived at clinic, and, sometimes this caused patients to become anxious. The matron said that staff could be better prepared if they had this information. A new electronic patient system was planned that was hoped would establish alerts for patients who needed additional support.
- The matron commented that there had been a recent complaint regarding access for patients on stretchers in ophthalmology. We saw that the doors were narrow and that it would be difficult to navigate a patient on a stretcher into a clinic room.
- Patient transport services were available for eligible patients travelling to and from hospital appointments from 9am to 5pm. Nursing staff told us that this meant that patients could only receive hospital appointments between 10am and 2.30pm to ensure that they arrived on time and were taken home before 5pm. This meant that patients requiring hospital transport only had access to restricted appointment slots. We were also informed that two vulnerable patients had been waiting in outpatients for seven hours to be collected by transport services after their appointments.
- We noticed that there was limited parking for patients at the hospital. One patient in the oncology clinic told us, "Parking has been difficult". They told us that their ticket was about to expire because their appointment was 40 minutes late and this made them feel "agitated". Another patient told us, "Parking is a major problem and headache".
- There was a volunteer-run coffee shop in the main reception area with a range of snacks and drinks. There were also refreshments available from vending machines for patients and visitors to use. There were magazines, children's toys and a large-screen television available for patients while they waited. There were comfortable seats for patients to sit on.

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Learning from complaints and concerns

- During our inspection we saw no evidence or literature on display about the complaints procedure or the Patient Advice and Liaison Service. A receptionist told us that, if patients asked, they would be given two leaflets providing information about how to raise a complaint and provide feedback. The receptionist gave us copies of these leaflets that were stored beneath the reception desk; both had expired their review dates.
- None of the nine patients we asked had been given any information about complaints or knew how to make a complaint.

Clinic waiting times

- We spoke with nine patients in various waiting areas about their clinic appointments. All of their appointments were delayed and they reported that this was normal.
- We spoke with two patients waiting for the ENT clinic, one patient told us, “Clinics are always late”, and, “They need more staff or to book in less patients”. Another patient commented, “Sometimes you wait a long time and other times it’s quicker”, and “You always get told if it’s late or it’s on the board”. No other staff or noticeboards informed patients that clinics were delayed.
- Five patients in the oncology clinic had not been told how long the waiting time was. One patient commented, “They are always running late”, and another, “Sometimes they let you know how long the wait is, but it depends who’s on”. One patient was seen 40 minutes late and another 55 minutes late.
- We spoke with a patient in the dermatology clinic who had three monthly appointments. They told us, “I don’t normally have to wait more than 10 to 15 minutes”, and that there were no delays in making appointments.
- We spoke with a patient and a relative in the ophthalmology clinic. The patient told us that, at their first appointment, they were in outpatient services from 3.30pm to 7.30pm. The relative commented that, “Appointments often get cancelled”, and, “Always delays in waiting time”.
- We found the ophthalmology department waiting room was overcrowded with patients waiting for glaucoma and macular degenerative clinic appointments.

- We spoke to an outpatient sister who told us that one of the main challenges in the service was regular delays for patients and the overbooking of clinics, as patients were allocated five-minute appointment slots.

Are outpatients services well-led?

Requires improvement



We found senior staff each had visions for the service at local-level, yet there seemed to be a lack of combined objectives and strategy to achieve an improved service. Issues had been identified within the service, but there were delays in resolving these. We were provided with minutes from divisional governance meetings which appeared to demonstrate that outpatient services were discussed in relevant speciality meetings rather than as a separate service and within these outpatients was discussed at any length. There were no discussions minuted relating to delays in appointments or cancellations. Staff we spoke with were not aware of key performance indicator targets or results for the service and therefore were not proactively managing the situation at clinic-level.

Vision and strategy for this service

- Senior staff told us what each of their visions for the service at local level were, yet there was a lack of shared objectives and strategy to achieve an improved service.
- None of the staff we spoke with acknowledged the trust’s vision or objectives.

Governance, risk management and quality measurement

- We were told by senior radiologists that there was a range of quality assurance and governance meetings within the trust to discuss issues at ground and board level, including a divisional board and governance meeting and an Ionising Radiation Medical Exposure Regulation (IRMER) committee meeting. We saw evidence of clinical audits, incidents, complaints and the risk register being discussed at monthly radiology governance meetings attended by senior staff.
- The trust had a referral-to-treatment work stream and a related plan to monitor the efficiency of outpatient booking. We saw evidence of a draft patient access policy to define the management of the 18-week referral-to-treatment and cancer waiting times, to

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achieve national objectives in reducing waiting times and improving patient care. This policy identified that patient waiting time for treatment was a significant quality and clinical governance issue and everyone had a responsibility, including the patient, to aim to achieve these targets.

- We were concerned that staff we spoke with – including a consultant, nursing staff and administrative staff working within outpatient services – were not aware of key performance indicator targets or results for the service and therefore were unable to proactively manage the situation at clinic level.

Leadership of service

- We spoke with three senior managers in outpatients; none of them reported having recent management or leadership training. One told us that they had no NHS management training.

Culture within the service

- We spoke with three senior outpatient managers who told us that they were proud of the staff working in outpatients and their commitment to the service.
- We spoke with three nursing staff who told us that local management was good, there was a team approach and they felt supported, but not above local level. One commented about trust executives, saying that, “We don’t see them, don’t even know what they look like.” All three staff had concerns about moving the service to Colchester General Hospital; one nurse commented, “We are anxious about the move, we’re not told much about it”; and another said, “We found out about Essex County closure on the news. Management had not told us”.
- One nurse told us that there was negativity from established clinicians and this lowered the morale within the nursing teams. This reflected the findings of the 2013 NHS Staff Survey that found poor motivation and job satisfaction among staff.
- We spoke with the newly appointed deputy service manager for outpatients who told us that one of the challenges was to change culture within the service and embed consistent processes.
- We spoke with staff working in radiology who told us that, “We have little contact with our manager”, “We are not supported by management”, and “We are not told much about the move”. They told us that they did have team meetings but these were in their unpaid lunch break and prevented them from having a clear break.

Public and staff engagement

- We were concerned that the matron for outpatients told us that there had been no outpatient survey or patient questionnaire since 2011. The service had trialled a Meridian computerised patient tracker service to gain patient feedback, but this had been unsuccessful. The matron reported that the plan was to target two clinics per week to complete the NHS Friends and Family Test, and to investigate a text message feedback survey. This meant that the service did not consider the views of patients, restricting learning and improvement.

Innovation, improvement and sustainability

- The matron for outpatients told us that the service had introduced associate practitioner posts and that there were competencies for staff to work towards. We spoke with a healthcare assistant who showed us evidence that they had study time included in their shift pattern. They told us that they felt supported by the sister.
- There was an overall lack of continual professional development reported among the qualified staff. Nursing staff reported that the practice development team focused on training for inpatient staff and that outpatient development was limited. They commented that outpatient nursing staff had little study leave as it was, “difficult to release staff,” and that there was, “no clear career progression.”
- Senior outpatient nursing staff could identify recent issues among staffing within the service, such as punctuality of staff, housekeeping, and the use of mobile phones. They reported no equipment issues or the storing of patient records prior to what we found. There was an overall lack of recognition of some issues and neglect to solve local-level issues that had been identified.
- We were concerned throughout outpatients about the delays in waiting times. A sister told us that one of the main challenges in the service was regular delays for patients and the overbooking of clinics, as patients were allocated five-minute appointment slots. They reported that they had no control over this. We spoke to three senior staff in outpatients who had all recognised the issue. One had recently found that around 900 different staff could make changes to appointment templates and, therefore, clinics were easily overbooked. This had been a hidden problem and was now being

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investigated. They reported that service managers were not aware of and not managing the problem. This indicated poor management of bookings across the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital **MUST** take to improve

- Review the decontamination procedures within the orthodontic clinic to ensure that these comply with the required national standards.
- Ensure that the use of the World Health Organisation (WHO) checklist is fully embedded in surgical practice, including the 'sign out' and debrief.
- Ensure that all staff have appropriate supervision and appraisal.
- Ensure that staff have access to training and development opportunities to ensure that they maintain the necessary skill for their role, this is to include management, leadership and professional development training.
- Ensure that there is a robust incident and accident reporting system in place and that lessons learnt from investigations of reports are shared with staff to improve patient safety and experience.
- Ensure that there are appropriate waste disposal procedures in place and these are implemented, particularly in the outpatients department.
- Ensure that all cleaning products are stored in accordance with manufacturing guidance and complies with legislative requirements.
- Ensure that all sterile equipment and products are appropriately stored to ensure that their sterility is maintained, including an adherence to expiry dates.

- Review the numbers and skill mix in the outpatients department to ensure that there are sufficient qualified and skilled staff to meet patient needs.
- Review the cancellation of outpatient appointments and take the necessary steps to ensure that issues identified are addressed and cancellations are kept to a minimum.
- Review waiting times in outpatients' clinics and take the necessary steps to ensure that issues identified are addressed.
- Review access into clinics to ensure that they are suitable for people with mobility problems.
- Ensure that information on how to complain is accessible to patients in all patient areas within the hospital.
- Review the involvement of staff in trust-wide issues to ensure that staff are fully conversant with the trust vision, strategies and objectives and can contribute to the development of services.
- Review the information provided to staff regarding future development of services and how staff can be involved and engaged in this process.

Action the hospital **SHOULD** take to improve

- Review the waste disposal bins in toilets designated for people with disabilities.
- Review issues identified and associated with transport problems when accessing outpatient appointments.