Care Quality Commission

Colchester Hospital University NHS Foundation Trust

Colchester General Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement 🟠
Urgent and emergency services	**Requires improvement** 🟠
Medical care (including older people's care)	**Good** 🟢
Surgery	**Good** 🟢
Critical care	**Good** 🟢
Maternity and gynaecology	**Good** 🟢
Services for children and young people	**Good** 🟢
End of life care	**Good** 🟢
Outpatients and diagnostic imaging	**Requires improvement** 🟠

Summary of findings

Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) carried out an announced comprehensive inspection of Colchester General Hospital on the 25 to 27 July 2017. This was to review care provided at the trust since the new senior management team had come into post in May 2016.

The inspection team also undertook a further announced inspection on 2 August 2017 at the outpatients department at Essex County Hospital. At the time of inspection Essex County Hospital was in the process of deregistering.

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 2018 and the only services currently provided on site are outpatient services and ophthalmic eye surgery under local anaesthesia. Colchester General hospital has 763 beds, spread across various core services, and provides district general hospital care to 370,000 in Colchester and the surrounding area of North East Essex and South Suffolk.

Colchester Hospital University NHS Foundation Trust was placed into special measures in November 2013 following an inspection into cancer waiting times. At the May 2014 inspection the trust well led aspect was rated as inadequate. The trust as a whole was rated inadequate following a comprehensive inspection in September 2015. The CQC undertook a further focussed unannounced inspection of Colchester General Hospital on 4 and 5 April 2016 looking specifically at the safety and caring elements of surgery, medicine and end of life care. The trust was not rated following this inspection. Overall findings were that significant improvements had not been made.

The CQC undertook regulatory action and imposed conditions under section 31 (1) (2) (a) of the Health and Social Care Act 2008 in December 2014, in respect of the emergency department, emergency assessment unit (EAU) and the operating theatres and the following regulated activities:

• Surgical Procedures

• Diagnostic and Screening

• Treatment of disease, disorder or injury

The trust reported regularly to the CQC to provide information and assurance that these conditions were adhered to, including exception reporting and risk assessments should the conditions be breached. We reviewed all aspects of the conditions during the inspection in July 2017 and the trust was compliant with imposed requirements following our previous inspection. The trust applied to have these conditions removed following this inspection.

A long-term partnership between Colchester General Hospital and Ipswich Hospital NHS Trust was recommended jointly by the CQC Chief Inspector of Hospitals, Professor Sir Mike Richards, and the Chief Executive of NHS Improvement as the only way of securing services for patients long into the future. Mr Nick Hulme was appointed as Chief Executive and Mr David White as Chair of the trust board on 17th May 2016. A managing Director was put in place to manage the trust on a day to day basis in June 2017. The respective boards are considering a Partnership between the two trusts The recommendation from the outline business case, 17 August 2017, was to form a single combined organisation with fully integrated clinical services.

We have been advised that subject to the boards approving the case, the Trusts will go on to develop detailed plans for the combined organisation. A final decision to form a single organisation will then be taken by both Trust boards around June 2018. This decision will also require approval from regulators NHS Improvement and the Competition and Markets Authority (CMA).

Summary of findings

During this inspection we found that significant improvement had been made across all services at the Trust. The chief executive and managing director had created stability in the senior executive team that had not been previously in place. The executive team understood the challenges to good quality care and the wider challenges faced by the NHS, and could see the importance of exploring solutions such as the long-term partnership with Ipswich Hospital.

The team in place now worked together with more structured disciplines being embedded around executive and performance behaviours and responsibilities. Within the every patient, every day programme (EPED), the responsibility, accountability and ownership of service improvement had been given back to the local leaders. We saw many examples of local leaders and senior staff being highly motivated, engaged in seeking solutions to drive improvements locally.

We have rated Colchester Hospital University NHS Foundation Trust as requires improvement overall despite significant improvement being seen at the trust. The trust recognises that it is on a journey to Good and senior and local leaders are aware of where actions are still required to improve services.

Our key findings were as follows:

We saw several areas of outstanding practice including:

- The service's dedicated childrens transition team was the only one in the region and other trusts sought advice from them. The transition team worked with other teams to meet the more complex individual needs of patients at the age of transitioning to other services. For example, they ran a joint clinic with the epilepsy specialist nurse three to four times a year.
- The neonatal unit (NNU) was piloting a 'discharge passport' to empower parent involvement in ensuring a timely discharge for babies.

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

Importantly, the trust must:

- The trust must ensure that nursing and medical staff complete all safeguarding and mandatory training including basic life support.
- The trust must ensure that all equipment is maintained and fit for purpose.
- The trust must ensure that initial assessments within the emergency department are undertaken and documented to maintain an accurate clinical record based on clinical judgement, and that initial assessments in the emergency department are documented.
- The trust must ensure access to a designated mental health assessment room.
- The trust must take action to ensure that patients are clinically risk assessed as safe to wait for out patient appointments.
- The trust must ensure that medical records contain completed risk assessments relevant to patient care.
- Ensure that patient's records are appropriately stored in accordance with legislation at all times
- The trust must ensure that staff administering contrast for diagnostic imaging investigations use a patient group direction or have it prescribed.
- Ensure that do not attempt cardiopulmonary resuscitation (DNACPR) decisions are undertaken in accordance with national guidance and best practice.
- The trust must ensure that the design and layout of the paediatric emergency department enables effective oversight of paediatric waiting areas to ensure patient safety.
- The trust must ensure that there is an effective governance and risk management framework in place to identify and assess all risks relevant to the emergency department.
- The trust must ensure that patient's dignity is protected in changing cubicles in In Beta X-ray.
- The Trust must ensure that the doors for Beta X-ray are fully fitted and a risk assessment is in place to ensure patients are not a risk of unnecessary exposure of ionising radiation.

Summary of findings

- The trust must ensure there is an effective process in place for timely review of policies and procedures and that these comply with national guidance and best practice.

Action the hospital SHOULD take to improve

- The trust should improve its overall performance in the management of referral to treatment times.
- The trust should ensure that clinics are not cancelled without exploring every option in order to contribute to reduced waiting times.
- The trust should ensure the clinics start on time.
- The trust should ensure that all staff are aware of translation services for non-English speakers.
- The trust should ensure that clinical audit is undertaken and where data is not submitted, that it is followed up.
- The trust should ensure that all staff have received an appraisal and frequent supervision.
- The trust should review admission times and fasting periods for patients awaiting surgery to meet the nutritional and hydration needs of the patient.
- The trust should ensure managers and senior staff have the relevant level of skill and experience to perform their roles.
- The trust should ensure that staffing levels reflect the needs of patients at all times.
- The trust should ensure that it reviews its existing staff practice in relation to MCA and DoLS specifically in relation to the cohorting of patients in supervised bays.
- The trust should ensure that domestic staff follow infection control procedures, wear correct uniform, identification and personal protective equipment at all times.
- The trust should improve its overall performance in the management of patient falls.
- Continue to work to improve delayed discharges and discharges that occur between the hours of 10pm and 7am.
- Continue to work to improve attendance and documentation of meeting minutes at mortality and morbidity meetings.
- To ensure that patients diaries are being completed in line with guidance, and that these diaries are used throughout the patient journey.
- To improve the recording of actions following governance meetings and ensure that these are followed up and that evidence of learning or changes in practice are recorded.
- Ensure there are appropriate formal systems to share actions and learning from incidents consistently among all staff in the service.
- Update the policy for safeguarding children in line with best practice and national guidance, for example to ensure all child protection cases are overseen by a paediatrician.

On the basis of this inspection, I have recommended that the trust be removed from the special measures process.

Professor Edward Baker

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?

Urgent and emergency services

Requires improvement 🟠

Why have we given this rating?

We rated this service as requires improvement overall because:

- We found out of date equipment and medicines in clinical areas, leading to concerns that the checking processes in place were not robust.
- The department lacked a dedicated mental health assessment room and medical records lacked a formal mental health risk assessment.
- There was no named safeguarding lead for the department and staff had not reached the Trust's safeguarding training target for safeguarding children and adults.
- Medical and nursing staffing levels were below establishment figures.
- Paediatric medical records did not always contain a documented pain score.

- The emergency department was not meeting the standard for the national four hour target, which states 95% of patients should be treated, discharged or admitted within four hours of arrival.
- The time patients spent in the emergency department was consistently higher that the England average from March 2016 to February 2017.

- Senior staff felt unsupported; there was a lack of support for senior emergency departmental staff from the executive team.
- Not all risks were identified on the emergency department's risk register.
- Divisional governance meetings and senior staff meetings appeared to lack a standard agenda.

However:

- Staff knew what constituted an incident and how to report and escalate incidents using the electronic system in place.
- Controlled drugs were stored securely and had been regularly checked.

Summary of findings

- Regular clinical assessment took place for patients waiting on ambulance trolleys to ensure that clinical deterioration was identified in a timely manner.

- The median time from arrival in the department to initial assessment was better than the England average for 11 months from March 2016 and February 2017.
- NHS Friends and family test results for people recommending the emergency department were better than England average.
- We observed staff caring for patients in a kind and compassionate manner.
- Staff took steps to ensure that the dignity and privacy of patients was respected.
- Staff had access to a range of specialist nurses and teams to tailor care to a patients specific needs.
- Medical records contained 'alerts' to indicate if a patient had additional needs meaning staff could address individual needs.
- Processes were in place to assess the demand on the department, with clear escalation processes to maintain patient flow.
- We saw that complaint information was shared with staff to enable learning from complaints.
- Local management in the emergency department were supportive and encouraging with staff.
- The emergency department used quality scorecards to monitor performance.
- There was a clear vision in place which staff were aware of.
- Staff reported a good culture within the department; in particular, they told us that senior nurses within the department were always approachable and supportive.

- The emergency department had implemented a public volunteer programme to provide support to patients and relatives within the department.

Summary of findings

Medical care (including older people's care)

Good ●

We rated this service as good because:

- Staff knew how to report incidents and deal with complaints.
- There were clear procedures for managing and referring safeguarding concerns in relation to children and adults who may be at risk of abuse. Staff we spoke with knew how to make a referral and who to refer their concerns to within the trust.
- We reviewed 36 patient records and found all risk assessments were completed, national early warning scores (NEWS) and risk assessments clearly documented.
- Staff adhered to the trust hand hygiene and 'bare below the elbow' policy, and wore personal protective equipment such as gloves and aprons during care.
- Staff used national early warning scores (NEWS) on the medical wards to monitor and identify any deteriorating patients. All records we reviewed showed that staff routinely completed NEWS and alerted senior staff to any patient that may be deteriorating.
- The trust had dedicated care pathways for both dementia and Parkinson's disease.
- The trust takes part in the quarterly Sentinel Stroke National Audit programme (SSNA). On a scale of A-E, where A is best, the trust achieved grade A in the latest audit, December 2016 to March 2017.
- The trust results in the 2015 Heart Failure Audit were better than the England and Wales average for all four of the standards relating to in-hospital care.
- The proportion of non-ST- elevation infarction (nSTEMI) patients referred for, or that had, angiography at the trust was 95.3%, which was better than the England average of 79%.
- Ward teams had access to a range of allied health professionals and team members described good collaborative working practices between the teams. There was a joined-up and thorough approach to assessing the range of patients' needs and a consistent approach to ensuring assessments were regularly reviewed and up to date.

Summary of findings

- The Friends and Family Test (FFT) response rate for medicine at the trust was 49%, which was better than the England average of 25% between March 2016 and February 2017.
- During our inspection we spoke with 12 patients and 14 relatives, all, with the exception of one family were consistently positive about their experience of care and support at the hospital.
- Staff respected and recognised patients' individual needs and choices at all times. Staff utilised care plans and person centred planning to respect patient decisions and promote choices in order to provide holistic care.
- Patients on the stroke unit had access to psychological support, and could be sign posted to specialist counselling services where appropriate.
- The trust had significantly invested in the recruitment of discharge co-coordinators who worked across the wards to promote the safe and timely discharge of patients.
- Between February 2016 and January 2017, the average length of stay for medical elective patients at the trust was 3.6 days, which is lower than England average of 4.2 days.
- The following specialties were better than the England average for admitted Referral to Treatment Times (RTT) (percentage within 18 weeks), geriatric medicine, neurology, and rheumatology.
- Local leaders, for example ward sisters and matrons were highly respected by staff we spoke with and staff felt respected and engaged with the services.
- The trust had action plans in place to address performance issues, for example in relation to the National Diabetes Inpatient Audit (NaDIA).
- All nursing staff we spoke with knew what the localised risks were and the risks on the medicine risk register.
- We found a strong culture of multidisciplinary staff working on the wards we visited
- Staff said that the senior leadership team held open forums, and that often the Chief Executive Officer would go onto the ward areas, sometimes as early as 6am to see the patients and staff.

Summary of findings

However:

- Data supplied by the trust from April 2017 showed the majority of wards within the medicine division were below the trusts identified staffing requirements. This issue was on the trusts corporate risk register and potentially impacting on patient care, for example the number of patient falls, and medication omissions.

- Data supplied by the trust showed a high level of patient falls on medicine wards between January 2017 and June 2017. Although staff had begun to cohort patients, the impact of this practice was still under review and patient falls were still occurring in some areas of the service in July 2017.

- Between January and June 2017, there had been 84 occasions where staff omitted patient medication on Peldon ward, this improved following a change of ward management and focused improvement plan.

- There were low rates of training compliance for medical and dental staff in respect of mandatory safeguarding courses with Safeguarding looked after children compliance the lowest at 48%.

- We found instances where staff did not follow the trust policy on Mental Capacity Act (MCA) or Deprivation of Liberty Safeguard (DoLS). We highlighted this to the staff and action was taken immediately.

- The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 65.7%, which did not meet the audit minimum standard of 90%.

- The trust was not JAG (Joint Advisory Group on Gastrointestinal Endoscopy) accredited at the time of our inspection.

- Trust figures provided prior to inspection showed an increase from the previous year in the number of patients having two or more ward moves, particularly in patients with two moves, which increased from 14% to 20%.

Summary of findings

- We reviewed clinical governance meeting notes from 2 March 2017 and noted the previous meeting was in November 2016, some three months previous. We noted that governance was key issue on the corporate risk register.
- The following specialties were above the England average for admitted RTT (percentage within 18 weeks), geriatric medicine, neurology, and rheumatology. Some staff we spoke with felt there was unnecessary pressure placed on them to take and discharge patients from the wards and that at times this was uncomfortable for them to manage.
- The majority of staff we spoke with on the wards were unaware of any local vision or strategy held by the trust in relation to the medical division. However, all staff said that they aimed to put the patients first.

Surgery Good ●

We rated surgical services as good overall because:

- We reviewed 31 patient records and found all risk assessments were completed, national early warning scores (NEWS) and risk assessments clearly documented.
- Staff adhered to the trust hand hygiene and 'bare below the elbow' policy, and wore personal protective equipment such as gloves and aprons during care.
- We found a strong culture of multidisciplinary staff working on the wards we visited.
- Between January 2016 and December 2016, patients at the trust had a lower than expected risk of readmission for elective admissions.
- During our inspection, we spoke with 22 patients and three relatives. Feedback was consistently positive about their experience of care and support at the hospital.
- Between March 2016 and February 2017, the Friends and Family Test (FFT) response rate for surgery at the trust was 40%, which was better than the England average of 29% during the same period.
- There were two dementia care nurse specialists (DCNS) within the trust. The DCNS are notified of every patient over 75 admitted as an emergency

Summary of findings

via the dementia assessment tool (DAT). All suitable patients are assessed as per FAIR (Find, Assess and Investigate, Refer) utilising the DAT tool for dementia and delirium.

- There was evidence of learning from complaints across the service.
- Between February 2016 and January 2017 the average length of stay for surgical patients, both elective and non-elective admissions, was lower (better) than the England average.
- Staff were aware of the new vision for the trust of, "Delivering great healthcare to every patient, every day". This was evident through the renaming of medical outliers to guests and the increased accountability for these patients.
- There was a clear governance structure in place for the service.
- There was an open culture of sharing and learning around complaints and incidents.
- Staff felt supported and valued by their colleagues.

However:

- Medical staff compliance with mandatory training was variable. Patient manual handling was the lowest performing subject area at 59%, with only 58 of 99 required staff members attending the training.
- Nursing staff compliance with safeguarding children update Level 3 was 58%
- Data supplied by the trust from April 2017 showed the majority of wards within the surgical division were below the required establishment figures. This issue was on the divisional risk register.
- The trust's referral to treatment time (RTT) data, between April 2016 and March 2017, for admitted pathways for surgical services had been consistently worse than the England average, and had remained relatively stable at around 60% over the 12 month period.
- Cancelled operations, not treated within 28 days, was higher than the England average at 12 %.
- Theatre utilisation had not shown any significant improvement in the 12 month period between April 2016 and April 2017, with the percentage of

used sessions, late starts, early finishes and cancellations remaining relatively static and all below trust target. This issue was on the divisional risk register.

- Only 76% of surgery staff had received an appraisal in the year April 2016 to April 2017.
- The average theatre utilisation rate at Colchester General Hospital in April 2017 was 78%. This issue was on the divisional risk register.
- Staff at a local level were uncertain as to the surgical strategy.
- Staff felt morale was improving, but nursing staff felt that the number of vacancies and subsequent pressure was still affecting staff morale.

Critical care

Good ●

We rated this service as Good because:

- There was a good culture of incident reporting and learning from incidents. Duty of candour was understood and discharged appropriately by staff, and we observed this directly during our inspection.

- There had been a significant improvement in the servicing and cleanliness of equipment since the last inspection. We found all equipment to be visibly clean and in date with electrical safety checking.
- Infection prevention and control practices were good as were compliance rates for internal audits.
- The critical care outreach team, provided outreach services into wards, proactively identifying patients who would benefit from closer monitoring, as well as monitoring patients discharged from the unit back into the wards.
- Nursing and medical staffing levels were in line with national guidance recommendations.
- Treatment and care was provided in line with best practice and recognised national guidelines.
- There were numerous examples of good team work across medical, nursing and allied health professionals. Staff worked collaboratively to provide the highest possible care for patients.

Summary of findings

- Feedback from patients and relatives during our inspection was overall very positive.
- The unit was very responsive to complaints and we saw evidence of where learning from complaints had occurred, as well as bespoke reflective learning and development for individual staff.
- There was a positive culture within the unit, and staff praised the leadership team for being supportive and approachable.

However:

- Whilst governance processes were in place, actions plans and some meeting minutes lacked detail. Governance recording processes and quality measures were yet to be embedded.
- Whilst the service had worked to improve attendance at the mortality and morbidity meetings, these were often poorly attended, with sparse minutes and no clear actions or learning from deaths recorded.
- Due to new staff taking over the nurse led follow up clinic, there had been a number of months in which data was not received in relation to numbers attended, patients referred to other services such as psychology, or feedback into the service from patients once they had been discharged.
- Data from the East of England critical care network showed that between April 2016 to March 2017 there were 179 delayed discharges (those between four to 24 hours). Discharges more than 24 hours were 239 from the same period. However it was noted that the unit was working to improve this by early identification of patients that could be discharged, as well as completing a business case to potentially expand the unit providing a high dependency/ level 1 facility that could be used for step down. There was no evidence that delayed discharges impacted upon timeliness of admission to the unit.

| **Maternity and gynaecology** | **Good** ● | We rated maternity and gynaecology services as good because: |

Summary of findings

- Equipment that was in use throughout the department was serviced and calibrated.
- The midwife-to-birth ratio was in line with or better than the recommended England average.
- The number of consultant hours provided to the service was in line with guidance from the Royal College of Obstetricians: Safer Childbirth; Minimum Standards for Organisation and Delivery of Care in Labour, 2007.
- Outcomes for women who used services were in line with or better than expected when compared with other similar sized services.
- An external organisation provided the termination of pregnancy service unless there was a confirmed fetal abnormality. The trust would perform the termination under these circumstances. We were assured that in doing so that the trust followed all elements of national guidelines and legislation.
- The service took part in national and local audits as well as reviewing their service in line with nationally published recommendations.
- Feedback from people who use the service, those who are close to them and stakeholders was positive about the way staff treated women. Most women were positive about the care provided.
- The service had responded to the changing demand of its service users.
- Access to the service was through a simple route, which enabled the medical team to see women soon after arrival.
- Bed occupancy rates for the service were generally lower than the England average of 58% with 55% occupancy for 2016.
- Staff spoke positively about the clinical leads for the service with their involvement and approachability.
- Governance and risk management systems within maternity and gynaecology were well established.
- The service engaged well with the women who lived within the catchment area by linking up with the local mother and baby groups to seek feedback on services provided by the hospital.

Summary of findings

- The Rosemary suite for mothers who had miscarried or delivered a stillbirth had undergone a refurbishment since our last inspection and provided a family room in addition to the delivery room and separate bedroom.

However:

- Whilst most staff attended mandatory training there was a low rate of training compliance for Immediate Life support for Adults at 25%.

- The staffing vacancy rate at Clacton was 16.32 whole time equivalent (WTE) below the actual required staffing levels of 20.9 WTE for Clacton. Increased bank staff and rotation of staff mitigated this when there was increased activity in an area.

- Medical staff training in safeguarding looked after children had a compliance rate at 53%.

- Several midwives expressed their concerns about feeling intimidated. They confirmed that the head of midwifery had completed a recent staff and student midwife survey, which had highlighted their concerns. This issue was being addressed by the management team at the time of our inspection.

- We received several comments through our comment cards about poor attitude of staff providing care to mothers on the postnatal ward. The waiting times for elective gynaecology have moved from a backlog of 91 in January 2016 to 148 in June 2017.

- The midwifery co-ordinator for the delivery suite was supervisory but not supernumerary on the staffing roster. This meant that when they cared for pregnant women there was the potential for them to be unavailable to support colleagues as and when required.

Services for children and young people

Good ●

We rated this service as good because:

- Nursing and medical staffing levels and skill mix were generally appropriate to meet patient needs.

Summary of findings

- There was a comprehensive local audit schedule to monitor performance, and participation in national audit, with actions for improvement following audits.
- Policies and procedures were up-to-date, and based on national guidance and best practice.
- Staff were well supported to develop their skills and competencies. For example, the transition nurse lead was on a degree pathway to complete an adolescent health course.
- Multidisciplinary team (MDT) working was strong both internally and externally. MDT meetings involved all relevant staff and everyone had an opportunity to contribute.
- All observations of staff interaction with patients showed compassionate care and staff tailored their communication to suit the needs of each child.
- Parents and families were actively involved in the care of their child and staff took time to ensure they understood information given to them.
- There was a dedicated community nursing team working in schools and the wider local area to meet the needs of the local population.

- Discharge planning was integral to patient care plans throughout the patient's stay in hospital. The NNU had implemented a 'discharge passport' aimed at involving parents more centrally in discharge planning. There was a focus on nurse-led discharges in straightforward cases, meaning nursing staff did not have to wait for a doctor to approve the discharge.
- There was a team of specialist nurses to provide support for patients with diabetes, epilepsy and asthma, gastroenterology, urology and oncology.
- There was a dedicated transition team for adolescents approaching their transfer to adult services. They worked with other teams to meet the more complex individual needs of patients at the age of transitioning to other services. For example, they ran a joint clinic with the epilepsy specialist nurse three to four times a year. There was a gradual, long-term approach to transition

Summary of findings

starting around the age of 14, which included a 'transition passport' system, where staff from both paediatric and adult services documented changes and progress.

- Complaints were discussed as part of the patient safety group which took place weekly as part of the medical handover.

- There was a comprehensive strategic vision for the service for the next three years.
- The risk register was closely monitored and up-to-date, and matched the areas of risk we saw on inspection. Risks were reviewed at a weekly risk management meeting by the service leads. This fed into the monthly 'two at the top' risks, which were circulated among staff and escalated up to the trust clinical governance team.
- The clinical and nursing leads showed strong leadership and oversight of the service. Staff said they were well-supported by the leads.
- There was a positive, supportive culture in the service.
- The service had initiatives to engage the local population and service users; for example, there was a support group called 'Little Miracles' for mothers who had previously had their children treated in the neonatal unit.

However:

- We were not assured that staff were consistently reporting all incidents through the electronic incident reporting system, or that formal systems to ensure actions from incidents were not shared consistently among all staff.
- There had been an increase in medicines incidents between March and May 2017. This was due to inconsistent checking of drug charts by theatre staff when children were taken for surgery, and different types of documentation used by the paediatric and theatre teams. However, the service had recently introduced red stickers in the patient notes as an action to address this.
- The 13 sets of patient records we reviewed were variable in their content and completion. For

example, one set of notes did not include the time of review or why the patient was reviewed, and a discharge summary did not indicate whether there were any medications allergies.

- The policy for safeguarding children was not in line with best practice; for example, it did not set out who was responsible for completing body maps, and it was not trust policy or procedure to have all child protection cases overseen by a paediatrician.
- Children undergoing surgery had to be transported through the adult recovery area to reach the children's recovery area.
- There was no flagging system within records to highlight clearly patients with learning disabilities.

End of life care

Good ⬤

End of life care at Colchester General Hospital was rated good overall.

- There were systems and processes in place to report and investigate incidents involving palliative care patients and those at the end of life.
- Staff were aware of their role and responsibilities in relation to safeguarding. The trust's mandatory induction programme provided training from the palliative and end of life care team.
- The trust had an end of life care facilitator, a palliative clinical skills nurse who worked across the trust to support ward based training and each ward had a palliative/end of life care champion.
- Care and treatment followed national guidelines within individualised care plans for patients.
- The trust monitored its own effectiveness with clinical audits and compared its performance with other trusts nationally.
- The trust specialist palliative care team provided support Monday to Sunday between 9am and 5pm.
- Staff were seen to provide kind and compassionate care across clinical areas. Patients' dignity was maintained at the end of life. Patients and relatives felt well informed about the care being provided.

Summary of findings

- The specialist palliative care team and chaplaincy service provided emotional support to patients and relatives.
- The specialist palliative care team (SPCT) and the ward staff were passionate about ensuring patients and people close to them received safe, effective and quality care.
- The SPCT was led by a consultant in palliative medicine. The SPCT and the trust's end of life care facilitator were focussed on raising staff awareness around end of life care (EOLC). The SPCT delivered education for medical, nursing and allied health care professionals at trust induction, preceptorship programme, study days, and also on the medical training programme.
- The chaplaincy was able to contact religious leaders of other faiths and had over 40 chaplaincy volunteers on the list.
- There was evidence of learning from complaints and concerns raised by patients and their relatives.
- Staff across all areas of the hospital acknowledged the importance of end of life care. The executive team and senior nursing team were aware of the concerns with end of life care and were receptive to the need to improve the service for patients.
- The trust had a clear strategy and vision in place for end of life care.
- The trust was robustly monitoring the effectiveness and the responsiveness of the service to patients and their families. Minutes of meetings both operational and business meetings did demonstrate a review of key performance indicators.

However:

- The Individual Care Record for The Last Days of Life (ICRLDL) recorded prescription, treatment and care plan. The ICRLDL had guidance on anticipatory prescribing but did not contain maximum doses or advise on the frequency of the administration of medication. This could

Summary of findings

potentially lead to inappropriate doses being administered. However we found no evidence that this had happened and there were systems in place so prescriptions were reviewed.

- There was a lack of consistency in how patient's mental capacity was assessed and not all decision-making was informed or in line with guidance and legislation when a do not attempt cardiopulmonary resuscitation order (DNACPR) was completed. In three cases we found that the patient was not made aware of the decision taken by medical staff not to resuscitate, despite the patient having capacity.
- The trust had a process in place for fast track discharge, however it was acknowledged by the trust to not always be rapid or fast, with some cases taking up to 189 hours (7.8 days) in May and 119 hours (five days) in June to get a patient discharged. There were focused action plans in place to monitor and address this through a range of initiatives in the Every Patient Every Day programme.

Outpatients and diagnostic imaging

Requires improvement

We rated this service as requires improvement because:

- Referral to treatment times (RTT) were worse than the England average in all but one measurement (urgent two week referrals where they were better) and below the operational standards.
- There were 2,863 patients out of 12,194 patients who had waited 13 weeks and over for a first appointment. The number waiting had been below 1,500 for most of the year April 2017 – May 2017 but had increased in the month prior to our inspection.
- There was still a significant backlog of patients shown as awaiting appointments although this had improved since the previous inspection, and review had shown that a large proportion of the backlog was likely due to appointments not being correctly reconciled on the system. There were processes in place to resolve this and every patient had been risk assessed whilst waiting in the backlog.

Summary of findings

- Medical staff compliance with mandatory training was variable, with adult basic life support being the lowest at 50%.
- The trust overall cancellation rate was around 25% for the period April 2016 to March 2017. However patient cancellations were high at around 14%. The hospital cancelled around 8% of clinics at short notice (less than 6 weeks' notice).

However:

- There were no significant concerns identified within the diagnostic services we inspected, we found that there was learning from incidents and effective processes in place.
- Leadership in the outpatients department was organised and effective and action plans had been implemented to address known concerns.
- There was a positive culture and staff were proud of the care they gave despite numerous recent leadership changes.
- Patients were treated with dignity and respect.
- Staff in radiology were supported to develop, with radiographers learning reporting skills and a new radiographer consultant post in breast imaging.

Colchester General Hospital

Detailed findings

Services we looked at

Urgent & emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and Gynaecology; Services for children and young people; End of life care; Outpatients & Diagnostic Imaging

Detailed findings

Contents

Background to Colchester General Hospital

Colchester General Hospital is a medium sized teaching hospital in Colchester with approximately 763 beds and is the main acute site for Colchester Hospital University NHS Foundation Trust. The hospital provides a range of elective and non-elective inpatient surgical and medical services as well as a 24-hour A&E, maternity and outpatient services to a surrounding population of around 370,000.

At our last inspection in April 2016, we found that significant improvements had not been made to how safe services were at Colchester Hospital University NHS Foundation Trust. The Chief Inspector of Hospitals wrote to the Secretary of State outlying our concerns and proposed next steps. A long-term partnership between

Colchester General Hospital and Ipswich Hospital NHS Trust was recommended and commenced in April 2016, with new chair, chief executive and managing director in post from May 2016.

Population served

The trust primarily serves a population of 370,000 people from Colchester and the surrounding area of North East Essex and South Suffolk.

Health and deprivation

The health of people in Colchester is similar to the England average. Deprivation is similar to the average and about 16% of children live in low-income families. Life expectancy for both men and women is similar to the England average.

Our inspection team

Our inspection team was led by:

Chair: Dr Sean O'Kelly,

Head of Hospital Inspections: Fiona Allinson, Care Quality Commission

Chief Inspector of Hospitals: Professor Sir Mike Richards attended the inspection on 26 July 2017

The team included ten CQC inspectors, three CQC inspection managers, a clinical specialist inspector IR(ME)R and a variety of specialist advisors including a board level director, two safeguarding specialists, eight doctors, seven specialist nurses and a midwife.

Detailed findings

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?

We carried out an announced inspection between 25 and 27 July 2017. We carried out unannounced inspections at Essex County hospital on 2 August 2017.

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); NHS Improvement, Health Education England (HEE); General Medical Council (GMC) and the local Healthwatch.

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 held a number of focus group sessions, across all staff grades, 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.

Facts and data about Colchester General Hospital

Colchester Hospital University NHS Foundation Trust is comprised of two main hospital sites which are Colchester General hospital and Essex County Hospital.

Number of beds

The trust has a total of 763 beds spread across various core services:

- 414 Medical beds (395 Inpatient, 19 day case)
- 229 Surgical beds (185 Inpatient, 44 day case)
- 55 Children's beds (45 Inpatient, 10 day case)
- 46 Maternity beds (46 Inpatient, 0 day case)
- 13 Critical Care beds (13 Inpatient, 0 day case)
- 6 Urgent and Emergency care beds (6 Inpatient, 0 day case)
- No beds were assigned to the End of Life Care core service

Clinical Commissioning Group

The trust's main CCG (Clinical Commissioning Group) is NHS North East Essex CCG.

Staff

As at April 2017, the trust employed 4100.59 whole time equivalent (WTE) staff out of an establishment of 4347.82 whole time equivalent staff, meaning the overall gap between planned staff WTE and actual staff WTE worked (includes agency and bank) at the trust was 6%.

– 507 Medical (against an establishment of 531)

– 1573 Nursing, midwifery and AHP (against an establishment of 1684)

– 2020 Other (against an establishment of 2132)

Budget and spending

In the latest financial year, 2016/17, the trust had an income of £301,678,000 and costs of £320,620,000 meaning it had a deficit of £18,942,000 for the year. The trust predicts that it will have a deficit of £22,056,000 2017/18.

Activity and patient throughput

Detailed findings

Between February 2016 and January 2017:

- 87,639 A&E attendances
- 90,792 Inpatient admissions
- 661,444 Outpatient appointments
- 3,574 births
- 1,675 deaths

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

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

Urgent and emergency services

Safe	**Requires improvement**	🟠
Effective	**Good**	🟢
Caring	**Good**	🟢
Responsive	**Good**	🟢
Well-led	**Requires improvement**	🟠
Overall	**Requires improvement**	🟠

Information about the service

The Emergency Department (ED) at Colchester hospital provides a 24 hour, seven day a week service for a population of approximately 370, 000 people across North East and South Suffolk. The emergency department offers immediate emergency and urgent care to the patients of North East Essex and South Suffolk.

Colchester hospital's emergency department had 85,974 attendances from April 2016 to March 2017, 16,658 of which were under 17 years of age. The number of patients attending urgent and emergency care services at Colchester hospital has increased by approximately 5,080 patients in comparison to April 2015 to March 2016.

The department consists of 16 majors cubicles and five resuscitation bays, one of which is specifically utilised for paediatric patients. There is a rapid assessment and treatment (RAT) area where patients can receive rapid assessment and intervention for life-threatening conditions, which has four cubicles with trolleys, a waiting area and two cubicles for chair based patient assessment. The clinical decisions unit (CDU) provides care for patients who require further investigations or a period of observation prior to being discharged, or admitted to hospital. The CDU consists of six bays with beds. The medical day unit (MDU) has 14 beds and predominantly accepts referrals from medicine, surgery and orthopaedic specialities.

The department has its own paediatric emergency department, which consists of one assessment room, one treatment room and three cubicles with trolleys. In addition, there is an observation room in the paediatric emergency department.

We conducted an announced inspection from 25 July 2017 to 27 July 2017. During our inspection, we spoke with eight patients and 22 members of staff employed in various roles including doctors, nurses, healthcare assistants, clerical and administrative staff and we reviewed 50 sets of patient records. We looked at a range of data provided by the trust prior to our inspection and observed care provided within this service.

Urgent and emergency services

Summary of findings

We rated this service as requires improvement overall because:

- We found out of date equipment and medicines in clinical areas, leading to concerns that the checking processes in place were not robust.
- The department lacked a dedicated mental health assessment room and medical records lacked a formal mental health risk assessment.
- There was no named safeguarding lead for the department and staff had not reached the Trust's safeguarding training target for safeguarding children and adults.
- Medical and nursing staffing levels were below establishment figures.
- Paediatric medical records did not always contain a documented pain score.
- The emergency department was not meeting the standard for the national four hour target, which states 95% of patients should be treated, discharged or admitted within four hours of arrival.
- The time patients spent in the emergency department was consistently higher that the England average from March 2016 to February 2017.
- Senior staff felt unsupported; there was a lack of support for senior emergency departmental staff from the executive team.
- Not all risks were identified on the emergency department's risk register.
- Divisional governance meetings and senior staff meetings appeared to lack a standard agenda.

However:

- Staff knew what constituted an incident and how to report and escalate incidents using the electronic system in place.
- Controlled drugs were stored securely and had been regularly checked.
- Regular clinical assessment took place for patients waiting on ambulance trolleys to ensure that clinical deterioration was identified in a timely manner.

- The median time from arrival in the department to initial assessment was better than the England average for 11 months from March 2016 and February 2017.
- NHS Friends and family test results for people recommending the emergency department were better than England average.
- We observed staff caring for patients in a kind and compassionate manner.
- Staff took steps to ensure that the dignity and privacy of patients was respected.
- Staff had access to a range of specialist nurses and teams to tailor care to a patients specific needs.
- Medical records contained 'alerts' to indicate if a patient had additional needs meaning staff could address individual needs.
- Processes were in place to assess the demand on the department, with clear escalation processes to maintain patient flow.
- We saw that complaint information was shared with staff to enable learning from complaints.
- Local management in the emergency department were supportive and encouraging with staff.
- The emergency department used quality scorecards to monitor performance.
- There was a clear vision in place which staff were aware of.
- Staff reported a good culture within the department; in particular, they told us that senior nurses within the department were always approachable and supportive.
- The emergency department had implemented a public volunteer programme to provide support to patients and relatives within the department.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement 🟠

We rated safe as requires improvement because:

- Nursing staff in the paediatric emergency department did not have clear oversight of children waiting to be seen.
- Medicine management processes were not effective as we found out of date medicines in clinical areas.
- The processes in place to maintain equipment and consumable items were not robust as we found out of date equipment in clinical areas.
- The department lacked a dedicated mental health assessment room.
- Medical records were not secure, leading to a possible breach of confidential personal information.
- Medical records lacked appropriate risk assessments.
- There was no named lead for safeguarding within the emergency department. Not all medical staff knew how to report a safeguarding concern.
- Medical staff compliance rate for safeguarding children training ,level one, two and three was 79%,76% and 52% respectively.
- There were low rates of mandatory training compliance for medical staff in respect of basic life support and advanced life support at 45% and 63.6% respectively.
- The department was not using a clinical tool to safely assess the needs of patients who self-presented to the emergency department.
- Data supplied by the trust showed that medical and nursing staffing were below establishment figures.

- Staff had limited knowledge about the duty of candour.
- Paediatric medical records did not always contain a documented pain score.
- Computer terminals in the department were not always secure leading to a possible breach of confidential personal information.
- Medical records lacked formal risk assessment for patients with mental health conditions.

However:

- Staff knew what constituted an incident and how to report and escalate incidents using the electronic system in place.

- The department was visibly clean, well organised and free from clutter.
- Medicines and controlled drugs were stored securely and had been regularly checked.
- Regular clinical assessment took place for patients waiting on ambulance trolleys to ensure that clinical deterioration was identified in a timely manner.
- The median time from arrival in the department to initial assessment was better than the England average for 11 months from March 2016 to February 2017.

Incidents

- Staff understood their responsibility to raise concerns and record patient safety incidents internally and externally using the electronic incident reporting system. We spoke with four members of staff who described what constituted an incident and how to report an incident using the electronic system.
- The trust's incident management policy named 'Procedure for the Reporting and Management of Incidents and Serious Incidents requiring Investigation' stated that all serious incidents would have a root cause analysis carried out.
- We reviewed two root cause analysis (RCA) investigations and saw that there were clear recommendations in place and actions to share learning.
- From May 2016 to April 2017, there were no reported never events for the emergency department. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic barriers, are available at a national level, and should have been implemented by all healthcare providers.
- The trust reported 13 serious incidents (SI's) within the emergency department from June 2016 to May 2017. There were six incidents related to treatment delay, four related to diagnostic incidents, one related to pressure ulcers, one medication incident and one episode of sub-optimal care of the deteriorating patient.
- The sharing of learning from incidents was taking place through a variety of methods. We saw displays in the staff room and daily meetings named 'wake up', which disseminated information about incidents. In addition, incident themes were attached to monthly payslips to increase staff awareness of incidents.

Urgent and emergency services

- We were given an example of where learning had been shared as a result of an incident relating to security in the department. The staff member confirmed that they had received feedback and actions were put in place to prevent a recurrence of a similar incident.
- Staff had received feedback and learning from an incident relating to the care of a patient with sepsis. We spoke with two members of staff who clearly articulated this incident and how learning had been shared as a result.
- Daily meetings named 'five topics of the day' took place in the department. This gave senior staff an opportunity to feed information relating to incidents back to staff. We saw an example of this taking place on the day of our inspection.
- Monthly governance and senior staff meetings discussed serious incidents, subsequent action plans, and how learning could be shared.
- Mortality and morbidity was discussed at divisional governance meetings. We were told that staff of all grades were encouraged to attend meetings and saw that upcoming dates for mortality and morbidity meetings were shared with staff in restroom areas.
- Staff had received training in the duty of candour . The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Duty of candour was included in an e-Learning package named 'incident reporting and risk assessment'. At the time of our inspection, 70% of medical staff, 86% of nurses and 92% of emergency nurse practitioners had completed this training. We spoke with eight nurses about their knowledge of the duty of candour, however only three out of eight staff were able to articulate what this term meant.
- The Trusts policy named 'Procedure for the Reporting and Management of Incidents and Serious Incidents requiring Investigation' clearly referenced the duty of candour and when it should be used. Staff had access to this policy on the intranet.
- We reviewed a root cause analysis, which showed that the duty of candour was undertaken both verbally and in writing in accordance with policy.

- We were given an example of when the duty of candour had been used in relation to a medicines error. The member of staff explained that the patient had received an immediate apology and explanation, with written apology after the event.

Safety Thermometer

- The trust utilised a safety thermometer to record the prevalence of patient harms. This included but was not limited to the monitoring the rate of patient falls, pressure ulcers and venous thromboembolism (VTE). This enabled frontline teams to monitor performance in delivering harm free care.
- Data from the patient safety thermometer showed that the urgent and emergency care department reported two new pressure ulcers, no falls with harm and six new catheter urinary tract infections from April 2016 to April 2017. This data related specifically to the emergency department.
- As a result of pressure ulcers (PU's), the department had actioned the purchase of special overlay mattresses to prevent PU's within the department. This was used in conjunction with a standard operating procedure to ensure all patients that required ongoing treatment would be transferred from a trolley to a bed within six hours.
- Patients safety thermometer information was displayed in staff rest room areas.

Cleanliness, infection control and hygiene

- The department had an effective system in place to ensure that standards of hygiene and cleanliness were maintained within the department. The emergency department participated in regular environmental audits to monitor cleanliness.
- An environmental audit that looked at the cleanliness of the department, showed overall compliance at 98.4% in January 2017, 92.8%in February 2017 and 90.5% in March 2017 with a target of 100%. Due to the deterioration in compliance the Matron was completing daily spot checks to ensure that cleanliness standards were being maintained.
- All clinical and non-clinical areas were visibly clean. We observed that regular cleaning was taking place over the course of our three day inspection.

Urgent and emergency services

- The department had an insolation room to ensure that patients with suspected or confirmed infectious diseases were cared for separately to prevent the spread of infection.
- There were no reported cases of Methicillin Resistant Staphylococcus aureus (MRSA) or clostridium difficille (C-diff) in the emergency department between the months of October 2016 and March 2017.
- Various equipment, trolleys and storage areas were labelled 'I am clean'. This meant that staff could be assured that equipment had been cleaned in between each patient use.
- We saw that cubicles were thoroughly cleaned in between each patient, mattresses were cleaned and labelled to indicate that cleaning had taken place.
- Staff had electronic access to infection prevention and control policies on the Trust's intranet.
- Personal protective equipment (PPE) was available at regular intervals throughout the adult and paediatric emergency department.
- Gloves, aprons and disinfecting hand gel were available in all clinical areas. In addition, disinfecting hand gel was available in the main waiting area of the department for public and patient use. Literature was on display providing information for staff and visitors on hand hygiene techniques.
- During the inspection, we saw that nursing and medical staff were compliant with the trust's 'arms bare below the elbow' policy to minimise the risk of the spreading infection.
- Hand hygiene audits results for the month of April 2017 showed overall compliance at 98.9%. From the months of October 2016 to March 2017, audits results ranged between 97% and 100%. During our inspection, we saw positive hand hygiene techniques with staff washing their hand before and after patient contact.
- Clinical waste bins contained correctly coloured bags to indicate potentially hazardous waste. We saw one general waste bin, located by the ambulance entrance that contained used disposable gloves, therefore these were not in the correct waste bin.
- Cubicle curtains in clinical areas were visibly clean and clearly stated when they had been replaced, all of which were within six months of installation.
- All clinical sharps (needle) containers were correctly assembled and labelled. Containers were within the recommended fill levels therefore minimising the risk of possible needle stick injury.

- Toys within the paediatric emergency department were checked and cleaned on a daily basis. We reviewed check sheets for the period of 1 April 2017 to 25 July 2017 and saw that checks had been carried out on each day during this period.

Environment and equipment

- All clinical and non-clinical areas of the adult and paediatric emergency department were free from clutter and well organised.
- The department was designed to enable effective access to and from various clinical areas including the diagnostic imaging department and resuscitation area.
- The trust had an ongoing equipment replacement programme in place. Effective processes were in place to ensure that equipment was monitored and serviced in line with manufacturers recommendations.
- We checked portable equipment including blood pressure machines, oxygen therapy heads and monitors. All equipment had been serviced within the recommended period with stickers clearly identifying when the next service was due.
- Defibrillators and electrocardiogram (ECG) equipment in the majors and rapid assessment and treatment (RAT) areas were within the recommended service intervals and visibly clean.
- Access to the RAT area, minors department, resuscitation and paediatric emergency department were security coded preventing unauthorised access.
- Access to the majors area of the department was not restricted meaning that unauthorised personnel could potentially access this area. However, access to this area was overseen by reception staff.
- Access to the paediatric waiting area was through the main adult waiting area and was separated by doors. There was clear audio and visual separation between the adult and paediatric waiting areas.
- The paediatric waiting room was adjacent to the main waiting room. The entrance to the paediatric emergency department was protected by swipe card access. The paediatric waiting area had an emergency buzzer for use in the event of deterioration of a child.
- Clear signage was in place advising relatives and carers to knock on the door between the waiting area and paediatric area to alert a member of staff should they

have any concerns over a child's condition. During our inspection we saw that staff responded in a timely manner when relatives and carers sought assistance by knocking on the door.

- There was limited oversight of the paediatric waiting room area from the paediatric emergency department. This meant that there was a risk that staff may not immediately notice if a patient was deteriorating. Reception staff had some CCTV coverage of this area however this did not cover all of the waiting area. Staff had one way glass to view the waiting area however this was poorly placed, meaning staff would have to physically walk to the end of the department to use this facility.

- The main waiting area was directly overseen by reception staff. This area provided seating for patients and relatives.

- Reception staff were located in the main waiting area behind safety glass. Staff had access to panic buttons in the event of requiring urgent assistance if a patient's health deteriorated or if a patient or visitor displayed challenging or aggressive behaviour.

- Resuscitation equipment should have been checked and signed for on a daily basis. Daily checks included testing of the defibrillator and presence of other resuscitation equipment. A full trolley check was carried out on the first day of each month; this included the checking of consumables and medicines. Once checked, the trolley was 'tagged' to indicate that contents were correct and in date.

- Two resuscitation trolleys were placed in the majors area and rapid assessment and treatment area. This meant there was effective access to this equipment in the event of an emergency.

- We checked both of the resuscitation trolleys and contents in the department and found that effective checks had not taken place.

- We reviewed the checks and contents of the resuscitation trolley in the RAT area. Monthly checks had taken place on the first of April, May, June and July 2017, with signatures in place for these checks. Daily checks had taken place on 24 out of 25 days for the month of July 2017. When viewing the full contents of the resuscitation trolley we found two bags of out of date intravenous fluids (expired May 2017) and six needles (expired March 2017). We escalated our findings to the matron of the emergency department who immediately instigated a full check and replenishment of stock.

- We reviewed the checks and contents of the resuscitation trolley in the majors area. Monthly checks had taken place on the first of January to July 2017, with signatures in place for these checks. Daily checks were absent on five days during this period. We found one set of defibrillator pads, 10 needles and seven blood sample containers that were past their expiry date. We escalated our findings to the matron. We could not gain assurances that the monthly checks were effective.

- There was a dedicated difficult airway trolley located in the resuscitation room. Trolley contents were complete, in-date and well organised.

- There was a dedicated bay for paediatric patients in the resuscitation area. We saw that this area was well organised and stocked. Consumable equipment was in date.

- The emergency department did not have a dedicated mental health assessment room. The department was in the process of re-design at the time of our inspection, with the aim to have a dedicated mental health room by October 2017.

- Mental health patients were accommodated in an isolation room adjacent to the majors area in the emergency department. This room had one point of access and exit, no panic buttons and lacked direct oversight from staff. There were ligature points on the door handle. This did not meet the Royal College of Emergency Medicine (RCEM) standards, in the mental health in the emergency department toolkit states that; 'an appropriate facility is available for the assessment of mental health patients in the ED'.

- The paediatric emergency department contained age appropriate toys, books and a television. The department was colourful and appealing for younger patients.

- The resuscitation area had a dedicated relative's room to provide a quiet space for relatives and carers who had loved ones in the resuscitation area. The room had access to a telephone and drinking water.

- Utility rooms throughout the department were well organised and tidy. All consumable stores within these areas were in date.

- The hospital helicopter landing pad was located adjacent to the emergency department. This allowed for the timely transfer of patients to clinical areas upon arrival by air.

Medicines

Urgent and emergency services

- Medicines were stored and managed in line with trust policy and relevant legislation.
- Controlled drugs (CDs) in the resuscitation room, majors area and CDU were securely stored in wall-mounted cupboards with one authorised member of staff holding keys to this stock.
- We checked the controlled drug book for CDU and found that all stock tallied to that recorded in the controlled drugs book. Checks were missing on three days over the period of May 2017 to 25 July 2017.
- Controlled drugs in the majors area of the department had been checked on a daily basis for the months of April, May, June 2017 to 25 July 2017. We checked a random selection of five controlled drugs, all of which tallied with the recorded total in the controlled drugs book.
- The CDU had bedside lockers to safely store medicines that a patient had brought with them to hospital.
- Fridges containing medicines were well organised and stocked. Medicines were easy to identify. We checked a random selection of medicines and found them to be in date.
- Fridges located in minors, majors, clinical decisions unit (CDU) and the resuscitation room were within the recommended service dates. Fridge temperatures had been checked on a daily basis in the resuscitation room for all applicable days in May, June and July 2017. In the CDU, fridge temperature checks were missing on three days during the same period. This could therefore potentially impact on the effectiveness of medications stored in this area. Portable oxygen cylinders were stored securely and within their expiry date.
- During our inspection, we witnessed a nurse administering oral medication without checking the patient's name, date of birth or checking the patient's prescription. This demonstrated non-adherence to the Nursing and Midwifery Council (NMC) standards for medicines management and the Trust's policy for the use of medicines.
- We escalated our concerns to the Matron in charge of the department who immediately discussed our observations with the member of staff concerned.
- There were processes in place to ensure that all staff including bank and agency were competent to administer medications. Agency and bank staff received medicines management checks on induction and information regarding competencies was included in the induction checklist.
- Induction information relating to medicines management for agency staff was also available in the staff restroom area.
- We checked at five sets of medical records for completed allergy status, documentation of arrival and triage time and the prescribing of antibiotics if applicable. All records had a completed allergy status and assessment and triage times. Antibiotics had been prescribed, administered and documented in a timely manner where applicable.
- We reviewed an additional 12 sets of medical records to ensure signatures were present for the administration of medications. We found that 11 out of 12 records had been signed correctly meaning that staff could be assured when previous medicines had been administered.

Records

- Staff received mandatory training in record keeping. Data showed 98% of nursing staff had completed this training, which met the trust target of 95%. However, training for medical staff was below the trust target at 75%.
- In the majors area, medical records were stored in wall mounted holders, relating to the cubicle number in the department. This area was not always overseen, particularly if the department was busy therefore leading to the risk of medical records being left unattended.
- In the CDU, medical records were stored behind the nurse's station out of sight. However, we saw that medical records were left unattended in the medical day unit (MDU), in an open storage unit in the main corridor. Therefore, these records were not secure, leading to a possible breach of confidential patient information.
- Medical records were not always maintained to provide a clear picture of a patient's treatment.
- Overall, we reviewed 17 sets of records for completeness of risk assessments, allergy status and the administration of medicines.
- We reviewed three sets of medical records from the CDU for the completion of pressure ulcer risk assessments. Two out of three demonstrated a completed risk assessment, the third record did not require a risk assessment to be carried out.

Urgent and emergency services

- We reviewed three sets of medical records from the CDU to ensure that venous thromboembolism (VTE) risk assessments had been completed. In two records, no VTE risk assessment had been completed.
- We reviewed the medical records of two patients with a mental health condition. We saw that the adult at risk section had not been completed in one set of records.
- We reviewed three sets of medical records from the paediatric emergency department. All records contained a correctly completed early warning score and evidence that safeguarding issues had been considered and if onward referral to a school nurse or health visitor was required.
- A senior nurse told us that they randomly selected a number of medical records for review on a daily basis, to ensure completeness and accurate records. This was not a formal audit however we saw this practice in action during our inspection. They reported that any concerns highlighted during this process would be fed back to the individual member of staff for learning.

Safeguarding

- Training data showed that as of April 2017, medical staff had not reached the target of 95% for training in safeguarding adults levels one (83%) and two (85%) and safeguarding children levels one (79%), two (76%) and three (52%).
- As of April 2017, nursing staff had reached the target of 95% for training in safeguarding adults levels one (96%) and two (95%). However, safeguarding children levels one (94%), two (74%) and three (44%) were below the target of 95%.However data for June 2017 showed that this had increased to 76%.
- We reviewed training compliance for safeguarding children level three relating to staff in the paediatric emergency department. Out of 18 staff working in the paediatric emergency department, 17 had received safeguarding children level three training within the last 12 months (94%).
- There was no named safeguarding lead for the emergency department. This role was currently in the process of being allocated to a clinical nurse educator, who was new to post and due to commence their role the week after our inspection. In the interim, we were told that a senior nurse from the emergency department attended trust safeguarding meetings however due to pressures in the department, this was not always possible.

- There was access to a paediatric 'consultant of the week' who was on call to respond to any concerns over safeguarding. In addition, there was always a registrar on call for all children's areas, either in the local area or on site so they could respond promptly to any safeguarding concern.
- Trust safeguarding meetings took place quarterly. We reviewed the minutes from February 2017 and May 2017 which indicated that there was no staff representation from the emergency department.
- Safeguarding referrals were made electronically, with support from the Trust's safeguarding team if required. All paediatric medical records were placed in to a tray to be reviewed by the safeguarding team within 24 hours and any concerns were noted in clinical notes.
- We looked at nine sets of paediatric records and found that they were mostly completed correctly with referrals made to local safeguarding authorities and information shared with school nurse/health visitor where appropriate. However, two out of the nine records were not completed correctly because no body map had been completed. This was not in line with the trust's policy named 'safeguarding children and young people', which stated a body map must be completed whenever there are injuries or unusual findings to ensure they are distinguished from non-accidental injury. Electronic alerts were placed on medical records so safeguarding details were highlighted to staff.
- The Trust safeguarding team visited the department on a daily basis to assist in the role of safeguarding adults and children. We saw the team visit during the course of our inspection.
- We asked two adult and three paediatric nurses on the action they would take in the event of identifying a vulnerable child or adult. All staff were clear on the process of identification, escalation and appropriate actions to take in the event of safeguarding concern.
- The paediatric department had recently had a cluster of safeguarding incidents that were under investigation at the time of our inspection. We spoke with two nurses and two doctors who were aware of the incidents who described that more detailed probing now took place with regards to questioning the patient and relatives on arrival.

Urgent and emergency services

- Nursing staff knew what constituted a safeguarding concern and how to report and escalate safeguarding concerns. We asked three nurses to show us electronic access to adult and child safeguarding policies. All staff located policies in a timely manner.
- A paediatric nurse described how they would start a safeguarding referral form and involve the doctors to allow them to document any concerns relating to a children's safeguarding concern.
- We spoke with four doctors from the adult emergency department on how they would report a potential safeguarding concern. Whilst all staff were able to articulate what constituted a safeguarding concerns, they were unclear on the actual process of reporting, stating further guidance would be sought from a consultant, paediatric consultant or the nurse in charge.
- Reception staff described the process of highlighting safeguarding concerns to the paediatric emergency department staff. They passed on concerns they might have picked up relating to a child and stated that they always 'felt listened to' when highlight concerns.
- The policy named 'safeguarding adults and the risk of abuse' made reference to female genital mutilation (FGM) and other types of abuse such as financial, emotional, domestic and sexual abuse. Information was provided to the guide staff on the appropriate actions to take in the event of a safeguarding concern being identified.
- Policies contained flow charts which provided clear guidance on how to manage types of potential abuse relating to children. Staff had access to a policy named 'safeguarding medical examination and management of children and young people with safeguarding concerns'. This document clearly referenced immobile children with bruising and injuries indicative of maltreatment and contained information about what staff should look for to identify a child with a 'suspicious' injury to ensure that appropriate referrals were made.
- We reviewed medical notes for an adult in a vulnerable situation who was at risk of abuse and saw that an appropriate referral had been made to the safeguarding team.

Mandatory training

- As of April 2017, data showed that medical staff had not met the trust target (95%)for mandatory training in any subject. Mandatory training included but was not limited to; learning disability and autism (88%),

dementia (84%), venous thromboembolism (VTE) awareness (81%), adult basic (55%) and advanced life support (71%), incident reporting (70%), sepsis (69%), and paediatric basic life support (52%).

- We requested up to date training compliance for medical staff for basic and advanced life support as previous figures provided were low. Records demonstrated that as of July 2017, medical staff were failing to meet the training target of 95% for basic life support (45%) and advanced life support (63.6%). We asked a senior member of staff to explain why training compliance was particularly poor in these subjects, they stated it was due to short staffing and a difficulty in releasing staff from their clinical role for mandatory training attendance.
- As of April 2017, data showed that nursing staff had met the 95% mandatory training target in the following subjects; learning disability and autism, record keeping and, end of life and palliative care. However, nurse staff had not met the 95% target for hand hygiene (94%), VTE awareness (90%), controlled drugs (90%), incident reporting (89%), adult basic life support (82%), conflict resolution (75%), paediatric basic life support (75%), adult immediate life support (72%) and adult advanced life support (63%).
- Overall, there was generally good attendance from nursing staff across most modules, with life support modules demonstrating the lowest attendees. At our inspection, we reviewed up to date mandatory training rates for nursing staff for adult basic life support training. Records showed that 100% of staff had received this training.
- In addition, staff participated in sepsis training. Nursing staff had reached the target of 95% with 96% of nurses having received this training. Medical staff did not reach this target achieving 69% in relation to sepsis training.
- A notice board in the staff room displayed information for staff on which training they needed to attend. In addition, staff received email alerts to inform them which training they were required to complete.

Assessing and responding to patient risk

- Self-presenting patients were seen by either a triage nurse or streamed by an emergency nurse practitioner (ENP) to the appropriate clinical area after initial assessment. Streaming processes allow the allocation of patients to different areas, dependent on their clinical needs.

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- Self-presenting patients attending the main waiting area of the emergency department and would be booked in at the reception desk prior to initial assessment.
- We reviewed the standard operating procedure (SOP) in place relating to streaming of patients. The SOP contained clear escalation guidance in the event of time to see a streaming nurse exceeding 20 minutes or there were more than 10 patients waiting.
- At times of peak demand, a second streamer was implemented to ensure that each patient was assessed in a safe and timely manner.
- The streaming process did not use a clinical tool to assess the needs of patients. A clinical assessment tool was built in to computer systems however, this was not being used and decisions were being based on clinical judgement, without documentation in place to support decision making.
- We highlighted our findings to a senior nurse within the department. They told us that they were due to re-implement the 'Manchester triage tool' to ensure that all clinical decisions were supported and documented appropriately however there was no set date for implementation for this.
- We reviewed one set of medical records for a patient who had been involved in a road traffic collision. Records did not identify if a neck injury had been excluded, prior to the patient being allocated back to the waiting room. Therefore, we could not gain assurances that the patient had received an appropriately detailed assessment. The emergency department used a rapid assessment and treatment (RAT) area. The aim of the RAT area was to ensure early assessment of 'majors' patients in emergency department, with the initiation of investigations and/or treatment in a timely manner. This included conditions such as cerebrovascular accident (CVA) and sepsis.
- We reviewed the standard operating procedure (SOP) for RAT and saw that it clearly stated specific grades of staff required to safely oversee this area. The SOP outlined actions with clear timescales for the handover and assessment, observations and clinical investigations that were required for patients within this area. A nurse (band five or above) received handover from other clinical areas such as minors or from ambulance crews in the RAT area.
- Ambulance crews brought patients directly in to the department where they would they be triaged in the RAT area. Depending on clinical presentation, the patient would then be moved to the appropriate area, or back in to the corridor if the department had no capacity. Patients remained accompanied at all times by a member of ambulance crew whilst awaiting formal handover.
- The trust was compliant with the imposed requirement following our previous inspection in regard to ensuring effective processes were in place to rapidly assess and treat patients who were waiting in the corridor.
- The main waiting area was directly overseen by reception staff. This meant that in the event of patient deterioration, reception staff were able to escalate a patient to clinical staff in a timely manner. Reception staff had access to an emergency alarm to summon help if required.
- The emergency department used the National Early Warning Score (NEWS) to monitor patients and detect deterioration in a timely manner as well as the Glasgow Coma Scale (GCS). The GCS provides a practical method for assessment of impairment of conscious level.
- We reviewed three sets of medical records for patients in the majors area. We found that the NEWS tool was being used to correctly score and identify patients at the risk of deterioration.
- There was always a doctor with advanced paediatric life support (APLS) or European paediatric advanced life support (EPALS) on each shift.
- We reviewed four paediatric medical records and saw that early warning scores had been correctly calculated where required. Two paediatric nurses told us that the department used three variations of early warning scoring; paediatric early warning score (PEWS), a modified traffic light system and a children's early warning score (CEWT). Staff were advised to use which ever system they felt most familiar with.
- We asked a senior paediatric nurse to confirm what early warning scoring system was in use. They told us that staff should be using PEWS to bring scoring in line with the children's assessment unit and paediatric wards. They told us the use of a traffic light system had proved difficult to use and the department was in the process of changing to the exclusive use PEWS at the time of our inspection.
- The emergency department had a number of instances of the time between ambulance arrival and formal patient handover exceeding 60 minutes. This is known as a black breach. From April 2016 to April 2017 the emergency department reported 1468 black breaches.

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However, the rate of black breaches had declined from 359 in April 2016 to 42 in April 2017 since the implementation of the RAT area. At times of high demand, the ambulance queue was monitored by a nurse and doctor on an hourly basis. We saw evidence that the corridor was checked on an hourly basis, or more frequently if required. Staff maintained a written log that indicated the number of patients waiting for a cubicle. This ensured that departmental pressures were monitored and that regular assessments were taking place for patients waiting for prolonged periods of time on ambulance trolleys.

- The median time from arrival to initial assessment for patients arriving by emergency ambulance was better than the England median in 11 out of 12 months for the period of March 2016 to February 2017. In February 2017 the trust's time to initial assessment was five minutes, in comparison with the England average of seven minutes.

- We looked at 10 sets of patient records for the time from arrival in the department to initial assessment. Seven of these patients were self-referred, five of which were initially assessed within 15 minutes. The remaining three patients arrived by ambulance, two of which were assessed within 15 minutes.

- The seven patients that self-referred had clear records demonstrating the time and location of where initial assessment had taken place, and who had carried out the assessment. Records also demonstrated which pathway the patient had been streamed to dependent on clinical need.

- The trust was compliant with imposed requirements following our previous inspection in regard to patient streaming in the emergency department and the completion of accurate records of where clinical assessment was commenced for each patient and by whom.

- The department had an SOP in place to ensure effective oversight and monitoring of ambulance patients waiting in the department. We reviewed the SOP and saw that it detailed clear lines of responsibility for clinicians within the department to ensure that patients were monitored and overseen on a regular basis.

- The department had a hospital ambulance liaison officer (HALO) in post between the hours of 10am and 10pm. This role facilitated communication between ambulance crews and hospital staff, including the escalation of deteriorating patients whilst awaiting handover or trolley space within the department.

- We spoke with the HALO who told us that the rapid assessment and treatment area had made a positive change to handovers occurring in a timely manner. In addition, the HALO confirmed that regular checks of the ambulance queue in the corridor took place by both doctors and nurses.

- We spoke with two members of ambulance crew who confirmed that regular monitoring of corridor took place by either a doctor or a nurse.

- Two members of hospital staff told us of a recent case where a critically unwell patient had been identified by a consultant assessing patients in the corridor after their arrival by ambulance. The patient was number 11 in the queue. As a result of regular checks, the patient's clinical status was rapidly identified and they were moved to the resuscitation area for emergency treatment.

- The trust was compliant with imposed requirements following our previous inspection in regard to ensuring that there were sufficient number (based on demand) of suitably qualified, skilled and experienced nurses and/ or doctors placed in the corridor where patients awaiting ambulance handover were located.

- The Royal College of Emergency Medicine (RCEM) recommends that all patients should wait no more than one hour from the time of arrival to receiving treatment. The emergency department met this standard for each month over the 12 month period from March 2016 to February 2017.

- The department had implemented a sepsis pathway which used an emergency '2222' bleep system to alert medical and nursing staff if sepsis was suspected. Sepsis is a life threatening condition and is also referred to as septicaemia or blood poisoning. We saw information posters directing staff to this bleep system during our inspection.

- In addition, departmental staff had access to a policy named 'procedure for the screening and management of sepsis in adults'. This document clearly state the roles and responsibilities of staff, and the assessment, indicated care and management of a patient with suspected or actual sepsis.

- The pathway was based on national guidance, indicating antibiotic treatment within one hour as per the National Institute of Clinical Excellence (NICE) guidelines: 'Sepsis: recognition, diagnosis and early management'.

- The department had recently recruited a sepsis compliance assistant to collect audit data, support the

clinical area to identify sepsis patients, to improve the education and adherence to the Sepsis pathway, and ensure that the escalation of the deteriorating septic patient was documented in medical records.

- The pathway was regularly overseen and audited by a senior nurse and sepsis compliance assistant. We reviewed daily reports which looked at patient time of arrival, treatment with antibiotics, oxygen administration and the taking of blood cultures and lactates. Out of the 12 records we reviewed, 11 patients had received antibiotics and other appropriate treatment in less than one hour from arrival to the department.
- Patient records indicated if a patient was high risk for serious medical conditions such as neutropenic sepsis. Neutropenic sepsis is a life threatening complication of anticancer treatment. During our inspection, we saw a patient with cancer presenting to the emergency department with possible neutropenic sepsis. This was identified during the streaming process and the patient was moved directly to an isolation room within five minutes.
- We asked a registered nurse what formal process was in place to assess a patient with a mental health condition, they responded "risk assessments are performed on a basis of intuition, no formal scoring system is in place". Therefore we could not gain assurances that patients with mental health conditions or environmental factors were being effectively risk assessed within the department.
- The emergency department did not have a dedicated mental health assessment room and there was no formal environmental risk assessment carried out in relation to patients that presented with mental health illness.
- The emergency department utilised a 'track and trigger tool' to maintain patient safety, minimise risk, maintain ambulance handover in a timely manner and mitigate pressures. We saw this process in use on the second day of our inspection. Empty bed number calculations within the emergency department were used to indicate the level of pressure the department was experiencing. Clear actions were in place to escalate pressures accordingly with regular communication taking place with the site management team to manage the flow of patients from the department to beds within the hospital if required.

- There was a standard operating procedure (SOP) in place for the transfer of patients to a bed after six hours on a trolley. We reviewed this document and saw clear timelines were in place for the completion of skin integrity assessments and the moving of patients from trolley to a bed within six hours.
- We reviewed three sets of medical records from the CDU for the completion of pressure ulcer risk assessments. Two out of three demonstrated a completed risk assessment, the third record did not require a risk assessment to be carried out.
- The SOP in place for the clinical decisions unit had clear inclusion and exclusion criteria for patient admission to this area. This ensured that only patients within this area had a relatively low severity of illness and that the level of service was appropriate for unit resources and staffing in place. During our inspection we saw that all patients in the CDU were within the scope of the unit.

Nursing staffing

- As of April 2017, the department had 95.8 whole time equivalent (WTE) nurses in urgent and emergency care and 11.4 WTE nurses in the clinical decisions unit. In April 2017, the emergency department reported a nurse vacancy rate of 27%. Continual recruitment drives for band 5 nursing vacancies were ongoing at the time of our inspection.
- The matron or nurse in charge completed a risk assessment to allocate and ensure adequate staffing in each clinical area. We saw this system in use during our inspection.
- Nursing handovers took place at times of shift change. We witnessed a handover during our inspection which was seen to discuss staffing levels that were present and planned in the department.
- The nurse in charge completed a daily risk assessment document for nurse staffing. This was amended as required throughout the day, with verbal updates given at each bed meeting. Bed meetings occurred at 8.30am, 12.45pm and 4pm.

- Daily reviews of staffing levels were carried out by the nurse in charge to ensure safe staffing on early, middle, late, twilight and night shifts. If necessary, staff were moved from other areas of the trust to work in the emergency department. In addition, staff often volunteered to work extra hours to cover shortfall in staffing. We saw this happen during our inspection.

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- Staffing was planned to ensure that there was one trained nurse to two adult patients within the resuscitation area. We saw a minimum of two registered nurses in the resuscitation area during the course of our inspection.

- Paediatric nursing staff varied depending on the time of day and always included a minimum of one paediatric registered nurse. From 11pm to 7am the paediatric emergency department was staffed by one paediatric registered nurse that had received training in paediatric immediate life support. We spoke with three paediatric nurses who confirmed that additional support was provided by the adult emergency department or children's assessment unit should the need arise and that the department always used a minimum of one trained paediatric nurse at all times.

- The overall lead for the paediatric emergency department was the matron based in the children and young people's division. All staff from the paediatric emergency would report to the matron when required.

- The CDU operated under separate staffing from the main emergency department. The unit was staffed with two registered nurses 24 hours a day.

- Between May 2016 and April 2017, nursing turnover rate was 18%. In the same period, the sickness rate for nurses was 3.46%.

- From May 2016 to April 2017, bank and agency usage rate was 13% for nursing staff. Agency staff completed an induction prior to commencement of work in the department.

- During periods where patients remained in the MDU overnight, this area was exclusively staffed by agency nurses who had previous experience of working in the unit. In the event of additional support being required, agency staff would seek support from the emergency assessment unit (EAU) co-ordinator.

Medical staffing

- The department had consultant presence between the hours of 8am and 10pm, which was below the current Royal College of Emergency Medicine (RCEM) workforce recommendations 2010. The RCEM recommendations state that a consultant presence in the emergency department should be a minimum of 16 hours a day, 7 days a week. Outside of these hours, the department had access to consultant cover on an on-call basis.

- In January 2017, the proportion of consultant staff reported to be working at the trust was below the England average. The proportion of junior (foundation year one and two) staff was the same as the England average.

- The department saw 16,658 children from the months of April 2016 to March 2017. There was no substantive paediatrician in the paediatric emergency department. At the time of our inspection, an adult consultant had taken the lead for paediatrics whilst training in paediatrics as a subspecialty.

- Staff had access to a 'paediatric consultant of the week' and in addition, a registrar was on call to attend the paediatric emergency department if required.

- As of April 2017 there was a vacancy rate of 30% for medical staffing. The highest rate was for medical staff below consultant grade.

- Between May 2016 and April 2017, medical staffing turnover figures were 25% in the urgent and emergency care. For the same period there was 3% sickness.

- Bank and agency use was variable from the months of April 2016 to March 2017. Figures ranged from 14% to 41%. Data showed that there had been a steady increase in the medical bank and locum usage rate in the department.

- There were processes in place to ensure that bank and agency medical staff were competent to administer medications. Agency and bank staff received medicines management checks on induction and information regarding competencies was included in the induction checklist.

- We spoke with two nurses in the paediatric emergency department who confirmed that consultant responses from the emergency and paediatric team took place in a timely manner upon request.

- Middle grade doctors worked Monday to Friday, covering a 24 hour rota, which included two middle grade doctors overnight. At the weekend, there were eight middle grade doctors working in the emergency department covering a 24 hour shift with two middle grades covering overnight.

- The emergency department had eight junior doctors working in the department Monday to Friday, covering a 24 hour shift pattern to include two middle grade doctors working overnight.

- We observed a handover during our inspection. The handover was consultant led. Every patient in the majors department was discussed and reviewed in

detail, with discussion around further planned care and treatment. During this process, consultants allocated patients to junior doctors with clear instructions to return to the consultant for further discussion once the patient had been assessed.

Major incident awareness and training

- The trust had an up to date major incident plan and policy in place. We reviewed this document and saw that it made specific reference to the emergency department, emergency assessment unit and radiology. The plan clearly specified the functions required of each area in the event of a major incident.
- Staff could access major incident plans and policies on the trust's intranet. The department had a specific 'grab folder' for major incidents. The folder contained an SOP indicating clear roles and responsibilities for the nurse in charge, lead consultant, nurses and healthcare assistants.
- There were two major incident equipment storage areas. Both were accessible by key code meaning that they could be accessed at all times of the day and night.
- Both storage areas were well lit, organised and contained patient record forms, tabards for staff and a major incident plan document. We checked the contents of a major incident grab bag and found all consumables and equipment to be in date.
- There had been a major incident table top exercise carried out in 2016.

Data showed that 86% of nurses within the department had received Hazardous Material (HAZMAT) training which included chemical, biological and radiological training.

Are urgent and emergency services effective?
(for example, treatment is effective)

Good ●

We rated effective as good because:

- Policies and pathways in use were based on national guidance.

- The emergency department had a comprehensive audit cycle in place to monitor for improvements after the implementation of action plans following previous audit results.
- The emergency department was meeting the nutritional and hydration needs of patients.
- Staff reported that the appraisal system was meaningful and that they felt developed in their role.
- The emergency department demonstrated good multidisciplinary team working with other healthcare professionals including alcohol liaison nurses, crisis teams and the ambulance service.
- Staff asked patients for verbal consent before carrying out examinations. Consent and mental capacity assessment had been recorded in patient medical records.
- Staff had access to relevant information to enable them to carry out their role, for example information on sepsis and other medical emergencies.
- All nursing staff working in the paediatric emergency department were specifically trained and registered in paediatrics.

However:

- Paediatric medical records did not always contain a documented pain score.
- Computer terminals in the department were not always secure leading to a possible breach of confidential personal information.
- Medical records lacked formal risk assessment for patients with mental health conditions.

Evidence-based care and treatment

- Local policies and pathways were available on the trust intranet in both the paediatric and adult emergency departments. We asked staff from both departments to locate specific policies, all of which could do so in a timely manner.
- Policies were based on national guidelines and best practice .We reviewed the sepsis pathway in detail and found it to be based on National Institute of Clinical Excellence (NICE) guidelines.
- We also reviewed the chronic obstructive pulmonary disease (COPD) acute exacerbation care bundle which was based on NICE (CG101).
- The adult head injury pathway reflected the Royal College of Emergency Medicine (RCEM) guidelines.

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- The department had access to an acute stroke nurse specialist. We followed a patients pathway who had arrived in the rapid assessment and treatment (RAT) area with stroke symptoms. The stroke nurse attended and was using the transient ischaemic attack (TIA) and stroke pathway. We reviewed this pathway and saw that it was up to date and referenced NICE guidance on stroke care.
- Medical records did not contain a formal risk assessment or scoring system to identify high risk patients with mental health conditions. This was not in line with the Royal College of Emergency Medicine standards detailed in the mental health in emergency department toolkit.
- The emergency department was not following the Royal College of Emergency guidance standards for mental health, which states: patients who have self-harmed should have a risk assessment in the emergency department.
- When reviewing medical records for a patient who had taken an overdose, there was no risk assessment carried out. This was not in line with the Royal College of Emergency Medicine standards detailed in the mental health in emergency department toolkit.
- We reviewed the medical records of a patient experiencing acute alcohol withdrawal. We saw that assessment included the use of an alcohol withdrawal assessment tool to identify the severity of symptoms. Appropriate medicines had been prescribed and administered resulting in an improvement in the patient's condition.

Pain relief

- We reviewed eight sets of adult medical records from the majors department and the CDU for documentation of pain scoring. Records demonstrated that seven out of eight records had a documented pain score.
- We reviewed a further seven adult medical records for evidence that analgesia had been prescribed and administered in a timely manner. Records demonstrated that if applicable, analgesia had been administered in a timely manner in five out of seven cases.
- We spoke with two adult patients about how they felt their pain had been managed. Both patients stated that staff had been responsive in the administration of pain relief, one patient stated "I didn't even have to ask for pain relief".

- We reviewed four sets of paediatric medical records for pain scoring and pain relief administration. Two out of four records had no documented pain score or prescription of pain relief. There was no documented reason as to why pain had not been scored or why pain relief was not offered.
- The Royal College of Emergency (RCEM) standard states that children should receive analgesia for moderate and severe pain within 20 minutes of arrival in the emergency department. Therefore we were not assured that children were being assessed for pain and offered pain relief in all cases.
- The emergency department participated in an annual children's pain audit, which was in line with the royal college of emergency medicine (RCEM) recommendations. Audit data from 1 August 2016 to 30 September 2016 showed that moderate to severe pain was treated as per guidelines in 8% of patients and reassessed in 7% of patients.
- A local audit revealed that pain was underrated in the emergency department and that there was poor compliance in the reporting and escalation of pain. Audit results were shared with departmental staff in March 2017 with a plan to carry out a further audit four to eight months later to monitor for improvements. This had not yet taken place at the time of our inspection.
- A local audit looking at pain management in children in the emergency department was carried out in November 2016. Data showed that the documentation of pain occurred in 61% of patients, pain was managed appropriately in 71% of patients, moderate to severe pain was treated as per guidelines in only 8 % of patients and moderate to severe pain was re assessed as per guidelines in only 7 % of patients

Nutrition and hydration

- Staff offered hot and cold drinks to patients at regular intervals. Patients had access to fresh drinking water if it was clinically safe for them to drink.
- Food was provided by catering services during the day. Out of hours a selection of sandwiches were available from a fridge located in the department.
- Out of hours, individual dietary requirements were met by contacting the catering department who could provide an alternative option if required.
- Patients, relatives and carers had access to food and drinks from vending machines located in the main waiting area.

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Patient outcomes

- The trust had a local audit plan in place which took into account the issues highlighted in national audits.

- Between March 2016 and February 2017, the Trust's unplanned re-attendance rate to the emergency department within seven days was worse than the national standard of 5% and better than the England average. In the latest period, unplanned re-attendance to the emergency department was 5.6% compared to an England average of 7.8%.

- The 2014/15 RCEM audit for mental health in the emergency department showed that the Trust was not meeting the one of the two fundamental standards of recording a risk assessment in patient's notes, with 10% of notes demonstrating that risk assessment had been recorded. The department also performed in the lower quartiles for; the taking and recording the history of a patient's previous mental health issues and the documentation of provisional diagnosis.

- We reviewed an action plan in response to the 2014/2015 RCEM audit for mental health in the emergency department. We saw that a mental health assessment proforma had been introduced into clinical notes however this did not include a detailed risk assessment in relation to patients with mental health conditions. The audit was due to be repeated in October 2017 after our inspection.

- In the 2016/17 RCEM audit for consultant sign-off, the trust was in the upper quartile compared to other hospitals for two of the four measures, between the upper and lower quartiles for one and did not submit any data for the remaining measure. The hospital did not meet the fundamental standard of having a consultant review for patients making an unscheduled return to the ED with the same condition within 72 hours of discharge. The measures for which the hospital performed in the upper quartile were: consultant review of patients aged 30 years and over experiencing atraumatic chest pain (19%) and a consultant review for patients aged 70 years and over experiencing abdominal pain (19%).

- In response to the 2016/17 RCEM audit for consultant sign off, the department had implemented an action plan. The action plan detailed steps to introduce in response to findings including teaching programmes to familiarise emergency department staff with the RCEM audit standards. The department was due to conduct a re-audit in September and October 2017 after our inspection.

- In the 2016/17 RCEM audit for severe sepsis and septic shock, the trust was in the upper quartile compared to other hospitals for three of the thirteen measures and was between the upper and lower quartiles for the remaining ten measures. The hospital did not meet the fundamental standards of having key vital signs recorded on arrival, having 100% of the first intravenous crystalloid fluid being given within four hours, or having 100% of antibiotics administered within four hours of arrival.

- However, in comparison to the 2013/14 audit, the trust had improved in four of the five comparable measures in the severe sepsis audit. The measure that deteriorated was relating to having oxygen initiated within one hour of arrival (decreasing from 50% to 39%). During our inspection, we saw that 11 patients had received antibiotics and other appropriate treatment in less than one hour from arrival to the department and that sepsis was a key area of focus within the department.

- The emergency department was monitoring performance in relation to sepsis with the recent implementation of a sepsis compliance assistant. We saw this role being utilised during our inspection and that regular audit data was fed back to departmental senior managers.

- The department participated in a number of local audits and used national guidance to assess if standards were being met.

- The department participated in the trauma audit and research network (TARN) audit 2016/17. The aim of the audit was to benchmark their trauma service with other providers across the country and drive improvements by looking at 10 indicators of care and treatment.

- Data showed that the trust were better or much better for seven indicators and worse or much worse for three indicators. It is to be noted that the sample size was small and two out of the three indicators where the trust was worse than average was in relation to the submission of data.

- We reviewed the major trauma unit operational policy and saw that it was based on trust polices and provided specific guidance on areas featured in the TARN audit.

Urgent and emergency services

Competent staff

- As of April 2017, data showed that 90% of medical staff and 75% of nursing staff had received an appraisal, the Trust's target was 100%.
- Nursing staff told us that the appraisal process was meaningful. Three nurses told us; "I feel well developed and am able to set clear and achievable goals". Another member of staff stated I feel developed and supported". Another nurse, who was in their first year post qualification, reported that they had been well supported throughout this phase of their career.
- All nurses working within the paediatric emergency department were specifically trained registered nurses (children's branch).
- Data showed that 62% of nurses had completed nurse triage training against a target of 95%.
- Data showed that 96% of nurses and 69% of medical staff had received training in sepsis against a target of 95%.
- The department had a clinical nurse educator in post to oversee compliance with the appraisal process ,ensure the maintenance of the Royal College of Nursing (RCN) staff competencies, induction and oversight of mandatory training compliance.
- A record of nursing and medical revalidation was held electronically at the Trust. The human resources department sent email reminders to medical and nursing staff when revalidation was due. All nursing staff within the emergency department were up to date with revalidation.
- We spoke with one doctor who reported they felt supported during the process of revalidation.
- The trusts did not provide formal advanced trauma life support training. A senior nurse told us that this was due to a lack of funding in the department. A consultant within the department carried out weekly sessions on various trauma scenarios to assist staff in the care of trauma patients.

Multidisciplinary working

- During our inspection, we saw evidence that the alcohol liaison nurse had been involved in a patient's care. This service was seen to interact well with the emergency department.
- Staff had access to mental health crisis teams 24 hours a day, seven days a week. During our inspection we saw evidence of multidisciplinary working with mental

health teams. Timely referral of a patient for mental health assessment had taken place with evidence of good communication between the emergency department and crisis team.
- There were clear processes in place to avoid patient admission where clinically safe to do so, for example in directing patients to a more appropriate place of care, such as walk in centres or minor injury units.
- We observed four alert calls arriving in the resuscitation area during our inspection. Alert calls take place to inform the emergency department that a critically unwell patient is on route to the department by ambulance so that staff can prepare equipment, staff and other items for the arrival of patient.
- We saw that preparation and response had taken place from specialities such as anaesthetics and critical care. Effective communication was seen to take place between different teams. In addition, we saw positive interactions between a consultant and ambulance crew, who praised ambulance staff on how well they had stabilised a patient prior to arrival at hospital.
- We observed effective communication taking place between the hospital ambulance liaison officer (HALO) and nurse in charge. This ensured that the department were informed of expected ambulances arrivals in the aim to maintain patient flow through the department.
- We saw that specialities had reviewed patients in a timely manner, however, two nurses we spoke with described that the response from the surgical and trauma and orthopaedics specialities were sometimes poor. A senior member of staff told us that nursing staff were encouraged to call the speciality consultants if registrars had failed to attend within 30 minutes.

Seven-day services

- The adult and paediatric emergency departments were open 24 hours a day, seven days a week.
- The department was meeting the NHS England's seven-day services priority standards five (hospital inpatients must have seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology).
- Diagnostic imaging provided access to a magnetic resonance imager (MRI), computerised tomography scanner (CT) and x-ray machines. This area was staffed by radiographers 24 hours a day, seven days a week.

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- Imaging requests could take place 24 hours a day. Outside of normal hours, radiographers could authorise scans based on a set criteria. Decision making was based on NICE guidance. This included conditions such as head injury, abdominal aneurism and multiple trauma.
- Out of hours, diagnostic images were interpreted by an external company to ensure images were reported on in a timely manner.
- Clinical pharmacy services were available 24 hours a day, seven-days a week with on call pharmacy service available outside of normal working hours.

Access to information

- Computer terminals were located in each clinical area. This enabled staff access to patient records, pathology systems and radiology systems in a timely manner.
- Permanent departmental staff had information technology (IT) login details. Locum doctors were provided with passwords to enable access to IT systems prior to commencement of their shift.
- Computer terminals were not always secure within the department. We saw unlocked computers on three occasions during our inspection. This meant that unauthorised personnel could potentially access confidential patient information.
- Medical records were stored in wall mounted brackets adjacent to the nursing station, detailing the patient's name on the front of the holder. Storage of records was well organised meaning staff had access to these in a timely manner when required.
- Once a patient had left the emergency department, paper medical records were scanned by reception staff so that any care and treatment could be electronically reviewed by the next clinician caring for the patient.
- Information signposting staff to specialist teams was on display in clinical areas. This included, but was not limited to contact details for trauma call activation for sepsis and abdominal aortic aneurism.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- As of April 2017, Mental Capacity Act (MCA) Level one training had been completed by 96% of staff within the emergency department. MCA training levels two and three were below the Trust target completion rate of 95%, with 93% and 90% respectively.

- Deprivation of Liberty Safeguards (DoLS) level one training had been completed by 96% of staff. DoLS level two and three training were both below the trust completion target of 95%, with 93% and 87% completion rates respectively.
- Medical records contained a specific section for documenting a mental capacity assessment and consent. We reviewed four medical records which demonstrated three out of four records had documented mental capacity and consent assessments.
- Staff had access to a document named 'guidance on restrictive practices'. Restrictive practices may be used to physically restrain a patient or use devices, medication or seclusion during examination and treatment. We reviewed this document which clearly referenced the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2007.
- Staff had access to electronic policies on the MCA and DoLs. We spoke with two staff who demonstrated a good understanding of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2007).
- During our inspection we saw staff asking patients for verbal consent before carrying out examinations including blood pressure, cannulation and electrocardiograms (ECG's).
- There was an up to date policy on adult consent which was available on the intranet. When requested, a nurse located this policy in a timely manner.
- Staff had access to a policy named consent. We reviewed this document and saw that it referenced the Gillick competence and how children and young people's capacity is assessed.

Are urgent and emergency services caring?

Good ●

We rated caring as good because:

- NHS Friends and family test results for people recommending the emergency department were better than England average.
- We observed staff caring for patients in a kind and compassionate manner.
- Staff took steps to ensure that the dignity and privacy of patients was respected.

Urgent and emergency services

- The emergency department provided emotional support and provided multi-faith support at all times.

Compassionate care

- The NHS Friends and Family Test (FFT) is used to help services understand whether their patients are happy with the service provided, or where improvements are needed. The percentage of people recommending the emergency department was generally better that the England average from April 2016 to March 2017. In March 2017, trust performance was 90% compared to an England average of 87%.
- The Care Quality Commission patient survey carried out in July 2016, showed that the trust scored 8.6 out of 10 (maximum score) for patients reporting that they had been given enough privacy when being examined or treated in the emergency department. This was about the same as other trusts.
- We reviewed eight FFT feedback cards. All feedback contained positive comments, reflecting that staff were kind, caring and attentive.
- During our inspection, we spoke with five patients and relatives of patients within the department. Staff were described as; "really good and caring", "brilliant, no complaints they have made sure my privacy was respected", "lovely and caring, they all work so hard" and "all staff have been very good to me".
- We observed staff caring for patients in a kind and compassionate manner.
- We saw a nurse comforting a patient who was very agitated and tearful. This resulted in the patient calming down and they were visibly reassured by the nurse's actions and presence.
- Resuscitation room staff were seen to speak with relatives in a kind and supportive manner during periods of emotional upset.
- Nursing staff were seen to ensure the privacy and dignity of patients by ensuring curtains were closed whilst assessment and treatment was carried out.

Understanding and involvement of patients and those close to them

- The Care Quality Commission patient survey carried out in July 2016, showed that the trust scored 8.2 out of 10 for patients reporting that they had been given enough information about their condition or treatment in the emergency department. This was about the same as other trusts.

- We asked three patients if they had felt involved in their care and treatment plans. One patient said "I feel up to date with what is going on", another stated "I have been told exactly what is happening" and the third patient said "I have felt involved in my care, I know what the plan is going forward".
- We saw that staff explained treatments and procedures to patients, involving relatives where appropriate.
- Further information on medical conditions and treatments were available in the department in a written format, available in various formats upon request.

Emotional support

- Multi-faith support was available through the hospital switchboard. There was an on-call rota for urgent referrals and support was available at all times.
- Staff could request support for patients from the Trust's chaplains or multi-faith volunteers.
- Bedside religious support was available for patients to receive Holy Communion.
- During our inspection we spoke with a multi-faith volunteer who described their role as one of support for patients, relatives, carers and staff. We saw an example of support being provided for a patient and their relatives in the resuscitation room, for a patient who was nearing the end of their life.
- There was a chapel on site with which staff and patients could access at all times.
- Counselling was available through the trust's occupational health department for staff that required support. In addition, team debriefing was available after episodes of emotionally traumatic care provision if required.

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

Good ●

We rated responsive as good because:

- Staff had access to a range of specialist nurses and teams to tailor care to a patients specific needs.
- Medical records contained 'alerts' to indicate if a patient had additional needs meaning staff could address individual needs.

Urgent and emergency services

- Processes were in place to assess the demand on the department, with clear escalation processes to maintain patient flow.
- We saw that complaint information was shared with staff to prevent the recurrence of complaints and aid learning.

However:

- The emergency department was not meeting four hour target which states 95% of patients should be treated, discharged or admitted within four hours of arrival.
- The time patients spent in the emergency department was consistently higher that the England average from March 2017 to February 2016.

Service planning and delivery to meet the needs of local people

- The waiting area for both the adult and paediatric emergency department contained adequate space and seating. Chairs were available nearby to the reception and booking in desk to allow patients to remain seated whilst waiting to be booked in.
- The emergency department was served by a local bus route enabling patients to use public transport to reach the site.
- The department had undergone re-design to improve the rapid assessment (RAT) and treatment area.
- Advanced nurse practitioners streamed patients to ensure that they were seen and treated by the appropriate service either at the hospital or after onward referral another healthcare provider.
- The department was in the process of further re-design at the time of our inspection. Implementation plans were in progress for a GP streaming service in the aim to reduce admission to the department and improve capacity and flow.

Meeting people's individual needs

- The department had access to a nurse specialising in learning disabilities. An online reporting system was in place so the learning disabilities hospital liaison nurse (LDHLN) could request an update from the emergency department on a daily basis to identify patients with learning difficulties to enable prompt follow up.
- We spoke with one nurse who told us that the trust lead for learning disability support was very supportive.

- Emergency department staff had access to two whole time equivalent (WTE) dementia care nurse specialists who screened patients for the presence of dementia or delirium. Medical records were 'flagged' to indicate if a patient was living with dementia.
- Staff received training in dementia. As of 1 April 2017, 84% of medical staff and 97% of nursing staff had received training in dementia awareness.
- An alcohol liaison nurse was available to provide specialist support to patients experiencing alcohol related conditions.
- The emergency department had access to a range of nurses specialising in oncology, diabetes, palliative care and physiotherapists.
- Medical records contained alerts to indicate if a patient was vulnerable or had any additional needs. We saw this alert system in use during our inspection which demonstrated a patient with a learning disability had been identified in a timely manner. This meant that staff had the information required to address the individual needs a patient may have.
- Information leaflets were available in both the adult and paediatric emergency departments. Literature included advice on minor injuries, fractures, head injury and febrile convulsions. All leaflets were available in alternative languages and formats if required.
- Play specialists were available in the paediatric emergency department. Staff helped to provide a child friendly environment and used various techniques to help children cope with any anxieties associated with an illness or injury.
- Information about alternative treatment providers such as minor injury units and walk in centres was clearly visible to visitors. In addition, senior streaming nurses would contact a patient's GP to book an appointment if clinically indicated.
- The clinical decisions unit had both male and female patients during our inspection. The unit was limited in space and due to the patient's transient nature of stay there was a limited opportunity to provide a single-sex ward in this area.
- Patients had access to washing and shower room facilities in the event that their stay on the CDU if required.
- We spoke with a nurse in this area who was aware of the limitations and would try and locate patients in the most sensitive way possible in the aim to maintain privacy and dignity.

Urgent and emergency services

- The department had introduced a new volunteer scheme, which had commenced in July 2017. The aim was to utilise volunteers to help support patients and their families during their time in the emergency department. Their role included attending to the non-clinical needs of patients such as speaking with them, offering support, updating patients on waiting times and providing refreshments.
- Overall, we observed call bells being answered in a timely manner. However, during a period of high demand we saw that a patient call bell rang for ten minutes before being answered.

Access and flow

- The emergency department was not meeting the department of health target which states that 95% of patients who attend should be treated and discharged or admitted within four hours of arrival. Data showed that from April 2016 to March 2017, the trust breached this standard.
- The trust performed worse than the England average against the 95% target however, data showed an improvement in performance since January 2017, with a continual improvement from 87% in January 2017, to 94% in March 2017. The implementation of the rapid treatment and assessment area had resulted in improved performance.
- The percentage of patients waiting between four and 12 hours before being admitted was better than the England average from April 2016 to March 2017. The data also showed an improvement from the months of January 2017 to March 2017 with 12% of patients waiting four to 12 hours for admission in January 2017. This figure had improved by March 2017, where 5% of patients were waiting between four and 12 hours.
- Between the months of April 2016 and March 2017, no patients waited more than 12 hours from the decision to admit (DTA) until being admitted.
- We reviewed ten medical records for evidence of timely decision making in relation to the admission of patients. Records demonstrated that all patients had waited less than 12 hours from the DTA to being admitted.
- From March 2016 to February 2017, the amount of patients leaving the emergency department before being seen for treatment was better than the England

average. Data reveals that the trust performance was consistently better that the England average for this period, ranging between 1% and 2% compared to the England average which ranged between 2% and 3%.
- From the months of March 2016 to February 2017, the average total time spent in the emergency department was consistently higher than the England average. On average, data showed that the average time patients spent in the department was between approximately 170 to 210 minutes, which was worse than the England average of approximately 140 to 160 minutes.
- The CDU was used to receive patients from the major treatment area to aid flow in the department.
- The CDU was used for patients that required further investigations or a period of observation prior to either admission to a hospital ward, or discharge from the department. Over a four-week period in July 2017, the use of CDU avoided 112 admissions to the trust.
- During times of high demand, staff informed patients of waiting times using notice boards. In addition, the department had recently implemented volunteers to keep patients up to date with waiting times and information around delays.
- Senior staff in the emergency department recognised that patient flow was a key issue. In April 2017 the rapid treatment and assessment (RAT) area was redesigned to include further space to effectively assess patients and an additional seating area was implemented. This aided flow from the minors area of the department and provided space for the further care and assessment of patients.
- The RAT area had an ambulatory care area. This enabled patients to be escalated to the assessment area to maintain flow from the waiting area.
- The department had effective processes in place to allow them to manage the access and flow through the department during periods of high demand.
- The status of the department was assessed on an hourly basis. The nurse in charge assessed the department to ascertain if escalation to senior management and bed management was required dependent on the level of alert. Action cards provided clear guidance on the escalation of flow issues to the site team.
- Regular communication with the site management team took place during bed management meetings.

Urgent and emergency services

These occurred on a daily basis at 8.30am, 12.45pm and 4pm. Additional bed meetings were arranged during periods of high demand. The trust utilised an electronic tool to monitor demand, capacity and discharges.

- The nurse in charge of the department updated a daily 'ED governance log' which diarised key events such as the outcomes of bed meetings.
- We attended a bed meeting which showed a broad range of attendance from areas within the hospital. It provided a structured overview to the position of the trust in relation to bed numbers. This enabled the emergency department to have an oversight of available beds within the trust to maintain flow through the department.

Learning from complaints and concerns

- There were 169 complaints between the months of April 2016 and March 2017. The most common complaint themes were staff attitude (22%) and diagnosis complaints (16%).
- Complaints information was shared with staff in the rest room areas. We saw a folder that contained a copy of patient complaints and subsequent responses from the department to provide staff with information to reflect and learn from.
- A senior nurse within the department contacted complainants by telephone to discuss any concerns and to request permission to share complaint details with staff to aid learning. We saw completed telephone logs evidencing that this practice was taking place.
- Staff were involved with the complaints investigation process. On receipt of a complaint, staff received a letter detailing the nature of the complaint and if a statement was required.
- Staff had access to the Trust's complaint policy on the intranet. We reviewed this policy which clearly referenced clear lines of accountability for the complaint handling process.
- Information on how to make a complaint was displayed in patient and public areas.
- Complaints discussion was a standard agenda item at monthly governance meetings. We reviewed meeting minutes which showed discussion of complaints took place and that learning was shared to staff.

Are urgent and emergency services well-led?

Requires improvement ●

We rated well-led as requires improvement because:

- Senior staff felt unsupported; there was a lack of support for senior emergency departmental staff from the executive team.
- Not all risks were identified on the emergency department's risk register.
- Divisional governance meetings and senior staff meetings appeared to lack a standard agenda.

However:

- Local management in the emergency department were supportive and encouraging with staff.
- The emergency department used quality scorecards to monitor performance.
- There was a clear vision in place which staff were aware of.
- Staff reported a good culture within the department, in particular they told us that senior nurses within the department were always approachable and supportive.
- The emergency department had recently implemented public volunteers to provide support to patients and relatives within the department.

Leadership of service

- The emergency department was in the division of medicine and emergency care and led by a head of nursing, divisional director and emergency department interim general manager.
- The emergency department was a part of the division of medicine and emergency care and was led head of nursing, divisional director and head of operations. At the time of our inspection, the clinical director post for emergency care was vacant. At a local level, the emergency department was being led by a matron, senior sister and consultant clinical lead.
- Two nurses told us that senior nurses in trust leadership roles lacked visibility within the department, which left emergency department staff feeling unsupported in their roles.
- Nursing staff were very positive about the matron and sister within the department. They reported that clear

local leadership was in place and that senior nursing staff were visible and supportive. A registered nurse said "I feel really well supported, the senior nurses are always available and easy to talk to if I have any concerns".

- During our inspection, we saw that senior nursing staff were visible and supporting staff in all clinical areas.
- We spoke with staff of various grades and roles about support offered to the emergency department from a senior operational perspective. Whilst we received positive feedback about some operational management within the division, staff raised concerns that they felt unsupported by senior staff within operations and that they didn't feel listened too when escalating concerns.
- Senior nurses within the department told us that they 'supported each other locally'.

Vision and strategy for this service

- The trust's vision was 'to deliver great healthcare to every patient, every day'. The vision was underpinned with three corporate objectives; To act in the best interests of every patient, every day. To support the workforce to look after every patient, every day and to achieve clinical, operational and financial resilience.
- The vision was displayed within the emergency department, in the view of both staff and patients. In addition, the vision and strategy were displayed on the trust's public website.
- We asked three staff if they were aware of the trust's vision. They were all able to articulate the vision and how it was centred on 'every patient, every day'.
- Locally, there was a clear strategy which aligned to the trust's overall vision and strategy. The local strategy detailed the key challenges, priorities and goals for the division over the period of 2017 to 2018.
- The matron was passionate about the delivery of 'every patient, every day' and had clear plans to drive service improvement.

Governance, risk management and quality measurement

- Governance and risk management was overseen by the division of medicine and emergency care.
- The department did not have effective governance and risk measurement processes in place.

- Divisional governance meetings took place every two to three months. We reviewed two set of governance meetings minutes from February 2017 and May 2017 which; there appeared to be no regular standing agenda items therefore meetings lacked structure.
- The February 2017 minutes lacked attendance from staff from the emergency department with only the divisional governance manager in attendance to represent the emergency department. Meeting minutes did not demonstrate that discussion had taken place around key areas such as capacity and flow or serious incidents.
- However, the governance meeting in May 2017 showed an improved attendance with representation from senior medical and nursing staff. It also demonstrated that discussion had taken place around key issues such as serious incidents, staffing and capacity. Senior staff meetings took place on a monthly basis. We reviewed meeting minutes from March, April and May 2017. Whilst the minutes from March 2017 demonstrated good attendance from a range of senior staff, the meeting minutes were limited. There appeared to be no regular standing agenda items for senior staff meetings.
- Meeting content varied from month to month. May 2017 minutes revealed discussion had taken place around the risks of staff shortages and lack of dedicated mental health room. However, minutes from March 2017 and April 2017 lacked key discussion around areas of risk.
- The emergency department had a local risk register. This fed in to the corporate risk register.
- All recorded risks had clear ownership, review dates and actions taken to address each risk. Staff responsible for the oversight of risks within the department included senior nursing staff and senior management staff from the division of medicine and emergency care.
- We reviewed the local risk register. We saw evidence of mitigation for high risks such as capacity and flow with evidence of working with other trust staff and departments such as discharge coordinators and the site team.
- However, the use of three different early warning scoring systems (EWS) for paediatrics was not identified as a risk. Whilst the department was moving towards the exclusive use of paediatric early warning scores (PEWS) at the time of our inspection, there was no oversight or actions plans in place to monitor and mitigate the risk that this posed.

Urgent and emergency services

- In addition, the local risk register did not contain the risks associated with the poor compliance with mandatory training and the lack of appropriate documented triage tool in use.
- We reviewed the divisional risk register. This demonstrated that risks throughout the division had been recorded appropriately for example, nursing and medical staffing vacancy rates within the department.
- Departmental risks were discussed during nursing handovers to ensure that staff were informed of particular risks and challenges the department was facing. We observed a meeting taking place during our inspection and saw that incidents, safety alerts and other relevant information was shared with staff.
- We also spoke with two senior nurses in the department who clearly articulated that staffing and capacity and flow were the two main risks in the department.
- Information on risks was displayed for staff information in the department including information on pressure ulcers and other patient safety information. The emergency department participated in a number of local audits to measure the quality of care, for example, management of pain in the emergency department, end of life care and the documentation of nutrition in medical records.
- The department monitored performance using a scorecard. Results from scorecards fed into the medicine and emergency care division and provided staff with data in relation to pressure ulcers, departmental cleanliness, venous thromboembolism.
- We reviewed the quality score cards from October 2016 to March 2017. Data showed an increased number of hospital acquired pressure ulcers over these months. We saw evidence the department had responded to the increase by the purchase of additional pressure relieving mattresses.

Culture within the service

- A freedom to speak up policy was issued in September 2016. We reviewed the policy and saw that it encouraged staff to feel able to raise concerns without the fear of recrimination.
- Freedom to speak up literature was clearly displayed in staff and public areas.

- We spoke with a middle grade doctor who told us they felt supported in their role and that they were very happy with the consultant support in place, however they felt morale was 'up and down' and depended on how much pressure the department was experiencing.
- This feeling was echoed by a senior nurse who recognised that morale amongst nurses fluctuated, particularly during winter months and periods of high demand in the department.
- The General Medical Council (GMC) conducts a yearly national training survey for doctors in training. Survey results for 2017 showed that the overall satisfaction of doctors in training had declined from 72/100 in 2016, to 61/100 in 2017.
- Areas with results significantly worse that the national average included; supportive environment, reporting systems, curriculum coverage, educational governance and study leave.
- Nursing staff described the department as 'supportive' and that they all 'looked after' each other. They praised the senior nursing team within the department stating that they were always approachable and supportive.
- A locum described how they had seen the department develop and become more 'open to change' over recent months. They gave the examples of the implementation of sepsis care and the RAT area having a positive impact for both staff and patients.
- A doctor told us that the department was 'very friendly, and although busy it was a pleasant place to work'.

Public engagement

- At the time of our inspection, there were no processes in place for public engagement in to the department. Plans were in place to establish a patient experience working group however there was no planned date of implementation due to long term sickness in the department.
- Feedback cards were available in the reception and waiting area for patients to complete and submit.
- Information about the emergency department was provided for patients on their external website. Patients, carers and the public could nominate the people that they felt had made positive contributions through the completion of an online survey.
- The department displayed 'you said, we did' notice boards to inform patients and visitors of changes that had occurred as a result of patient feedback.

Urgent and emergency services

Staff engagement

- Staff could attend 'five topics of the day' meetings to hear information on various subjects. This provided staff with an up to date overview of any issues in the department and allowed for dissemination of any other pertinent information.
- Staff commendations from the chief executive officer were displayed in the staff restroom area. This provided staff with positive feedback by recognising occasions where good care had been provided. Staff or patients could nominate an individual that they felt had provided a positive contribution.
- A nurse told us that all staff celebrating a birthday were invited to a breakfast event to meet with the executive team.

Innovation, improvement and sustainability

- The trust had recently introduced an innovative way to monitor compliance with sepsis response and treatment. A new sepsis compliance assistant had been implemented to ensure the timely identification, treatment and auditing of patients with sepsis.
- The department of Health (DoH) had agreed additional funding for the provision of a GP streaming unit for the emergency department to help meet the 95% standard of admitting, transferring, or discharging patients within 4 hours by ensuring patients are treated in the most appropriate setting during 2018.

Medical care (including older people's care)

Safe	**Requires improvement**	🟠
Effective	**Good**	🟢
Caring	**Good**	🟢
Responsive	**Good**	🟢
Well-led	**Good**	🟢
Overall	**Good**	🟢

Information about the service

The medical care service at the trust provides care and treatment as part of the medicine division and cancer services. Specialties included gastroenterology, respiratory, cardiology, rheumatology, neurology, dermatology, endocrinology, care of the elderly, stroke, oncology and, haematology.

Colchester General Hospital has 395 medical inpatient beds and 19 day-case beds located across 20 units and wards.

The trust had 45,361 medical admissions between February 2016 and January 2017. Emergency admissions accounted for 20,758 (46%), 422 (1%) were elective, and the remaining 24,181 (53%) were day case.

Admissions for the top three medical specialties were:

• General Medicine: 15,287

• Clinical Oncology (previously Radiotherapy): 8,448

• Gastroenterology: 6,122

During this inspection we visited 14 wards including Acute Medical Unit, Peldon ward, D'Arcy ward, Birch ward, Tiptree ward, the Stroke Unit, Endoscopy, and Elmstead ward amongst others.

We used a variety of methods to help us gather evidence in order to assess and rate the medicine services at Colchester Hospital. We spoke with 26 patients and relatives, 66 members of staff including nurses, doctors, therapists, health care assistants, discharge coordinators, the director of nursing, and non-clinical staff amongst others.

We also reviewed 36 patient records including records in relation to patient medication during this inspection. We observed the environment and the care of patients, and reviewed medical and nursing documentation including patient care records. We also looked at a wide range of documents, including policies, minutes of meetings, action plans, risk assessments, and audit results.

Medical care (including older people's care)

Summary of findings

We rated this service as good because:

- Staff knew how to report incidents and deal with complaints.
- There were clear procedures for managing and referring safeguarding concerns in relation to children and adults who may be at risk of abuse. Staff we spoke with knew how to make a referral and who to refer their concerns to within the trust.
- We reviewed 36 patient records and found all risk assessments were completed, national early warning scores (NEWS) and risk assessments clearly documented.
- Staff adhered to the trust hand hygiene and 'bare below the elbow' policy, and wore personal protective equipment such as gloves and aprons during care.
- Staff used national early warning scores (NEWS) on the medical wards to monitor and identify any deteriorating patients. All records we reviewed showed that staff routinely completed NEWS and alerted senior staff to any patient that may be deteriorating.
- The trust had dedicated care pathways for both dementia and Parkinson's disease.
- The trust takes part in the quarterly Sentinel Stroke National Audit programme (SSNA). On a scale of A-E, where A is best, the trust achieved grade A in the latest audit, December 2016 to March 2017.
- The trust results in the 2015 Heart Failure Audit were better than the England and Wales average for all four of the standards relating to in-hospital care.
- The proportion of non-ST- elevation infarction (nSTEMI) patients referred for, or that had, angiography at the trust was 95.3%, which was better than the England average of 79%.
- Ward teams had access to a range of allied health professionals and team members described good collaborative working practices between the teams. There was a joined-up and thorough approach to assessing the range of patients' needs and a consistent approach to ensuring assessments were regularly reviewed and up to date.

- The Friends and Family Test (FFT) response rate for medicine at the trust was 49%, which was better than the England average of 25% between March 2016 and February 2017.
- During our inspection we spoke with 12 patients and 14 relatives, all, with the exception of one family were consistently positive about their experience of care and support at the hospital.
- Staff respected and recognised patients' individual needs and choices at all times. Staff utilised care plans and person centred planning to respect patient decisions and promote choices in order to provide holistic care.
- Patients on the stroke unit had access to psychological support, and could be sign posted to specialist counselling services where appropriate.
- The trust had significantly invested in the recruitment of discharge co-coordinators who worked across the wards to promote the safe and timely discharge of patients.
- Between February 2016 and January 2017, the average length of stay for medical elective patients at the trust was 3.6 days, which is lower than England average of 4.2 days.
- The following specialties were better than the England average for admitted Referral to Treatment Times (RTT) (percentage within 18 weeks), geriatric medicine, neurology, and rheumatology.
- Local leaders, for example ward sisters and matrons were highly respected by staff we spoke with and staff felt respected and engaged with the services.
- The trust had action plans in place to address performance issues, for example in relation to the National Diabetes Inpatient Audit (NaDIA).
- All nursing staff we spoke with knew what the localised risks were and the risks on the medicine risk register.
- We found a strong culture of multidisciplinary staff working on the wards we visited
- Staff said that the senior leadership team held open forums, and that often the Chief Executive Officer would go onto the ward areas, sometimes as early as 6am to see the patients and staff.

However:

Medical care (including older people's care)

- Data supplied by the trust from April 2017 showed the majority of wards within the medicine division were below the trusts identified staffing requirements. This issue was on the trusts corporate risk register and potentially impacting on patient care, for example the number of patient falls, and medication omissions.

- Data supplied by the trust showed a high level of patient falls on medicine wards between January 2017 and June 2017. Although staff had begun to cohort patients, the impact of this practice was still under review and patient falls were still occurring in some areas of the service in July 2017.

- Between January and June 2107, there had been 84 occasions where staff omitted patient medication on Peldon ward, this improved following a change of ward management and focused improvement plan.

- There were low rates of training compliance for medical and dental staff in respect of mandatory safeguarding courses with Safeguarding looked after children compliance the lowest at 48%.

- We found instances where staff did not follow the trust policy on Mental Capacity Act (MCA) or Deprivation of Liberty Safeguard (DoLS). We highlighted this to the staff and action was taken immediately.

- The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 65.7%, which did not meet the audit minimum standard of 90%.

- The trust did not participate in the National Audit of Inpatient Falls during 2016-2017.

- The trust was not JAG (Joint Advisory Group on Gastrointestinal Endoscopy) accredited at the time of our inspection.

- Trust figures provided prior to inspection showed an increase from the previous year in the number of patients having two or more ward moves, particularly in patients with two moves, which increased from 14% to 20%.

- We reviewed clinical governance meeting notes from 2 March 2017 and noted the previous meeting was in November 2016, some three months previous. We noted that governance was key issue on the corporate risk register.

- The following specialties were above the England average for admitted RTT (percentage within 18 weeks), geriatric medicine, neurology, and rheumatology. Some staff we spoke with felt there was unnecessary pressure placed on them to take and discharge patients from the wards and that at times this was uncomfortable for them to manage.

- The majority of staff we spoke with on the wards were unaware of any local vision or strategy held by the trust in relation to the medical division. However, all staff said that they aimed to put the patients first.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement ●

We rated safe as requires improvement because:

- Data supplied by the trust from April 2017 showed the majority of wards within the medicine division were below the trusts identified staffing requirements. This issue was on the trusts corporate risk register and potentially impacting on patient care, for example the number of patient falls, and medication ommisions.

- Data supplied by the trust showed a large number of patient falls on medicine wards between January 2017 and June 2017. Although staff had begun to cohort patients, the impact of this practice was still under review and patient falls were still occurring in some areas of the service in July 2017.

- Between January and June 2107, there had been 84 occasions where staff omitted patient medication on Peldon ward. Staff actively sought to reduce these at the time of our inspection.

- Data supplied by the trust showed that in April 2017, the percentage of patients receiving the Sepsis six care bundle within one hour was 50.7%, which is below the trust target of 100%. In May 2017, compliance rose slightly to 51.9% and increased again in June 2017 to 60.7%.

- There were low rates of training compliance for medical and dental staff in respect of mandatory safeguarding courses with Safeguarding looked after children compliance the lowest at 48%.

- Data supplied by the trust prior to inspection showed issues with attendances of medical and dental staff, with a quarter of modules having less than 70% attendance rate.

However:

- Staff knew how to report incidents and deal with complaints and there was a learning culture within the medicine division.

- There were clear procedures for managing and referring safeguarding concerns in relation to children and adults who may be at risk of abuse. Staff we spoke with knew how to make a referral and who to refer their concerns to within the trust.

- We reviewed 36 patient records and found all risk assessments were completed, national early warning scores (NEWS) and risk assessments clearly documented.

- Staff adhered to the trust hand hygiene and 'bare below the elbow' policy, and wore personal protective equipment such as gloves and aprons during care.

- Staff used national early warning scores (NEWS) on the medical wards to monitor and identify any deteriorating patients. All 36 records we reviewed showed that staff routinely completed NEWS and alerted senior staff to any patient that may be deteriorating.

Incidents

- Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

- Between May 2016 and April 2017, the trust reported one incident which was classified as a never event for medicine. The incident in June 2016 was classified as a diagnostic incident including delay, meeting the serious incident (SI) criteria (including failure to act on test results). The trust carried out a root cause analysis of the SI and took actions taken to mitigate the risk of a similar reoccurrence. We saw that learning from the never event was contained within learning and governance folders on the ward.

- In accordance with the Serious Incident Framework 2015, the trust reported 29 serious incidents in medicine, which met the reporting criteria set by NHS England between June 2016 and May 2017. Of these, the most common type of incident reported were slips, trips, falls meeting serious incident (SI) criteria (31%).

- All staff we spoke with knew how to report incidents on the trust electronic reporting system and stated that they received feedback from any incidents via email, monthly newsletter, from their line manager and at team meetings. Staff also said that they were actively encouraged to report incidents by their managers, to enable learning and to ensure incidents were minimised in the future

- On all the wards we visited, the ward sisters stored learning from incidents in a governance and learning folder. Feedback on the incident included what went wrong, the method of reporting and all actions taken by the trust to prevent the incident happening again.

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- The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. All nursing and medical staff we spoke with knew what the duty of candour was and that it was about being open and transparent when things go wrong.
- The trust held monthly mortality and morbidity meetings that included a wide range of multi-disciplinary support. We reviewed the mortality and morbidity notes from March 2017 and found these to be comprehensive. However, the majority of staff we spoke with said they had limited opportunity to attend the meetings on a regular basis, due to staffing constraints on the wards.

Safety thermometer

- The 'Safety Thermometer' is used to record data relating to the number of patient falls, pressure ulcers, catheter and urinary tract infections and venous thromboembolism (VTE). Data collection takes place one day each month, a suggested date for data collection is given but wards can change this. Staff must submit data within 10 days of suggested data collection date.
- Data from the patient safety thermometer showed that the trust reported 18 new pressure ulcers, 8 falls with harm, and 33 new catheter urinary tract infections between April 2016 and April 2017 for medical services.
- Data supplied by the trust showed that between April 2017 and June 2017, VTE risk assessment completion across medicine wards was above the trust compliance rate of 95%. Compliance was 96.7%, 96.1%, and 96.5% respectively.
- Data supplied by the trust showed that between April 2017 and June 2017, VTE prophylaxis compliance across medicine wards was above the trust compliance rate of 95%. Compliance was 98.8%, 98.8%, and 98.4% respectively.
- The trust was in the process of implementing a heat map system, which was not fully implemented at the time of our inspection. The heat map showed where incidents were more prevalent and enabled staff to identify issues of concern and trends in safety performance.

- All of the wards we visited used the green safety cross system to record performance against pressure ulcers, medication omissions, Methicillin-resistant Staphylococcus Aureus (MRSA), C-diff, complaints and incidents relating to patient falls where no harm occurred.
- Falls prevention was a recognised area of focus on all medical wards. Data provided between January and June 2017 showed improvement across a number of areas. For example on D'Arcy ward between January 2017 and June 2017, there had been 11 patient falls. However, between 1 July and 25 July 2017 staff reported no patient falls, showing an improvement within that month.
- During the same period, there had been 31 patient falls on Peldon ward. However, this had reduced to one patient fall in July 2017, showing an improvement within that month. On Easthorpe ward, 15 patient falls occurred between January 2017 and June 2017. In the same period, 18 patient falls occurred on the acute cardiac unit (ACU). However, this had reduced to one patient fall on Easthorpe ward and the ACU respectively during July 2017, showing an improvement within that month.
- On Layer Marney ward between January 2017 and June 2017 there had been 43 patient falls, this reduced to two patient falls in July 2017, showing an improvement within that month. Staff we spoke with explained that there had been a shift in staffing and responsibilities on the ward during April 2017, and that a temporary ward leadership structure implemented to address performance in relation to patient safety issues.
- On the Emergency Assessment Unit (EAU) the safety cross system showed between 1 July 2017 and 25 July 2017, there were 10 patient falls.
- Data supplied by the trust showed between May 2016 and May 2017, nine patient falls led to harm. Two incidences occurred in May 2016, one in October 2016, two in November 2016, one in December 2016 and a further three incidences in February 2017.
- We reviewed the route cause analysis (RCA) of three SI's involving falls, held within the governance and learning folders. All of the SI's had been thoroughly investigated, and detailed the recommendations and actions taken to minimise events in the future. Staff could access the

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governance and learning folder at any time and SI's were discussed at team meetings and where necessary in supervision with staff to increase staff understanding of SI's.

- We spoke with a senior member of staff in relation to the prevalence of falls within medicine. They informed us that in all cases where staff reported a patient fall via the trusts electronic reporting system an investigation with the hospitals falls prevention nurse took place to establish if patient harm occurred. If patient harm did occur, staff escalated incidents appropriately in line with the trusts safeguarding adult's policy.

Cleanliness, infection control and hygiene

- We found during the inspection that on D'Arcy ward patients who may pose an infection risk were cohorted with other patients, as all isolation rooms on the ward were in use. Staff assessed the risks of these patients with the infection control team, and placed the patient next to hand washing facilities with clear signage warning of the risk of infection.

- On the emergency assessment unit (EAU), one member of the domestic team was not wearing safety shoes, uniform, personal protective equipment, or hospital identity badge (ID) whilst engaged in domestic activities. We immediately brought this to the attention of the senior nurse in charge. During our inspection, we noted three of the domestic staff not wearing hospital uniform, personal protective equipment (PE) or safety shoes, engaged in house cleaning activities.

- We spoke with three domestic staff during our inspection. We noted they were continually engaged in cleaning activities, frequently emptying waste bins during the course of the day and that the environments we visited were visibly clean. However, despite all the wards we visited being visibly clean, none of the domestic staff could show us a cleaning schedule, one of them said, "It's in my head I have done it that long."

- On all wards we visited staff used the safety cross system to show performance in relation to Methicillin-resistant Staphylococcus Aureus (MRSA) and C-difficille (C-diff). The majority of wards showed no incidences of Methicillin-resistant Staphylococcus Aureus (MRSA) between January and July 2017, with Peldon ward showing only one incidence of C-Diff in January 2017.

- Nursing and medical staff adhered to the trust hand hygiene and 'bare below the elbow' policy, and wore personal protective equipment such as gloves and aprons during care.

- Staff washed their hands in line with the World Health Organisation's "Five Moments of Hand Hygiene" guidance between personal care activities with patients and utilised the hand sanitiser where appropriate.

- Hand hygiene audits carried out by the trust on five areas within the medicine division showed that in June 2017, they achieved 100% with hand hygiene compliance. These included Layer Marney ward, Easthorpe ward and the acute cardiac unit amongst others.

- Staff explained the protocol for patients with possible infectious disease and demonstrated they had good understanding of infection, prevention, promotion, and control in their day-to-day activities with patients.

- Hand sanitiser was available at the entrance to each ward area and clear signage was in place asking all staff and visitors to wash their hands and to follow the trust policy on infection prevention, protection, and control when entering or leaving wards or departmental areas. However, on Birch ward and the Stroke Unit, we found hand sanitizers on entry to the wards, which were empty.

- All wards we visited had an abundant stock of cleaning and sanitising equipment and key guidance for staff and patients on infection prevention, protection, and control was available at all hand washing areas.

- Staff utilised green 'I am clean' stickers across the wards we visited stating that staff had cleaned and checked equipment and that it was clean and safe to use.

- In March 2017, the trust carried out an environmental hygiene audit of the Gainsborough clinic areas, which achieved a 98.1% compliance rating. Items checked included commodes, bathroom hoists, weighing scales, and drip stands amongst others.

- Data supplied by the trust showed that staff carried out Methicillin-resistant Staphylococcus Aureus (MRSA) screening on both elective and non-elective patients within the medicine division. In April 2017, staff screened 43.6% of elective patients, in May 2017 46.5% and June 2017 32.8%. In April 2017, staff screened 77% of non-elective patients, in May 2017 81.4% and June 2017 85.6%. Both non-elective and elective patient screening was below the trust 95% compliance target.

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Environment and equipment

- We examined equipment check labels, for example on airflow mattresses, blood pressure monitors, hoists and patient monitoring equipment, amongst others. Staff from the hospitals EBME (Electrical and Biomedical Engineering) team serviced equipment within the medicine wards and we found no out of date equipment during our inspection.

- On the majority of wards, we found staff completed daily safety checks on resuscitation trolleys between January 2017 and July 2017, with no omissions. However, staff did not check Birch ward resuscitation trolley on the 15, 19, 20 June 2017, and the 1 and 15 July 2017.

- We spoke with staff who explained they open the resuscitation trolleys once a month to check medication expiry dates and ensure stock is of the correct type and volume.

- We noted on the medical day unit (MDU) that staff routinely checked the sepsis trolley between May and July 2017, except on the 22 and 23 June 2017, which staff omitted. All the equipment on the trolley was safely stored, packaging clean and intact.

- Patient trolleys, equipment, and curtains providing privacy appeared visibly clean throughout the wards. Curtains displayed an expiry check date and we found all curtains to be within service date and in good condition.

- All wards utilised signage to identify the nurse in charge, the number of staff planned and actual staff on duty. Signage was clear and enabled staff, patients and relatives to see the number of staff on duty, identify staff roles, and see who was in charge of the department.

- Staff managed clinical waste in line with trust guidance. Waste bins were appropriately colour coded for the appropriate waste disposal method and we noted bins routinely emptied by domestic staff during our inspection.

- In the Endoscopy unit, we found that all four endoscope washing units were fully functioning. One of the machines was not in use, as it was in a decontamination process. The machines were near the end of their working life cycle and new machines had been placed on order.

- We checked the equipment in the endoscopy dirty utility room and found all equipment serviced and reviewed in May 2017 including the dryers.

- At our last inspection of Endoscopy in September 2015, the decontamination process was inconsistent across all areas where endoscopes (an instrument introduced into the body to give a view of its internal parts) were processed. The decontamination process ensures equipment is safe, clean and disinfected or sterilised to control the spread of microorganisms.

- During this inspection, we found staff carried out decontamination processes correctly and completed protein testing consistently across all three areas. Endoscopes undergo additional checks for the effectiveness of the cleaning process by using a protein testing kit to swab the scopes. This detects any protein residue following the decontamination process; a protein residue would indicate the decontamination process had not been successful and may therefore, present an infection control risk to other patients.

- The Endoscopy department provided separate changing areas for male and female patients and the environment was visibly clean.

Medicines

- Mandatory training for staff included controlled drugs training, with an expected compliance rate of 95%. Layer Marny ward, Peldon ward and Elmstead ward amongst others, showed a 100% compliance rate. However the EAU was 85% compliant, Easthorpe ward 94% and D'Arcy ward 92%.

- We found that there were effective systems in place for medicine management with regard to handling, storage, and security of medicines. On all the wards we visited, staff stored medication in locked rooms, neatly within cupboards and visibly clean.

- Controlled drugs (CD) records were legible and dated by nursing staff without any omissions and CD's were stored securely in an appropriate cupboard within the medicines storage rooms.

- We found the books for recording fridge temperatures on all wards were well maintained and completed daily with no omissions. For example on D'Arcy ward and Easthorpe ward amongst others, staff recorded the refrigeration temperatures between January 2017 and 25 July 2017, with no omissions.

- On the stroke unit, the ward sister had installed digital key pads enabling staff to enter storage cupboards via a single digital pushbutton code. This meant staff did not have to carry keys on the ward or be responsible for handing keys in and out. This sped up access to

medication and reduced the risk of keys being lost or left on the ward by staff. At the time of our inspection, the ward sister was writing a standard operating procedure for the management of the system, including key code changes on a routine basis.

- We observed medication rounds and found these to be well managed, calm and staff always carried out appropriate checks before dispensing or administering medication to patients.
- Staff wore red disposable aprons reminding staff and patients not to disturb staff whilst doing the medication round and followed the five "R's" - checking the right patient, the right drug, the right dose, the right route, and the right time when supporting patients.
- We observed one member of staff on D'Arcy ward who was particularly supportive of a patient, who became confused at the time of medication administration. The staff member sat with the patient, allowed them time to discuss the medication, check their own wristband and patient medication chart prior to administering the medication in order to reassure the patient.
- We reviewed 31 patient medication records and found that all were accurate, and reflected the needs of the patients. However, between January and June 2107, the green safety cross system showed there had been 84 occasions where staff omitted patient medication on Peldon ward. Staff actively sought to reduce these at the time of our inspection. Between May and June 2017 these had reduced to six omitted medicines following a change of ward management and a focused improvement plan.

Records

- We reviewed 36 patient records as part of this inspection. Staff kept patient records either outside the patient's room, or at the end of the patient's bed and in a records trolley meaning records were not secure at all times.
- Staff completed risk assessments and reviews frequently during the patient's admission. Risk assessments included Early Warning Scores (EWS), Malnutrition Universal Screening Tool (MUST), Braden Scale, and falls risk assessments amongst others.
- We found good evidence of multidisciplinary team recording in patient records, to provide accurate details of care pathways needed to ensure consistency of care.

Safeguarding

- The trust set a target of 95% for completion of safeguarding adults and children training.
- Medical and dental staff within the medical service at the trust did not achieve the target of 95% for any of the safeguarding courses. Safeguarding looked after children compliance was the lowest at 48%.
- Nursing and midwifery staff within the medical core service at the trust achieved the target of 95% for five of the nine safeguarding courses. Safeguarding looked after children, safeguarding children level 3 and level 3 update had the lowest compliance rates, at 35% and 10% respectively.
- There were clear processes and procedures in place for safeguarding adults and children, accessible through the trust's electronic system. Staff we spoke with knew how to recognise abuse and make a referral to the safeguarding lead.
- We spoke with a junior doctor, middle grade doctor and a consultant, all knew the safeguarding referral process. They explained how they would use a range of resources, for example pictorial symbols, typing concerns out for patients and involving speech and language therapists for patients who may be nonverbal but wished to raise a concern.
- All of the nursing and health care assistants we spoke with knew how to raise, record and escalate a safeguarding concern. Staff we spoke with gave examples of the types of abuse, for example domestic violence, neglect, sexual and psychological abuse.
- Staff within the trust had dedicated information boards within the ward areas, offering advice and guidance to staff on recognising and responding to abuse.
- Data supplied by the trust showed two safeguard concerns raised in relation to care on wards during July 2017, one in relation to alleged neglect and one alleged financial abuse. The trust monitored safeguarding allegations and provided reports to the trust governance teams, to ensure transparency regarding safeguarding concerns.

Mandatory training

- The trust set a target of 95% for completion of mandatory training. Data supplied by the trust prior to inspection showed serious issues with attendances with doctors medical and dental staff, with a quarter of modules having less than 70% attendance rate and no modules hitting the 95% target.

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- Data supplied by the trust prior to inspection showed that attendance rates for nursing and midwifery staff varied greatly. Staff achieved above the 95% compliance rate for falls prevention, record keeping, Sepsis, dementia awareness, and diversity awareness.
- However, in the main mandatory training was below the 95% compliance rate set by the trust, this included incident reporting and risk assessments, health and safety, adult basic life support, manual handling and immediate life support for adults amongst others.
- The majority of nursing and health care assistants staff we spoke with said it was hard for them to access training due to staffing issues in the main and the lack of computer access on the wards. Staff did say they could complete training on line at home, however they said this affected their home and work life balance so struggled to complete the required training.
- Most training was offered via E-Learning packages, however some were face-to-face, but again staff we spoke with said this was limited due to staffing issues.

Assessing and responding to patient risk

- Staff used national early warning scores (NEWS) on the medical wards to monitor and identify any deteriorating patients. All records we reviewed showed that staff routinely completed NEWS and alerted senior staff to any patient that may be deteriorating.
- Data supplied by the trust showed NEWS documentation audits for April 2017 to June 2017 were above the trust 95% compliance rate at 97.4%, 97.6%, and 96.7% respectively.
- Guidance on the use of NEWS and the sepsis bundle was available at all staff workstations and all staff we spoke with knew the escalation process for any patient seen to be deteriorating.
- The trust had a focus on sepsis and this was included in work stream for the every patient everday. The trust set a target of 100% compliance target to ensure that patients who present with neutropenic sepsis receive treatment within one hour. Data supplied by the trust showed in April 2017 compliance was 76.5%, in May 2017 this dropped to 53.3%. However, the trust achieved 100% compliance in June 2017.
- Data supplied by the trust showed that in April 2017, the percentage of patients receiving the sepsis six care

bundle within one hour was 50.7%, which is below the trust target of 100%. In May 2017, compliance rose slightly to 51.9% and increased again in June 2017 to 60.7%, both below the 100% compliance target.
- Due to a high level of patient falls on medicine wards between January 2017 and June 2017, staff had introduced a 'bay watch' system and cohorted patients at higher risk of falls or requiring increased observation into designated bays within the wards.
- The trust provided a 24 hour, seven day a week acute stroke unit to ensure staff monitored patients at risk appropriately.
- Staff held daily safety handovers that included discussions on patients at risk, where they were located in the ward or hospital and actions required to manage any specific risks.
- Staff we spoke with explained how they would contact the outreach team if a patient deteriorated suddenly or if the patient NEWS score was above five.
- Staff held a "Two at the top" meeting, once per month. The meetings involved the senior nurse and a doctor, (the two at the top) to discuss issues in relation to patient incidents, risks on the ward and general issues affecting risk and patient safety.
- The EAU had a 'high observation bay' used by staff to cohort patients who had a NEWS score of greater than or equal to five or, patients requiring a defined level of care of two in accordance with the Intensive Care Society's guideline 'Levels of Critical Care for Adult Patients (revised 2009)'.
- The 'high observation bay' was staffed appropriately, with one registered nurse to two patients at all times. Consultants carried out rounds twice a day and the team had access to specialist medical registrar and the intensive care outreach team in the case of a patient suffering sudden deterioration.
- During our last inspection in September 2015, on the medical day unit (MDU) and the emergency

assessment unit (EAU) we had concerns about the length of time patients were laying on trolleys. During this inspection, staff transferred all patients to a bed in a timely manner and we found no patients waiting on a trolley.

- Staff we spoke with on the MDU explained that they monitor the time patients spend on trolleys from arrival and aim to keep this to a maximum six-hour period. All elderly or at risk patients are assessed for the risk of

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developing pressure damage during this period. The trust had a dedicated standard operating procedure to guide staff on transferring patients from a trolley to a bed, including key times to carry out checks on patient wellbeing.

- The dementia care nurse specialists (DCNS) are notified of every patient over 75 admitted as an emergency via the dementia assessment tool (DAT) daily. All the patient are assessed as per FAIR (Find, Assess and Investigate, Refer) utilising the DAT tool for dementia and delirium.

- Local audit activity in endoscopy included an audit of the World Health Organisation (WHO) surgical safety checklist. Audit results for June 2017 demonstrated 95% compliance with this checklist, and 100% compliance in July 2017. The lack of compliance in June 2017 was due to staff failure to complete the form correctly.

Nursing staffing

- The trust was compliant with imposed requirements following our previous inspection in regard to staffing in the emergency assessment unit. A ratio of one staff to six patients was maintained, with a risk assessment process in place should a situation occur where staffing dropped below this level.

- Staff utilised the "Safer Nursing" acuity tool to allocate staff based on patient acuity.

- Most of the wards we visited had vacancies for either registered nurses (RN) or health care assistants (HCA). We noted during our inspection that the majority of wards were understaffed against the planned establishment; in these cases, the trust employed agency or bank staff. Staffing and recruitment was a recognised risk on the trusts risk register.

- Data supplied by the trust from April 2017 showed the majority of wards within the medicine division were below the required nurse staffing requirements with a reported vacancy rate of 24%. Between May 2016 and April 2017, the trust reported a staff turnover rate of 16% and a sickness rate of 3.8%.

- The trust were actively recruiting to various nursing roles, and utilising bank and agency staff to fill any gaps in working rotas. Bank and agency usage was 12% between May 2016 and April 2017. We spoke with nursing staff who told us that they had actively been engaged in supporting the trust with its recruitment processes, including travelling abroad to recruit nurses internationally, and via skype interviews.

- The hyper acute stroke unit (HASU) nurse staffing did not meet guidance Royal College of Physicians: National clinical guideline for stroke. We had identified this at our last inspection in September 2015. At the time of our inspection, the trust was actively seeking to recruit into any vacant posts.

- The skills mix on the acute cardiac unit was also a recognised risk. This was due to the lack of experienced and qualified cardiac nurses in post. The trust were engaged in looking at other alternatives such as recruitment of newly qualified staff that could be trained to a higher level, in order to support patients and the staff team.

- We spoke with some staff who told us they often moved to other wards due to staffing levels and they felt this was unfair on their regular teams. Staff appreciated they had to move and all received an induction to the wards they moved to, but they felt the staffing levels should be correct and managed to avoid staff having to be moved frequently.

- At the time of our inspection, the endoscopy team had a number of staff vacancies across all levels of nursing staff. Staff we spoke with explained that the staff recruitment process was staggered to induct new staff appropriately into the department.

- We observed a nursing handover, and found this to be comprehensive and focused on the patient and their individual needs whilst ensuring that staffing levels met patient acuity.

- We observed the daily stand up meeting; this happened every day at midday, at the huddle notice boards on the ward areas. These were comprehensive and covered issues such as governance, bed issues, and staffing levels and were attended by matrons, and service leads amongst others.

Medical staffing

- As of April 2017, the trust reported a medical staffing vacancy rate of 14% in medicine, a turnover rate of 9% and a sickness rate of 0.8%. As a result between April 2016 and March 2017, bank and locum usage rates were variable in medicine although were predominantly between 0% and 20%.

- In January 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was higher.

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- All medical wards had a dedicated level of medical cover on a daily basis. Acute physicians provide consultant cover between the hours of 8am to 10pm seven days per week alongside two consultants working from 1pm to 4pm. From 4pm to 10pm one in-reach care of the elderly consultant is available, a speciality cardiology and gastroenterology consultants, who reviews appropriate patients between 9am to 12pm, also provides support.
- Staff access an on-call consultant who is available from home 10pm to 8am and an on-call registrar 8.45am to 9.15pm on rotational basis from acute wards, this is mirrored by an on call registrar 9pm to 9.30am.
- Medical doctors on call from FY1 (FY1 enables medical graduates to begin to take supervised responsibility for patient care and consolidate the skills that they have learned at medical school) grade to speciality trainees (ST), general practitioners (GP), or core medical trainee (CMT) level, provide the remainder of the medical cover:
- Weekend consultant cover included three consultants, one 8.45am to 1.15pm covering Nayland ward and outliers and acute patients, second consultant 8am to 5pm and third 8am to 1pm returning at 5pm to 10pm, this rotates the following day. The on-call registrar is available as per weekdays and a patient safety registrar available 8.45am to 9pm.
- In the majority of clinical areas, consultants reviewed patients on a daily basis from Monday to Friday and all new admissions are seen by a consultant at weekends.
- In the stroke service, there was a consultant ward round five days per week and on Saturdays and Sundays, the on call team were available to review patients.
- We spoke with an FY1 doctor who said that the day shift on call rota was not stretching in terms of workload. However, if any member of the team was missing for any reason on the night shift, this could cause issues with meeting patient needs.
- We spoke to a respiratory consultant on Layer Marney ward, who told us that consultant to patient ratio currently was less than planned. The consultant said there were concerns regarding workloads at busy times and general concerns regarding recruitment and retention amongst the consultants. Data provided by the trust after the inspection stated that there were 4.6 wte consultants in post with funding for five, however to support the gap a registrar was on the ward full time.

- Handovers were comprehensive and included reviews of any patients deemed as high risk due to their condition, or likely deterioration.
- We observed the 8.45am handover meeting, led by a consultant. The meeting focused on patient admissions and changes overnight. The meeting was also utilised as an opportunity to remind staff of specific aspects of practice, such as appropriate prescription of oxygen and escalation for sepsis.

Major incident awareness and training

- Data supplied by the trust prior to inspection showed from April 2017, 209 staff had completed local major incident training within the medicine division, compared to a required 153 staff, giving a completion rate of 137%.
- We spoke with staff on the ward areas, all of them knew the process for escalation of a major incident.

Are medical care services effective?

Good ●

We rated effective as good because:

- The trust had dedicated care pathways for both dementia and Parkinson's.
- The trust regularly reviewed the effectiveness of care through the collection and monitoring of patient outcomes and participation in local and national audit.
- The trust participated in the quarterly Sentinel Stroke National Audit programme (SSNA). On a scale of A-E, where A is best, the trust achieved grade A in the latest audit, December 2016 to March 2017.
- The trust results in a number of cardiac audits for inpateints was better than the England average, however there was some varibality in relation to discharge, . These included the heart failure audit and the non-ST- elevation infarction (nSTEMI) audit.
- Ward teams had access to a range of allied health professionals and team members described good collaborative working practices between the teams. There was a joined-up and thorough approach to assessing the range of patients' needs and a consistent approach to ensuring assessments were regularly reviewed and kept up to date.

However:

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- The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a cancer nurse specialist was 65.7%, which did not meet the audit minimum standard of 90%.
- We found some guidance out of date.
- As of April 2017, 76% of staff within medicine at the trust had received an appraisal.
- We found instances where staff did not follow the trust policy on Mental Capacity Act (MCA) or Deprivation of Liberty Safeguard (DoLS). We highlighted this to the staff and action was taken immediately .

Evidence-based care and treatment

- On the stroke unit nursing and medical staff, assessed patient needs, care, and treatment in line with the National Institute for Health and Care Excellence (NICE) quality standard CG58 Stroke: Diagnosis and initial management of acute stroke and transient ischaemic attack (TIA).
- Across the division of medicine, staff followed NICE guidance (CG92) in the assessment and management of venous thromboembolism (VTE).
- We reviewed 31 medication prescription charts, all of these demonstrated where patients had received a venous thromboembolism (VTE) risk assessment and had prophylactic venous thromboembolism (VTE) medication if indicated.
- At our last inspection in September 2015, we did not see care pathways in place for the management of those patients with long-term conditions for example Parkinson's or dementia. However, we found at this inspection that the trust had made significant improvements in this area and had dedicated care pathways for patients living with both dementia and Parkinson's.
- Local policy and procedure guidelines for all specialties were available on the trust intranet and were easily accessible by all members of staff.
- We found some guidance out of date, for example Dopamine approved 2008, for review March 2012, and Doubutamine approved 2008, for review 2010, amongst others.
- Local audits were taking place in the medicine division, for example hand hygiene, the assessment of deep vein thrombosis (DVT) and venous thromboembolism (VTE) and national early warning scores (NEWS), amongst others.

- In the Endoscopy department, staff completed a number of audits including, the World Health Organisation (WHO) checklist, cleaning audits, and gastrointestinal bleed audits, amongst others.

Pain relief

- We reviewed 36 patient care records during our inspection, staff routinely recorded the patient's level of pain on the early warning score chart in line with the Faculty of Pain Medicine's Core Standards for Pain Management (2015) 1-10 pain score.
- Staff asked patients to rate their pain each time they took their physiological observations and staff assessed patient pain. Staff completed pain charts appropriately in all patient notes we reviewed.
- A review of 31 medication prescription charts demonstrated staff gave patients pain relief where appropriate and at regular intervals.
- During the inspection, we noted staff routinely speaking with patients, asking if they were comfortable, in any pain or needed repositioning or extra pain relief where appropriate.

Nutrition and hydration

- The medicine wards used a 'red tray' system to identify patients who needed help with eating. This enabled staff to identify and monitor those patients who needed encouragement or special diets in order to maintain their well-being.
- We reviewed 36 patient records and found that in all cases where it was appropriate, a malnutrition universal screening tool (MUST) score had been completed and patients fluid and diet charts completed.
- Staff identified patients who needed encouragement with their fluid intake by serving fluids in a water jug with a red top. This enabled staff to identify patients likely to be at risk of dehydration or in need of extra hydration in order to maintain their well-being. Staff also used a water jug with a green lid system, to restrict fluids for patients who had to have limited fluid intake.
- Patients on medicine wards could choose meals from a menu supported by staff to make choices if required. We noted that patients could ask for vegetarian, vegan, and soft options to promote their wellbeing and respect individual beliefs.
- Meal times were well organised and not rushed. Staff ensured that patients, where possible, sat up in bed or at tables to eat meals.

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Patient outcomes

- The trust regularly reviewed the effectiveness of care through the collection and monitoring of patient outcomes and participation in local and national audit.

- Between January 2016 and December 2016, patients at the trust had a similar expected risk of readmission for elective admissions and a similar expected risk for non-elective admissions when compared to the England average.

- Elective clinical oncology had the highest risk of readmission out of the top three specialties based on count of activity. Elective clinical haematology had the lowest relative risk of readmission.

- The trust takes part in the quarterly Sentinel Stroke National Audit programme (SSNA). On a scale of A-E, where A is best, the trust achieved grade A in the latest audit, December 2016 to March 2017. All overall scores remained the same at the highest possible rating of A. At patient centred performance and team centred performance, all scores remained above C. However, the score from thrombolysis for both patient and team centre fell from A to B.

- The trust results in the 2015 heart failure audit were better than the England and Wales average for all four of the standards relating to in-hospital care. The trust results were worse than the England and Wales average for four of the seven standards relating to discharge.

- The trust clinical practice indicators in the heart failure audit scored 98% or higher, this is notably higher than the England average. The clinical practice indicator for referral to cardiology follow up performed the worst at 25%, compared to the England average of 54%.

- The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement. The audit attributes a quartile to each metric, which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 %, whereas quartile 4 means that the result is in the highest 25 % for that audit year.

- The 2016 NaDIA audit identified 78 in-patients with diabetes at the trust, some of these showed poor performance, in these cases the trust had responded by implementing an action plan to address any shortfalls:

- 87.9% of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this trust in quartile 3.
- 13% of patients in the 2016 NaDIA audit with diabetes experienced one or more mild hypoglycaemic episode, which places this trust in quartile 1.
- 32.8% of patients with diabetes experienced one or more medication error, which places this trust in quartile 2.
- 11.5% of patients with diabetes experienced at least one prescription error, which places this site in quartile 1.
- 47.2% of patients with diabetes received a visit from a member of the diabetes team, which places this site in quartile 4.

- All hospitals in England that treat heart attack patients submit data to Myocardial Ischaemia National Audit Project (MINAP) by hospital site (as opposed to trust). Between April 2014 and March 2015, 69.5% of non-ST-elevation infarction (nSTEMI) patients were admitted to a cardiac unit or ward and 95.6% were seen by a cardiologist or member of the team compared to an England average of 95.1% and 55%.

- The proportion of non-ST- elevation infarction (nSTEMI) patients referred for or receiving angiography at the trust was 95.3% compared to an England average of 79%.
- The trust participated in the 2016 lung cancer audit and the proportion of patients seen by a cancer nurse specialist was 65.7%, which does not meet the audit minimum standard of 90%.
- The proportion of patients with histologically confirmed non-small cell lung cancer (NSCLC) receiving surgery was 19.9%; this is not significantly different from the national level. The 2015 figure was 32.8%.
- The proportion of medically fit patients with advanced (NSCLC) receiving chemotherapy was 62.36%; this is not significantly different from the national level. The 2015 figure was 51.6%.
- The proportion of patients with small cell lung cancer (SCLC) receiving chemotherapy was 70%; this is not significantly different from the national level. The 2015 figure was 69.6%.
- The trust participated in the National Audit of Inpatient Falls during 2016-2017, results were not available at the time of inspection.

Medical care (including older people's care)

- The trust was not JAG (Joint Advisory Group on Gastrointestinal Endoscopy) accredited at the time of our inspection. However, the trust was aiming to apply for the accreditation in December 2017 and had a dedicated operational improvement, endoscopy project plan towards achieving this. The majority of actions on the plan were either compete or in progress, with only four areas identified as overdue, these included:
- Development of brief – Clacton
- Development of brief – Primary care centre
- Development of project cost plan
- Lead in period for modular building units

Competent staff

- As of April 2017, 76% of staff within medicine at the trust had received an appraisal. Appraisal completion varied across the medicine division, with medical and dental staff at 97%, allied health professionals 93% and nursing and midwifery registered staff at 69%.
- All staff we spoke with said that appraisals were a positive experience and managers often followed up with staff to ensure they had completed their appraisal and set targets.
- However, a minority of staff said that the appraisal process was often a tick box exercise. They stated that due to the lack of training the appraisal system did not enable staff to progress or offer opportunities to attend higher level training opportunities.
- We spoke with nursing staff who explained the process for revalidation. Staff had access to a named nurse who supported them through the process and helping gather evidence for their revalidation submission.
- Nursing staff and health care assistants held a continual professional development (CPD) folder, to store certificates and details in relation to any training achieved. Staff could also access training information via the hospital intranet to see if they were up to date with mandatory training in order to book into sessions and update their CPD.
- Staff reported having access to additional training to enable them to carry out their role effectively. Some staff, for example within the acute cardiac unit team, arranged additional training sessions in the evenings and weekends, with guest speakers and themes to build team morale and access additional training themes.

- The trust developed a number of 'Link' nurses, linked to specific specialism to offer support, guidance, and advice to staff on issues such as diabetes, dementia, and safeguarding amongst others.

Multidisciplinary working

- Ward teams had access to a range of allied health professionals and team members described good collaborative working practices between the teams. There was a joined-up and thorough approach to assessing the range of patients' needs and a consistent approach to ensuring assessments were regularly reviewed and kept up to date.
- Therapy staff we spoke with stated that they felt part of a strong multidisciplinary team (MDT) and their views and opinions were valued by staff across various professional teams. All staff described teams working well together and sharing best practice to improve patient outcomes.
- Interactions observed between members of the MDT were noted to be positive and clearly showed mutual respect for each other's roles.
- There was joint working with discharge coordinators and therapy teams to identify patients awaiting discharge. The discharge coordinators would review every patient awaiting a rehabilitation bed and attend ward rounds to promote early intervention and discharge where possible.
- Doctors led medical handovers efficiently, with effective verbal and written communication regarding the location of patients and their conditions. Consultants and multiple specialist nurses attended handovers and all of the medical specialities were represented. At this meeting, every admitted patient was discussed and patients who had not already been seen by a consultant were assigned to the most appropriate specialist. Staff discussed each patient that had been discharged to ensure appropriate plans and follow-up had been arranged.
- Records showed multidisciplinary care and treatment took place. For example, occupational therapists, physiotherapists, and speech and language therapists fully documented patient progress and updates within the patient care record. Information was recorded on a yellow set of notes held within the patient's daily records, so it was easily identifiable amongst the patients other records.

Medical care (including older people's care)

Seven-day services

- Physiotherapy was available to patients 8.30am to 4.30pm seven-days-per week with a reduced service at weekends and provided an on call facility overnight for patients who may need intervention, for example respiratory needs.
- The occupational therapists and physiotherapists on the stroke unit worked a seven-day rota to ensure Seven Day Services Clinical Standards (February 2017) were met.
- We spoke with the discharge planning coordinators who explained that the integrated discharge team was available seven-days per week. Staff we spoke with on the ward areas explained how this encouraged access to community services at the weekends.
- The endoscopy department offered services from 7am to 7pm, seven-days per week.
- The outreach team provide a 24 hour service seven days a week. Staff could bleep the outreach team directly for support and staff we spoke with on the emergency assessment unit and ward areas said that the outreach team provided a comprehensive and professional response to any patient escalation concerns.
- Clinical pharmacy services include pharmacists, technicians, and assistants covering designated wards five days per week. The service operates at weekends where pharmacists are available between 10am and 2pm, and an on call pharmacy service is available out of hours.

Access to information

- Information needed to deliver effective care and treatment was available to staff in a timely and accessible way. Policies and procedures were available in paper format and via the trust intranet. However, some information in paper format was out of date and not reflecting current evidence based guidance.
- The medicine teams could directly refer patients to the discharge planning team, electronically, via the "Hub", a central collection point where all referrals were made. The discharge team felt this improved the referral process, some ward staff in the focus groups felt the hub process was a hindrance as it took more time, as it was computer based. Others felt it had been a positive move and enabled the quick sharing of information.

- All staff had access to the governance and learning folders held on each medicine area. The folders contained information relating to current trust issues, incidents, and complaints.
- Administration staff sent patient discharge summaries electronically to the patient's general practitioner (GP) on discharge to ensure continuity of care within the community.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Data supplied by the trust prior to inspection showed that as of April 2017, 97% of staff within medicine completed Mental Capacity Act (MCA) level 1 training, 97% completed level 2 training, which is above the 95% trust target. Eighty-five percent of staff completed level 3, which is below the trust 95% target.
- Data supplied by the trust prior to inspection showed that as of April 2017, 96% of staff within medicine completed Deprivation of Liberty Safeguards (DoLS) Level 1 training and 97% completed level 2, which is above the 95% trust target. Eighty-seven percent of staff completed level 3, which is below the trust 95% target.
- Nursing, medical, and health care assistants we spoke with could explain what MCA and DoLS meant and that this supported decision-making and best interests of the patients.
- Patient care records allowed staff to record patient's capacity and consent in one place within the document. Throughout our inspection, we noted that staff did not use the trusts MCA paperwork from its MCA policy when supporting decision making regarding a patients capacity.
- We reviewed the care records of a patient on Birch ward. Staff had recorded the patient had evidence of difficult behaviour, and the patient appeared highly confused. Records showed no MCA had been completed for the patient despite an obvious change in their condition. The trust addressed this immediately.
- We reviewed the care records of a patient on Peldon ward. We found no evidence of an MCA or DoLS in the patient's records despite their obvious confusion, and discussed with staff the use of the medication and whether this was a form of chemical restraint. Staff agreed that given the patient's condition, an MCA and DoLS should have been in place and agreed to address the issue immediately.

Medical care (including older people's care)

- On the acute cardiac unit, staff followed the delirium pathway document to support an urgent DoLS application where a patient lacked capacity, and had not used the trusts MCA documentation. We spoke with the head of safeguarding who said that the delirium pathway mirrored the decision-making processes in the trusts MCA policy. They stated as long as staff applied the MCA principles to support the decision making process that was the key point.
- The MCA is a key part of the DoLS application process, whilst the delirium pathway is a tool to support patients who may have delirium, it should not be a replacement for the trusts MCA policy where patients lack capacity.

Are medical care services caring?

Good ●

We rated caring as good because:

- Between March 2016 and February 2017, the Friends and Family Test (FFT) response rate for medicine at the trust was 49%, which was better than the England average of 25%.
- During our inspection, we spoke with 12 patients and 14 relatives and all, with the exception of one family, were consistently positive about their experience of care and support at the hospital.
- Staff utilised care plans and person centred planning to respect pateint decisions and promote choices in order to provide holistic care.
- Staff respected and recognised patients' individual needs and choices at all times.
- Throughout our inspection, we observed staff treating patients with compassion, dignity, and respect. Staff drew curtains, and respected privacy when supporting patients with personal care.
- The majority of patients, (94%) were satisfied with the level of support the Parkinson's disease nurse service offers
- Patients on the stroke unit had access to psychological support, and could be sign posted to specialist counselling services where appropriate.

Compassionate care

- Staff utilised care plans and person centred planning to respect patient decisions and promote choices in order to provide holistic care.
- Between March 2016 and February 2017, the Friends and Family Test (FFT) response rate for medicine at the trust was 49%, which was better than the England average of 25%.
- During our inspection we spoke with 12 patients and 14 relatives. All, with the exception of one family, were consistently positive about their experience of care and support at the hospital.
- Staff respected and recognised patients' individual needs and choices at all times. Staff displayed kind and gentle behaviour, offering reassurance and positive support to patients who were often uncomfortable and needing reassurance.
- We spoke with a patient on Easthorpe ward who said, "I would recommend this hospital for treatment."

Understanding and involvement of patients and those close to them

- In the CQC Inpatient Survey 2015, the trust performed about the same as other trusts for all the 12 questions.
- Nurses, health care assistants, doctors, and therapists all introduced themselves to patients at all times, and explained to patients and their relatives about the care and treatment options.
- Family or carers could stay with patients who were cared for in a side room and visiting times were flexible. This was to promote the patients welfare for example, a confused patient or a patient not having appetite following treatment or to support a patient who may be at the end of their life.
- A relative on the stroke ward said, "They always tell me what's going on with my mum, I haven't had to ask a question yet." Another relative on Easthorpe ward stated, "The staff went out of their way to talk to us and go through things."
- The staff support carers to visit and stay with the patients outside of visiting times where necessary, allowing more time for procedures and explanations.
- The hospitals Parkinson's disease nurse service sent a questionnaire to patient's home address to complete and return back using a freepost service. Patients said they were given the opportunity to be involved in the decisions made in regards to their care plan and having

their input listened to and incorporated into their plan. The majority of patients were satisfied with the level of support the Parkinson's disease nurse service offers (94%).

Emotional support

- The hospital chaplain often supported patients, families, and staff in very difficult situations. The chaplaincy supported people of all faiths and beliefs and specialist support for various faiths was available.
- Patients on the stroke unit had access to psychological support, and could be sign posted to specialist counselling services where appropriate.
- We met with two volunteers on the stroke unit, a previous patient and his wife. They often came to the stroke unit to offer advice and guidance to patients and families dealing with the aftermath of a stroke.

Are medical care services responsive?

Good 🟢

We rated responsive as good because:

- The trust had significantly invested in the recruitment of discharge co-coordinators who worked across the wards to promote the safe and timely discharge of patients.
- Between February 2016 and January 2017, the average length of stay for medical elective patients at the trust was 3.6 days, which is lower than England average of 4.2 days.
- Between April 2016 and March 2017, the trust's referral to treatment time (RTT) for admitted pathways for medicine was similar to the England average.
- The trust had introduced a "red day and green day" system. The system enabled nursing staff to identify patients as "red" if they required further intervention or services, or "green" if their care pathway was on track.
- The medicine division had two dedicated dementia care specialist nurses, who were soon to become Admiral Nurses.
- The following specialties were better than the England average for admitted Referral to Treatment Times (RTT) (percentage within 18 weeks), geriatric medicine, neurology, and rheumatology.

However:

- Trust figures provided prior to inspection showed an increase from the previous year in the number of patients having two or more ward moves, particularly in patients with two moves, which increased from 14% to 20%.

Service planning and delivery to meet the needs of local people

- The trust implemented a nurse led discharge process on Peldon ward in May 2017. The ward operated a strict patient admission criteria, where staff only accepted medically fit patients onto the ward. Staff would then actively work with the hospitals discharge teams to discharge patients back into the community to their own home or appropriate care facilities.
- During autumn 2017, the trust are planning to launch the frailty short stay unit, on Tiptree ward, a short stay inpatient and day case facility. The aim of this was to treat patients quickly and with early intervention of other services.

Access and flow

- Between March 2016 and February 2017, the main reasons for delayed transfer of care at the trust were patient or family choice (24.8%), followed by completion of assessment (19.8%).
- Staff within the medical day unit (MDU) and the emergency assessment unit (EAU) said when patient demand was high in the emergency department (ED); ED staff would often transfer patients to them to ensure they did not breach the four-hour waiting time key performance indicator.
- Data supplied by the trust showed that between April 2016 and June 2017, the MDU admitted 6,291 from the emergency department. During the same period, the EAU admitted 9,819 from the emergency department.
- Data supplied by the trust showed 10,292 patients admitted from the ED to medicine wards between April 2016 and June 2017. Of these 6,405 patients were admitted to medicine wards via the EAU, and 3,887 via the MDU.
- At the time of our inspection, the MDU and EAU were at full capacity. This was a blend of patient's referred form the ED, but also via local general practitioners (GP).

Medical care (including older people's care)

- At the time of our inspection, medicine wards were 100% occupied.

- The trust had introduced a red day and green day system. The system enabled staff to identified patients as red if they required further intervention or services, or green if their pathway was on track. Staff said they often felt under pressure from site managers to discharge or take patients, when due to issues in relation to community spaces or simply getting a patient to their own home, made discharge difficult.

- The trust had significantly invested in the recruitment of discharge co-coordinators who worked across the wards to promote the safe and timely discharge of patients. The coordinators worked with the ward staff, multidisciplinary team, and external agencies, for example community care and families to improve discharge outcomes.

- We spoke with two discharge coordinators; both said that there remained challenges in discharging patients due to the constraints of community care and repatriating patient's home. All staff we spoke with on the wards valued the support of the discharge coordinators and felt the role had made a positive impact on the patient discharge process.

- Between April 2016 and March 2017, the trust's referral to treatment time (RTT) for admitted pathways for medicine was similar to the England average.

- The following specialties were above the England average for admitted RTT (percentage within 18 weeks), geriatric medicine, neurology, and rheumatology.

- The following specialties were below the England average for admitted RTT (percentage within 18 weeks), dermatology, cardiology, gastroenterology, and thoracic medicine.

- Between February 2016 and January 2017, the average length of stay for medical elective patients at the trust was 3.6 days, which is lower than England average of 4.2 days. For medical non-elective patients, the average length of stay was 6.1 days, which is lower than England average of 6.7 days. Clinical Oncology had the greatest difference between the hospitals length of stay (4.8) compared to the England average (2.4).

- At the time of our inspection on the 26 July 2017, 25 patients were allocated bed spaces on medicine wards but should have been on other wards during the inspection. Nurses and medical staff assured us that the team reviewed outliers daily.

- Between May 2016 and April 2017, 41% of patients did not move wards during their admission, and 59% moved once or more. Trust figures provided prior to inspection showed an increase from the previous year in the share of patients having two or more moves, particularly in patients with two moves, which increased from 14% to 20%.

- In April 2016, 630 patients were waiting for an endoscopy procedure (excluding Cystoscopies), this number reduced on a monthly basis until November 2016, where 370 patients were on the waiting list. Between December 2016 and April 2017, the number of patients on the waiting list fluctuated. In December 2016 the number of patients waiting for endoscopy procedures was 371, in January 2017 this increased to 389, reducing to 375 in February 2017, increasing again in March 2017 to 400, before reducing again to 387 in April 2017.

- Between July 2016 and June 2017, the average number of day's patients spent waiting for an endoscopy procedure ranged between 2.1 and 5.5 days.

Meeting people's individual needs

- The trust had a dementia strategy 2016-2019 and delirium pathway in place.

- The medicine division had two dedicated dementia care specialist nurses, who were soon to become Admiral Nurses. Admiral Nurses work alongside people with dementia, and their families: to offer one-to-one support, guidance, and practical solutions. The dementia team assisted ward staff with expertise in how to care for patients living with dementia.

- Patients living with dementia and those who had suffered stroke had a specific health passport in place. This passport gave detailed information in relation to patient's preferences of care, family, and social circumstances.

- Speech and language therapy (SaLT) team saw patients who had had a stroke promptly to reduce the time

patients spent nil by mouth. Records reviewed showed a prompt review by SaLT, and staff we spoke with spoke highly of the specialist support offered specifically in relation to swallowing.

- We observed occupational and physiotherapists working closely with the nursing and medical teams to promote patient welfare and condition management. Therapists promoted individual needs and the use of specialist equipment to promote mobility and activities of day-to-day living to promote patient independence.

- The staff had access to one whole time equivalent (WTE) specialist nurse for learning disabilities. The learning disabilities hospital liaison nurse specialist (LDHLN) is notified of patients attending the hospital with a learning disability by ward staff, care homes, parents, carers, social workers, and community health team members. An online reporting system has recently been set up where the LDHLN identifies patients admitted who have an alert for learning disabilities on the hospitals IT network.

- Staff had prompt access to specialist equipment including bariatric and pressure relieving equipment.

- Staff had access to translation services for patients whose first language was not English.

- Leaflets on various conditions were available throughout the wards, as guidance for patients and families. Staff could order these in different languages formats when necessary.

- We noted that staff on Tiptree ward had significant consideration for patients living with dementia, and utilised coloured paint to identify the entrances to bays and bed areas. Staff explained this was to enable patients to recognise where their individual bay was and promote safety of patients within the ward area.

Learning from complaints and concerns

- Between April 2016 and March 2017, there were 173 complaints about medical care. The trust took an average of 39 days to investigate and close complaints, with the longest taking 205 days although this was reopened and had an extension for the completion date. Staff attitude was the most frequent primary theme for complaint with 30 complaints.

- All staff we spoke with knew how to report a complaint and that feedback from complaints would be shared on a one-to-one basis where necessary or via team meetings.

- One member of staff gave an example of speaking with a patient's family early in the complaints process, in order to gain resolution early and successfully resolve the complaint. Another member of staff gave an example of a complaint that had escalated into a safeguarding issue and how they had referred this to the safeguarding team.

Are medical care services well-led?

Good 🟢

We rated well-led as good because:

- Local leaders, for example ward sisters and matrons were highly respected by staff we spoke with and staff felt respected and engaged with the services.
- All nursing staff we spoke with knew what the localised risks were and the risks on the medicine risk register.
- The trust had action plans in place to address performance issues, for example in relation to the National Diabetes Inpatient Audit (NaDIA).
- We found a strong culture of multidisciplinary staff working on the wards we visited.
- Staff said that the senior leadership team held open forums, and that often the chief executive officer was visible on the ward areas, sometimes as early as 6am to see the patients and staff.
-
- The majority of staff we spoke with on the wards were unaware of any local vision or strategy held by the trust in relation to the medical division. However, all staff said that they aimed to put the patients first.
- We were not assured that staff managed patient risks consistently, especially in relation to the application of the Mental Capacity Act and Deprivation of Liberty.
- We reviewed clinical governance meeting minutes from 2 March 2017 and noted the previous meeting was in November 2016, some three months previous. We noted that governance was key issue on the corporate risk register.

Leadership of service

Medical care (including older people's care)

- The division was led by the divisional director, medicine clinical director, head of nursing and a general manager.

- All of the nursing, medical and health care assistant staff felt supported and valued by their direct line manager.

- The majority of staff we spoke with said that they had been through a turbulent time with the senior management and leadership changes, but they felt with the newly established posts, staff were starting to get to know who was in charge.

- Local leaders, for example ward sisters and matrons were highly respected by staff we spoke with and staff felt respected and engaged with the services.

- All the senior members of nursing staff we spoke with had a good understanding of the current staffing levels, staff vacancies and staff sickness levels and were taking appropriate action to provide cover where necessary.

- Data supplied by the trust showed the proportion of sick days due to stress was 2% in April 2017, 1.9% in May 2017, and 1.9% in June 2017 all below the trust compliance target of 10%.

Vision and strategy for this service

- The majority of staff we spoke with on the wards did not know of any local vision or strategy held by the trust in relation to the medical division. However, all staff said that they aimed to put the patients first.

Governance, risk management and quality measurement

- We reviewed the medicine division risk register, the risks included amongst others:

- failure to ensure the correct medication is prescribed and administered, caused by incorrect prescribing and/ or administration checks, may result in patients being administered the wrong medication and may result in harm as a result.
- Staffing (nurses)
- Skills Matrix Acute Cardiac Unit

- The risk register had clear lines of accountability, including staff roles and timelines for the management of risks across the medicine division.The trust had action plans in place to address performance issues, for example in relation to the National Diabetes Inpatient Audit (NaDIA).

- We reviewed clinical governance meeting minutes from 2 March 2017 and noted the previous meeting was in November 2016, some three months previous. We noted that governance was key issue on the corporate risk register.

- When clinical governance meetings occurred, they included a broad mix of nursing, medical, and multidisciplinary staff amongst others and details of the meeting and minutes circulated to staff.

- We noted on all wards we visited that localised risks for each ward were on display, these included issues such as patient falls, hospital acquired patient pressure sores, call bell response times and the timely, and accurate recording on patient charts amongst others.

- All nursing staff we spoke with knew what the localised risks were and the risks on the medicine risk register.

- The medicine departments participated in a number of audits to measure the quality of provision, these included local audits, for example hand hygiene, record keeping, medication, and care planning.

Culture within the service

- Junior nurses we spoke with told us that the medical division was a good place to start their career. Managers gave them clear leadership and feedback on their performance on a regular basis and made them feel valued as part of the team.

- All staff we spoke with told us they felt the medicine division was a supportive and interesting place to work. We saw staff interacted in a supportive way within the department to ensure safety and efficiency for patient care and that there was a positive and calm feeling within the team, even during very busy periods.

- We found a strong culture of multidisciplinary staff working on the wards we visited. Therapy staff felt included by nursing and medical staff in decisions related to patient care and treatment. We observed staff working closely, recording guidance in patient notes and positive communication to meet the needs of patients and staff on the wards.

- The trust was working to promote accountability and responsibility for medical patients who were admitted to non medical wards. These patients are usually called

Medical care (including older people's care)

outliers in other hospitals but were called guests by the trust. This promoted a different significance to these patients and we found that staff were responsive to this move.

Public engagement

- The trust offered patients and their relatives the opportunity to complete a specific questionnaire if they had utilised support via the learning disability and autism services.

- The hospital encourages every patient to complete a short survey at the end of their stay as appropriate via a questionnaire for carers to complete post discharge. The dementia team review the feedback on a monthly basis, to formulate recommendations to improve the services provided. The findings and developments are shared at the trusts quarterly dementia management group, reporting to quality and patient safety via the safeguarding committee.

Staff engagement

- Staff we spoke with told us they attended regular team meetings with their managers and received information in a number of ways including face-to-face, email, and newsletters.

- Staff said that the senior leadership team held open forums, and that often the Chief Executive Officer would go onto the ward areas, sometimes as early as 6.00am to see the patients and staff.

- Staff could access a 'Contact Officer', to support staff and advise them what to do if they are being bullied or harassed at work as well as 'Health Ambassadors' to increase engagement and the wellbeing of staff.

- The 'Staff Involvement Group' is an executive led meeting that happens on a monthly basis, allowing staff to raise issues, concerns and highlight good practice.

Innovation, improvement and sustainability

- Nursing staff implemented the "Baywatch" initiative across the care of the elderly wards and pilot wards Darcy, Tiptree, and Easthorpe to reduce patient falls. The process involves patients cohorted into bay areas and under continual supervision by a member of staff, to reduce the risks of patient falls. At the time of our inspection, this initiative extended across care of the elderly and medical wards.

- The Time Garden project aims to provide a garden and chalet for patients and families to have quiet time and privacy in the last few days of life.

- One component of the frailty project is the discharge hub has opened, providing a central point of referral for medicine ward staff to progress discharge plans for patients supported by health and social care.

- The nurse led discharge unit is dedicated to optimising discharge and rehabilitation plans for medically fit patients that no longer require medical intervention.

- The trust are planning to launch the frailty short stay unit, on Tiptree ward, a short stay inpatient and day case facility to safely minimise admissions onto the wider medicine wards.

- The SAFER project is part of 'Every Patient Every Day' patient flow programme, SAFER focuses on clinicians concentrating on getting patients home from the point of admission as quickly as possible with the right support.
- The acute cardiac care team have developed a business case to employ an advanced nurse practitioner, who would support patients waiting for a bed on the cardiology ward.

Surgery

Safe	**Good**	🟢
Effective	**Good**	🟢
Caring	**Good**	🟢
Responsive	**Requires improvement**	🟠
Well-led	**Good**	🟢
Overall	**Good**	🟢

Information about the service

Colchester Hospital University NHS Foundation Trust provides a range of surgical services including general surgery, elective and trauma orthopaedics, ear, nose and throat (ENT), urology and vascular. Patients access ophthalmology surgery at Essex County Hospital.

The service consists of nine surgical wards, divided into patient elective and emergency admissions. The elective care centre and surgical assessment unit is designed to facilitate patient access and flow through the hospital.

There are four operating theatre suites; main theatres, orthopaedic and gynaecology theatres in the Constable Wing, day surgery situated in the Elmstead day unit and ophthalmic theatres at Essex County Hospital. At the time of our inspection Aldham ward was being refurbished and Naylan ward was being used for surgery patients.

We visited all nine wards within the surgery service, and the three theatre suites a Colchester General Hospital. We did not inspect the ophthalmology surgery service at Essex County Hospital as part of this inspection.

The trust had 29,983 patient surgical admissions between February 2016 and January 2017. Emergency admissions accounted for 8,341 (28%), 5,457 (18%) were elective, and 16,185 (54%) day admissions.

We spoke with 97 staff, including medical and nursing staff, 22 patients, and three relatives. We reviewed 30 sets of medical records and information requested by us and provided from the trust.

Summary of findings

We rated surgical services as good overall because:

- We reviewed 31 patient records and found all risk assessments were completed, national early warning scores (NEWS) and risk assessments clearly documented.
- Staff adhered to the trust hand hygiene and 'bare below the elbow' policy, and wore personal protective equipment such as gloves and aprons during care.
- We found a strong culture of multidisciplinary staff working on the wards we visited.
- Between January 2016 and December 2016, patients at the trust had a lower than expected risk of readmission for elective admissions.
- During our inspection, we spoke with 22 patients and three relatives. Feedback was consistently positive about their experience of care and support at the hospital.
- Between March 2016 and February 2017, the Friends and Family Test (FFT) response rate for surgery at the trust was 40%, which was better than the England average of 29% during the same period.
- There were two dementia care nurse specialists (DCNS) within the trust. The DCNS are notified of every patient over 75 admitted as an emergency via the dementia assessment tool (DAT). All suitable patients are assessed as per FAIR (Find, Assess and Investigate, Refer) utilising the DAT tool for dementia and delirium.

Surgery

- There was evidence of learning from complaints across the service.
- Between February 2016 and January 2017 the average length of stay for surgical patients, both elective and non-elective admissions, was lower (better) than the England average.
- Staff were aware of the new vision for the trust of, "Delivering great healthcare to every patient, every day". This was evident through the renaming of medical outliers to guests and the increased accountability for these patients.
- There was a clear governance structure in place for the service.
- There was an open culture of sharing and learning around complaints and incidents.
- Staff felt supported and valued by their colleagues.

However:

- Medical staff compliance with mandatory training was variable. Patient manual handling was the lowest performing subject area at 59%, with only 58 of 99 required staff members attending the training.
- Nursing staff compliance with safeguarding children update Level 3 was 58%
- Data supplied by the trust from April 2017 showed the majority of wards within the surgical division were below the required establishment figures. This issue was on the divisional risk register.
- The trust's referral to treatment time (RTT) data, between April 2016 and March 2017, for admitted pathways for surgical services had been consistently worse than the England average, and had remained relatively stable at around 60% over the 12 month period.
- Cancelled operations, not treated within 28 days, was higher than the England average at 12 %.
- Theatre utilisation had not shown any significant improvement in the 12 month period between April 2016 and April 2017, with the percentage of used sessions, late starts, early finishes and cancellations remaining relatively static and all below trust target. This issue was on the divisional risk register.
- Only 76% of surgery staff had received an appraisal in the year April 2016 to April 2017.

- The average theatre utilisation rate at Colchester General Hospital in April 2017 was 78%. This issue was on the divisional risk register.
- Staff at a local were uncertain as to the surgical strategy.
- Staff felt morale was improving, but nursing staff felt that the number of vacancies and subsequent pressure was still affecting staff morale.

Surgery

Are surgery services safe?

Good ●

We rated safe as good because:

- There was a strong incident reporting culture where staff were encouraged to report incidents and received feedback from incidents to minimise the risk of similar incidents reoccurring.
- Minutes of morbidity and mortality meetings documented comprehensive discussion of patient deaths and a breakdown of the contributory factors, which was beneficial for staff learning.
- Staff we spoke with knew of the duty of candour and could give examples of when they had used it.
- Medical assessment and patient review was consistent across the surgery wards, with daily patient review by a middle grade doctor or consultant recorded.
- National early warning scores (NEWS) were correctly recorded and escalated by staff according to guidance where appropriate.
- There was good infection control practice and hand hygiene by staff.
- Nurses correctly checked and stored medicines, including controlled drugs (CDs). Medicines checked were stored appropriately, locked away and in date.
- During our observations in theatres, we found good compliance with the World Health Organisation (WHO) 'five steps to safer surgery' checklist, designed to reduce the risks of mistakes in surgery. We observed a positive culture for completion of the checklist amongst theatre staff and a robust system of review of compliance that involved all disciplines of staff within the department, enabling open, constructive feedback amongst peers..

However:

- Medical staff compliance with mandatory training was variable. Patient manual handling was the lowest performing subject area at 59%, with only 58 of 99 required staff members attending the training.
- Nursing staff compliance with safeguarding children update Level 3 was 58%

- Data from April 2017 showed the majority of wards within the surgical division were below the required establishment figures. This issue was on the divisional risk register.
- Mersea ward was the largest ward in the surgical division. It is three times larger than the other surgical wards. This increased the risk to patient safety, as observation capabilities were very restricted. However the trust had taken steps to mitigate the risk by using a two team system.

Incidents

- There had been one never event and 20 serious incidents relating to surgery between June 2016 and May 2017. Nursing and medical staff were aware of the serious incidents and never event. Never events are serious incidents, which are wholly preventable as guidance and safety recommendations are available that provide strong systemic protective barriers at a national level. Although each never event has the potential to cause harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- We reviewed the actions taken by the trust after the never event, which occurred in October 2016 in theatres. The trust had taken a number of actions following the event including a review of checking procedures on equipment and artificial implants in theatres, and staff going on human factors training.
- The most common type of serious incident reported was surgical invasive procedure incident, which occurred on seven occasions between June 2016 and May 2017.
- We reviewed incidents reported on the trust electronic reporting system for the period May 2016 to April 2017 and found evidence of reporting and appropriate grading of incidents.
- Governance and learning folders were available in all surgical areas, which outlined incidents, investigations and outcomes that had occurred in the surgery division, to educate staff. The folders contained signing sheets, which staff signed to confirm they had read about the relevant incidents.
- We reviewed the root cause analysis (RCA) for one serious incident (SI), in the governance and learning folder on Elmstead ward. The SI had been thoroughly investigated, detailed the recommendations and actions taken to minimise events in the future. Staff

could access the governance and learning folder at any time and SI's were discussed at team meetings and where necessary in one to one supervision with staff to increase staff understanding of SI's.

- A system and process for the reporting of incidents was in place. Staff we spoke to understood how to report incidents and. The incident reporting form was accessible via the trusts electronic online system. One nurse gave an example of a medication incident regarding incorrect checks on the controlled drugs cupboard. The member of staff involved had received extra support and training and learning was shared with other staff on the ward.
- The monthly surgical clinical governance meetings included a review of patient mortality and morbidity. This meant that senior medical and nursing staff reviewed recent patient deaths to identify any concerns and identify potential learning to improve patient safety. We reviewed the minutes from the meetings between May and July 2017. Meetings documented comprehensive discussion of patient deaths and a breakdown of the contributory factors.
- Nursing staff were aware of the principles of duty of candour. We reviewed patient notes that included details of duty of candour being applied after an incident. The incident involved a patient fall on the ward. A discussion was held with the family with a specialist falls practitioner in attendance.

Safety thermometer

- The 'Safety Thermometer' is used to record data relating to aspects such as the number of patient falls, pressure ulcers, catheter and urinary tract infections and venous thromboembolism (VTE). Data collection takes place one day each month, a suggested date for data collection is given but wards can change this. Staff must submit data within 10 days of suggested data collection date.
- Data from the Safety Thermometer showed that the trust reported 20 new pressure ulcers, 3 falls with harm and 15 new catheter urinary tract infections between April 2016 and April 2017 for surgery. We reviewed a root cause analysis and saw learning was disseminated to staff through learning folders on wards.

- The quality and safety dashboard data was visible in each area. Safety crosses were on notice boards throughout the surgery wards and displayed results for meticillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile (C. diff), falls, pressure ulcers (PU).
- The trusts most recent VTE audit report from May 2017 showed 88.7% of VTE assessments for non-elective patients were completed, which was below the trusts target of 95%. The trust did meet the target for elective patients with 98.28% being completed.

Cleanliness, infection control and hygiene

- Surgical wards were visibly clean and uncluttered. "I am clean" stickers were visible on equipment such as electrocardiogram (ECG) machines and resuscitation equipment.
- Disposable curtains were in place in each bay area and dated appropriately to indicate the minimum change date.
- All theatre areas we visited were visibly clean, including storage rooms and sluice rooms. However, the storage space in the main theatres was limited, with corridors cluttered with equipment and stock, which was an infection control risk. The trust was going through an improvement programme to increase storage space.
- Hand sanitiser was available at the entrance to each ward area and clear signage was in place asking all staff and visitors to wash their hands and to follow the trust policy on infection prevention, protection, and control when entering or leaving wards or departmental areas.
- Staff washed their hands in line with the World Health Organisation's "Five Moments of Hand Hygiene" guidance between personal care activities with patients and utilised the hand sanitiser where appropriate.
- The trust carried out hand hygiene audits in seven areas within the surgery division in March 2017. Results showed that in April 2017, Wivenhoe, Mersea and Great Tey wards achieved 100% compliance with hand hygiene.However, Fordham ward achieved 97.06% compliance , Aldham ward 92.31% and the Surgical Assessment Unit (SAU) 90.91% . The audit result on Emlstead Surgical was 75% and the overall score for the surgery division was 98.64%.
- Cleaning audit results for orthopaedic theatres showed 95.2% compliance in February 2017 and 95.5%

compliance in March. Results showed 97.5% compliance in February 2017 and 94.5% compliance in March in general surgery theatres. A score of over 90% receives a green rating from the trust.

- Staff adhered to trust policies and guidance on the use of personal protective equipment (PPE), and to 'bare below the elbow' guidance, to help prevent the spread of infection. There was adequate provision of gloves, aprons and visors throughout.

- Staff had good infection control practices in theatre including waste management, specimen handling, surgical techniques, and maintenance of sterile field.

- Staff cleaned theatre equipment appropriately between cases using neutral detergent or disinfectant wipes in adherence to the trust decontamination procedure.

- Data supplied by the trust showed the surgery division had one case of Methicillin-resistant Staphylococcus aureus (MRSA),between April 2016 and March 2017.

- The surgery division reported six cases of Clostridium difficile (c.diff). There had been no cases of MRSA or c.diff reported in April 2017.

- All staff we spoke with in theatre were aware of MRSA policy, patients identified with MRSA were last on the operating list. This meant that a high clean would be undertaken and significant air changes occur before the next operation to reduce the risk of contamination.

- Surgical site infection (SSI) rates from the most recent Public Health England audits covering October to December 2016 showed an SSI rate of 2.4% in neck of femur, which is worse than the national average of 1.4%.Vascular showed an SSI rate of 3.5%, which is better than the national average of 4.7%. Senior staff told us that staff with an infection prevention link role were responsible for improving the SSI rates. However, we found no analysis of the figures or formal regular meetings occurring regarding SSI rates.

- Contaminated waste was stored securely behind locked doors in theatres and wards and disposed of in line with trust policy.

Environment and equipment

- Staff access to the theatres and wards was by key card. Visitors accessed wards by ringing a buzzer near the theatre entrance and waiting for authority to enter from staff.

- Wards were in the main, well-laid out to promote safety, with nurse stations in position to view all bays and side rooms. However, the layout of Mersea ward did not support the acuity of the patients.

- Mersea ward is a 32 bed elective surgical ward consisting of 16 side rooms and four bays, each with four beds. The ward is an elective surgical ward but also takes emergency, medical outliers and orthopaedic patients when there are bed shortages across the hospital. The footprint is three times the size of other surgical wards, which could increase the risk to patient safety, because observation of patients is restricted. However, the trust was managing the risk by dividing responsibility for the ward between two teams to ensure sufficient cover across all areas.

- We checked a range of equipment in each area including blood pressure machines, and syringe drivers (both in storage areas and on the wards) and found they were all in service date. Weighing scales had all been calibrated and had a next service/calibration date sticker to indicate when they were due for review. Staff from the hospitals EBME (Electrical and Biomedical Engineering) team serviced all equipment.

- Staff labelled sharps bins appropriately, identifying the date, signature and location of origin. They were not overfilled, which reduced the risk of injury to staff.

- Nursing staff carried out daily checks of resuscitation trolleys and emergency equipment within the surgical wards and theatres. These checks were consistent across all surgery wards at Colchester University hospital. We reviewed the resuscitation trolleys all surgery wards, all of which had received daily checks between May 2017 and June 2017. Checklists were in place and records were complete.

- Specialist equipment was available on wards including bariatric equipment and pressure relieving equipment.

Medicines

- The pharmacy team visited all wards each weekday. Arrangements were in place for staff to obtain medicines after the pharmacy had closed. A list of all medications stored on the wards was available on the intranet and there was an on call pharmacist.

- There was a pharmacy top-up service for ward stock and process for ordering other medications on an individual basis, which meant that medicines were stocked and available when required.

Surgery

- We reviewed the storage and records of medicines on all surgery wards and theatres we visited. Medicines, including those requiring cool storage, were stored appropriately. Records showed staff kept medicines at the correct temperature, and fit for use.
- Staff checked and recorded refrigeration temperatures daily. However, on Mersea ward the medicine refrigerator thermometer had been out of order between December 2016 and June 2017, when the refrigerator was replaced. We raised this with the ward sister who informed us it had been an issue with the company responsible for the servicing of the equipment. The pharmacy team had checked all medications in the refrigerator during the period the thermometer had been out of service and confirmed they were still safe for use.
- Staff stored medicines in a locked room on all wards and stock was well organised. Staff locked controlled drugs in a metal cabinet and the nurse in charge held the keys on each ward to maintain security and safety of the medication. We reviewed the storage and administration of controlled drugs (CD's) on four wards. (Controlled drugs are prescription medicines controlled under the Misuse of Drugs legislation). We found them to be stored appropriately and drug records were accurately completed.
- We reviewed 10 sets of patient prescription and medication records. Records were well completed, with medications, doses, allergies and signatures all recorded correctly.

Records

- We reviewed 30 patient records as part of this inspection. Staff kept patient observation records and assessments either outside the patient's room, or at the end of the patient's bed and detailed patients records were kept in a records trolley.
- Records trolleys were keypad locked and stored within sight of the nurses station on all wards we visited.
- Staff completed records to a good standard with all necessary documentation completed including consultant assessment, venous thromboembolism (VTE) assessment and nutritional needs using the Malnutrition Universal Screening Tool (MUST).
- We found good evidence of multidisciplinary team recording in patient records, to provide accurate details of care pathways needed to maintain patient wellbeing.

Safeguarding

- The trust set a target of 95% for completion of safeguarding training. Safeguarding training is mandatory for all staff.
- Data provided for nursing staff showed that safeguarding of vulnerable adults (SOVA) training level 1 was 98% and level 2 was also 98%.
- 94% of nursing staff had completed child protection training at level 1, 92% at level 2, and 87% of nursing staff had completed safeguarding children core level 3.
- Nursing staff achieved the trust set target of 95% for four of the nine safeguarding training modules. The module with the lowest compliance rate was safeguarding children update Level 3 with 58% completion.
- Medical staff did not achieve the target for any of the safeguarding courses. Data showed that SOVA training level 1 was 91% and level 2 was 90%.
- Child protection training was completed by 90% of medical staff at level 1 and 88% completed level 2. Medical staff achieved 73% completion safeguarding children core level 3 training. The module with the lowest compliance rate was safeguarding looked after children, which was completed by 57% of medical staff.
- Information folders were available on the wards containing contacts for escalating a safeguarding concern. Staff we spoke with in all areas could explain the escalation process for a safeguarding concern and could provide examples of where they would raise concerns or seek advice from the trust safeguarding lead. A member of nursing staff on the Elective Care Centre was able to give an example of escalating a concern to the safeguarding team for a patient prior to surgery.

Mandatory training

- The trust set a target of 95% for completion of mandatory training. Delivery of mandatory training was by a variety of methods including E-Learning and face-to-face sessions.
- Training included fire safety, basic life support, health and safety, infection control and information governance, amongst others.
- Data showed that out of 26 topics nursing staff had achieved the target of 95% completion in 11 subject areas, which included 100% for falls prevention and 98% for learning disability and Autism Level 1 and record keeping.

Surgery

- The least compliant subject area was Advanced Life Support at 63% where five of eight staff requiring training had completed the course. The next lowest scoring subject area was Immediate Life Support – Adults, which was completed by 72% of required staff.
- Data showed that out of 20 training modules medical staff had not reached the 95% compliance target in any subject area. The most compliant subject areas were Dementia Level 1, Learning Disability and Autism Level 1, and venous thromboembolism VTE Awareness, which had been completed by 90% of medical staff. Patient manual handling was the lowest performing subject area at 59%, with only 58 of 99 required staff members attending the training.
- Sepsis training was completed by 81% of medical staff and 96% of nursing staff. The trust target completion is 95%.
- At the time of our inspection, all staff we spoke with said they were up-to-date with mandatory training and reported they received reminders and encouragement to attend training updates. All staff thought they received sufficient protected learning time to complete their mandatory training.

Assessing and responding to patient risk

- Staff used the National Early Warning Score (NEWS) assessment tool to determine the degree of illness of a patient using six physiological symptoms including temperature, pulse and respirations. All patient records we reviewed showed that staff routinely completed NEWS and alerted senior staff to any patient that may be deteriorating.
- The most recent trust Deterioration and Prevalence Audit from September 2016 showed 100% compliance with the use of NEWS on Great Tey and Aldham wards.
- Nursing and medical staff held daily safety handovers that included discussions on patients at risk and steps for monitoring and improving their recovery. We observed a morning handover on Mersea ward, which was delivered efficiently, with effective verbal and written communication regarding the location of patients and their conditions
- Staff held a "Two at the top" meeting, once per month. These are meetings between a senior nurse and doctor, to discuss issues in relation to patient incidents, risks on the ward and general issues affecting risk and patient safety.

- The trust was compliant with imposed requirements following our previous inspection regarding the World Health Organisation (WHO) five steps to safer surgery checklist, which is designed to reduce the risks of mistakes in surgery. During our observations in theatres, we found good compliance with the checklist,. Staff recorded completion of the checklist electronically and could not move onto the next step until the previous step had been completed to ensure risk was minimised. Staff completed the checklist with the full surgical team present.
- There was a process for checking theatre compliance checklist that included internal review of completion against all five steps (briefing, sign in, time out, sign out and debrief) and a system of observational peer review, with summary of findings evidenced and fed back to theatre team.
- We observed a positive culture for completion of the checklist amongst theatre staff and a robust system of peer review of compliance that involved all disciplines of staff within the department. Members of the recovery team assessed the documentation for completion, any non compliance was recorded on the electronic incident system. Data provided demonstrated there had been no non compliance reported between May and July 2017. Observational peer review is undertaken by various members of the theatre team, including healthcare assistants, oerating department practitioners and qualified nursing staff, and covers all five steps with documented findings, actions and lessons learnt.
- The trust had a focus on sepsis and this was included in the work stream for the every patient every day programme. All patients with NEWS score of five or above had a completed sepsis screening tool present in the healthcare record. The trust used 'Sepsis Six'- a set of six tasks including oxygen, cultures, antibiotics, fluids, lactate measurement and urine output monitoring- to be instituted within one hour of admission for all patients diagnosed with sepsis.
- Guidance on the use of NEWS and the Sepsis bundle was available at all staff workstations and all staff we spoke with knew the escalation process for any patient seen to be deteriorating.

Nursing staffing

- As of April 2017, the trust reported a nursing vacancy rate of 17% in surgical care, a turnover rate of 12% and a sickness rate of 3%.

Surgery

- There was ongoing nurse recruitment across the surgical areas including from overseas.

- Staff displayed the number of staff on duty both planned and actual at the entry to wards to enable staff, patients, and family members to see staffing levels on the ward. We checked all of these on the wards we visited and found they displayed accurate and up to date information.

- The most recent data from the trust showed that of 596.7 whole time equivalent (WTE) posts scheduled, 565.3 WTE were worked in the month of April 2017.

- Nursing staff raised concerns to us during the inspection with regard to staffing levels across the surgery service. Staff told us that they moved around on a regular basis to fill staff shortages on other wards.

- Nursing handovers occurred at every shift change. During handovers, staff communicated any changes in patient's conditions to ensure staff took action to minimise any potential risk to patients.

- All nurses and health care assistants (HCA's) we spoke with were happy with their induction procedures and felt well equipped for working on their ward.

- At the time of our inspection, a new acuity tool was being trialled by staff, which reviewed staffing levels three times during the day on a hand held electronic tablet, which was reviewed by the trust site team to identify any "hot spots" in which extra staff was needed.

- The tool provided information on the number of Level 1, 2 or 3 patients. This was in addition to the six monthly "Safer Nursing Care Tool" (SNCT) assessment, which would assess patients acuity and dependency to ensure that nursing establishments reflected patient need.

- The trust uses the SNCT every six months to review the staff skill mix for all in patient wards. The skill mix review is presented to the trust Board for final approval by the director of nursing. The latest skill mix review (October 2016) recommendations showed a range in Registered Nurses with patient ratios of one-to-five to one-to-seven during the day and one-to-seven to one-to-tenat night across the surgical wards. Where nurse vacancies existed agency and bank staff were utilised to bridge gaps.

Surgical staffing

- As of April 2017, the trust reported a surgical staff vacancy rate of 9% in surgical care, a turnover of 13% and a sickness rate of 1%. As a result, between April 2016 and March 2017, bank and locum surgical staff usage rates were variable in surgery although were predominantly between 0-20%. In March 2017, the following units had the highest bank and locum usage: haematology 35%, orthopaedics 18%, and theatres and anaesthetics 11%.

- Overall vacancy rates at the trust were higher in non-consultant grade medical staff although the vacancies within clinical haematology were all for consultant or equivalent staff.

- As of January 2017, the proportion of consultant and junior (foundation year 1-2) staff reported to be working at the trust was about the same as the England average.

- The trust used a 'Hot' consultant of the day system, who is free from other activities to assist on surgery wards.

- Consultant level ward rounds occurred daily including at the weekends in all specialties.

- Consultant cover varies across specialities, but includes 24 hour seven day a week cover in vascular, urology, ear nose and throat (ENT), and general surgery. Trauma and orthopaedics had a consultant and middle grade doctor on call 24 hours a day.

- During our inspection the surgical staffing and skill mix was sufficient in all areas we visited in order to treat patients safely. Staff confirmed this; for example, junior doctors and registrars told us that consultant supervision was never lacking.

- Junior medical staff told us they felt supported and they received sufficient training for their roles.

- We observed a handover as a patient was taken into theatre and saw it was completed safely and according to recognised processes.

Major incident awareness and training

- There was a major incident policy in place relating to all services within the trust including surgical services.

- Staff knowledge regarding major incidents was limited within the surgical areas with some staff uncertain as to what constituted a major incident and what their role would be if a major incident occurred.

- The trust did not set a target for completion of local major incident training. As of April 2017, 522 staff had completed local major incident training within surgery.

Are surgery services effective?

Surgery

Good ●

We rated effective as good because:

- Patients received care and treatment by trained and competent staff.
- The service provided evidence based care and treatment in accordance with national and local guidelines including National Institute for Health and Care Excellence (NICE) guidance.
- Staff managed and assessed patient pain in line with the Faculty of Pain Medicine's Core Standards for Pain Management (2015).
- There was good evidence of multidisciplinary team (MDT) working in all surgical areas to help maximise patient outcomes.
- Staff monitored and reviewed patient's surgical outcomes through formal national and local audits.

However:

- Between January 2016 and December 2016, patients at the trust had a higher than expected risk of readmission for non-elective surgery admissions when compared to the England average.
- The trust 2016, hip fracture audit showed an overall improvement from 2015. However, the proportion of patients having surgery on the day of or day after admission was 67.5%, which does not meet the national standard of 85% and was worse than the 2015 figure.
- Within carotid endarterectomy, the trust median time from symptom to surgery was 17 days, worse than the national standard of 14 days. Delayed surgery is associated with risks of recurrent symptoms.

Evidence-based care and treatment

- Practice guidelines were available to staff on the trust intranet to ensure practice remained in line with national guidance.
- Trust policies and procedures were evidence based and adhered to national guidelines.
- All staff we spoke with could identify how to locate policies when required. Staff confirmed that policies were regularly updated and that they were notified of updates. Most polices and standard operating procedures were within their review date. However, the five steps to safer surgery and prosthesis for implantation operating procedures had no review date.
- Monthly audit of World Health Organisation (WHO) checklist compliance was in place with all five steps to safer surgery monitored. Data showed compliance at 100% for steps in May 2017, except debrief, which was 99.7% compliant. Data showed compliance at 100% for all steps in June 2017.
- The national early warning system (NEWS) was in place across the surgical areas to monitor acutely ill patients in accordance with National Institute for Health and Care Excellence (NICE) guidance CG50.
- An anaesthetist reviewed all vascular patients in pre-assessment.
- The surgical audit plan 2016/2017 identified audits in which the surgical departments participated. The audit data identified starts dates, dates of proposed completion and the responsible member of staff.
- The trust conducted quarterly surgical site infection audits. Patients are monitored following the Public Health England Surgical site infection surveillance service protocol. The most recent audit in March 2017 showed an infection rate of 4.54% (one out of 22 patients audited), which resulted in no further action from the trust.
- The trust participated in annual NICE Quality standard audits, including for NICE QS 20 - Colorectal Cancer, NICE QS 49 - Surgical site infection, NICE QS 104 - Gallstone disease, and NICE QS 16 - Hip Fracture.
- The trust conducted a variety of local audits including an Assessment and documentation of Neurovascular status in upper and lower limb trauma patients audit. Action from the audit included the production of a pro-forma that shows how to perform a neurovascular examination and an educational poster circulated amongst staff.
- The trust also conducted an audit looking at rates of senior review of orthopaedic trauma inpatients in March 2017. The findings of the audit showed that patients were not all getting a daily review by a doctor on a weekday and not all Senior House Officers (SHO) realised this was expected. SHO's were educated on the requirements in a meeting and the introduction of a 'hot consultant' is designed to ensure that patients are getting senior reviews regularly,

Surgery

Pain relief

- Patients we spoke with confirmed that they had received their medication and pain relief in a timely manner.
- Staff assessed patient pain in line with the Faculty of Pain Medicine's Core Standards for Pain Management (2015) 1-10 pain score. Staff completed pain charts appropriately in all patient notes we reviewed.
- During the inspection, we noted staff routinely asking patients if they were comfortable, in any pain, and offering extra pain relief where appropriate.
- Staff could request a review of the medication prescription for patients via the online portal system.

Nutrition and hydration

- The surgery wards used a 'red tray' system to identify patients who needed help with eating and the staff served meals on red trays to those patients. Staff, relatives and volunteers could then assist those patients when required.
- Water jugs were available and placed within easy reach for patients. Patients reported the jugs refilled regularly. Staff identified patients who needed encouragement with their fluid intake by serving fluids in a water jug with a red top. This enabled staff to identify patients likely to be at risk of dehydration or in need of extra hydration in order to maintain their well-being.
- Patients were positive about the quality of the food offered, but stated that the options were limited.
- We observed meal times were calm and well managed.
- There was no system in place to ensure that patients going to surgery in the afternoon had appropriate hydration. One patient in the Elective Care Centre had not eaten since the evening before. The patient had arrived as requested at 7am, had not had any fluids from 11am and were still waiting for surgery at 3pm when they spoke to a member of the inspection team. The patient went to surgery at approximately 3.30pm.

Patient outcomes

- The trust regularly reviewed the effectiveness of care through the collection and monitoring of patient outcomes and participation in local and national audit.
- Between January 2016 and December 2016, data provided demonstrated the risk of readmission following elective surgical procedures was below the expected rate, with fewer readmissions observed

compared to the England average. The only speciality identified where there was a slightly higher number of readmissions compared to the England average for elective surgery was Urology. For non elective, (emergency), surgery the data provided demonstrated that there was a slightly higher risk of readmissions in all specialties with the exception of trauma and orthopaedic that was comparable to the England average.

- Patient Reported Outcome Measures (PROM) scores for April 2016 to March 2017 were mostly the same as the England average. Hip replacement was in line with the England average for all three measures. Knee replacement was slightly better than the England average, with an improvement rate of 86.8% compared to an England average of 80.9%, and similar to England for the remaining two measures.
- The trust 2016 hip fracture audit showed an overall improvement from 2015. For example, in the 2016 hip fracture audit, the risk-adjusted 30-day mortality rate was 6.9%, which falls within the expected range. The 2015 figure was 9.7%.
- The proportion of patients having surgery on the day of or day after admission was 67.5%, which does not meet the national standard of 85%.
- The perioperative period is used to prepare the patient both physically and psychologically for the surgical procedure and after surgery. The perioperative surgical assessment rate was 91.1%, which does not meet the national standard of 100%.
- The proportion of patients not developing pressure ulcers was 95.6%, which falls in the middle 50% of trusts.
- The average length of stay for hip fracture patients was 15.2 days, which falls in the best 25% of trusts.
- In the 2015 bowel cancer audit, 58.6% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than the national aggregate.
- The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 42.5%, which falls within the expected range.
- In the 2016 national vascular registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 0.5% for abdominal aortic aneurysms, indicating that the trust performed within expectations.

Surgery

- Within carotid endarterectomy, the median time from symptom to surgery was 17 days, worse than the national standard of 14 days. The 30-day risk-adjusted mortality and stroke rate was within the expected range at 2.4%. The 2013 figure was 1.8%.
- In the 2016 oesophago-gastric cancer national audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 13.7%. This placed the trust within the highest 25% of all trusts for this measure.
- The proportion of patients treated with curative intent in the Strategic Clinical Network was 33.8%, which is significantly lower than the national aggregate. Treatment with curative intent refers to health care practices that treat patients with the intent of curing them, rather than just reducing their pain or stress.
- The trust participated in the 2016 National emergency Laparotomy Audit (NELA), which uses a Red, Amber, or Green (RAG) scoring system for audited areas. NELA aims to look at structure, process and outcome measures for the quality of care received by patients undergoing emergency laparotomy, and comprises both organisational and patient audits.
- In the 2016 NELA, the trust achieved an amber rating (between 50% and 80%) for the crude proportion of cases with pre-operative documentation of risk of death.
- The trust achieved a green (above 80%) rating for the crude proportion of cases with access to theatres within clinically appropriate time frames.
- The trust achieved a green (>80%) rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre.
- The trust achieved an amber rating (between 50% and 80%) for the crude proportion of highest-risk cases admitted to critical care post-operatively.
- The risk-adjusted 30-day mortality for the trust was within expectations, based on 362 cases. The 30-day time period is used, because it reflects when deaths are most likely to be related to the care patients received at the hospital. Lower death (mortality) rates generally reflect better patient care.

Competent staff

- As of April 2017, 76% of surgery staff at the trust received an annual appraisal.

- All staff we spoke with said that appraisals were a positive experience with follow up from managers. Staff told us that they felt well supported and senior staff gave support and supervision.
- The trust had a formal induction programme, which was compulsory for all new members of staff.
- Health care assistants had the opportunity to train in basic physiotherapy skills to support the work of the physiotherapy team.
- Nursing staff we spoke with told us they felt supported to develop new skills, train and progress within the hospital.
- Revalidation for nursing staff was recorded on the electronic staff rota system. Staff also received an email from the human resources department to inform them when their revalidation was required. The trust had organised workshops for staff to attend to support them in the process of revalidation.
- Bank and agency staff had to undertake an induction process and orientation of the relevant ward. Orientation included a tour of the ward and facilities, fire procedure, bleep system, and risk event reporting. Any temporary working staff on wards completed an induction checklist. Checklists were comprehensive and provided relevant key information about the hospital and wards.

Multidisciplinary working

- All wards had designated physiotherapy and occupational therapy staff based locally to assist patients along their treatment pathway.
- Staff we spoke with confirmed there was effective multi-disciplinary team (MDT) working throughout the service.
- Our observations of patient care showed surgical and nursing staff communicating effectively to maximise patient care.
- Dieticians were available to offer nutritional support to patients.
- The general surgery and trauma morning handover meetings were organised and well attended. Both included the on call junior and middle grade for both shifts (night and day) and on call surgical consultant.
- Each ward had a designated pharmacist available five days per week.

Surgery

- The discharge team worked closely with other health care professionals, for example community physiotherapists. This was to meet the patient's discharge support needs prior to their discharge home or to another healthcare provider.

Seven-day services

- The outreach team (who are specialist critical care nurses) provide a 24 hour service seven days a week. Staff could bleep the outreach team directly for support.
- The physiotherapy service was available from 8.30am to 4.30pm seven days a week. A physiotherapist was available on call 24 hours a day seven days a week and was available to attend this hospital within 40 minutes of a call.
- Emergency theatres were available 24 hours a day seven days a week.
- Occupational therapy (OT) provision was Monday to Friday 8.30am to 4.30pm with no cover for weekends.
- Pharmacy supported the wards during the week (Monday – Friday) and on a Saturday from 8am until 12.30pm. There were on call arrangements for pharmacy staff out of hours, Sundays and bank holidays.

Access to information

- Substantive, agency and bank nursing and medical staff had access to documentation and care records for patients to ensure continuity of care.
- There were computers throughout the individual ward areas to enable staff to access patient information including test results, diagnostics, and records systems.
- Overnight, the duty matron prioritised all clinical requests logged via the hospital at night computer system using an electronic hand held tablet. All junior doctors received a smart phone to accommodate the system. This meant that doctors could receive tasks whilst moving around the hospital.
- Agency staff and locums told us they had sufficient access to the online systems to request test results, diagnostics and records systems.
- Care summaries are sent to patients general practitioners (GP's) on discharge, including the details of the surgery, medications, and any implant used, to ensure continuity of care within the community.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust reported that as of April 2017, 94% of staff within surgery completed Mental Capacity Act (MCA) Level 1 training. MCA training level 2 had a completion rate of 95% and level 3 a completion rate of 80%.
- Deprivation of Liberty (DoLS) Level 1 training had been completed by 94% of staff. DoLS level 2 had been completed by 94% of staff and level 3 had the lowest completion rate of 85%. The trust set a target of 95% for completion of MCA and DoLS training, with only MCA training level 2 meeting the target.
- The most recent trust consent audit from November 2016 showed a compliance rate in the surgery division of 92% against a trust target of 90%.
- All staff we asked demonstrated an understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and how they would be applied.
- Staff were able tell us the process for obtaining consent from patients prior to surgery.
- All of the notes reviewed had signed patient consent forms.
- Staff were able tell us the process of consent and recognise the impact of variable capacity which demonstrated a good knowledge of consent and the MCA.
- We followed a patient pathway through theatre and witnessed that appropriate consent was taken.
- One member of staff described a patient that lacked capacity and had required a best interest decision prior to surgery. They were able to describe the process for making a best interest decision and the process for discussing this with the patients' relatives.

Are surgery services caring?

Good ●

We rated caring as good because:

- All interactions between staff and patients and relatives were kind and compassionate, and patients and relatives spoke highly of the care received.
- Friends and Family Test (FFT) results for surgical specialities were consistently high, in May 2017, all surgical wards had a recommendation rate of 91% or higher.
- Staff showed respect for the privacy and dignity of patients at all times.

Surgery

- We spoke with 22 patients who all said they were kept well informed by surgical and nursing staff on their care and progress.

Compassionate care

- All interactions between staff and patients and relatives were kind and compassionate, and patients spoke highly of the care, saying they were treated as individuals and theatre staff were very kind. One patient said staff were polite, friendly and respectful.
- A patient on Mersea ward said their stay was "the best hospital care I've ever received".
- All observations of patient care during our inspection showed respect for the privacy and dignity of patients, including in theatres and recovery. For example, we observed nurses ensuring side room doors were closed and bay curtains were drawn when patients were having a consultation with staff or receiving care.

- The Friends and Family Test (FFT) response rate for surgery at the trust was 40%, which was better than the England average of 29% between March 2016 and February 2017. In May 2017, all surgical wards had a recommendation rate of 91% or higher.
- The inpatient satisfaction survey results for uro-oncology clinical nurse specialist service across the Essex Cancer Network from December 2016 were broadly positive. Eighty-six percent of patients said they were highly likely and 10% said they were quite likely to recommend the service to friends or family if they needed similar care or treatment.

Understanding and involvement of patients and those close to them

- During our observation of a patient journey through theatre the patient was fully briefed beforehand and their relative was informed about the likely duration and directed to waiting areas.
- Patients said they were kept well informed by surgical and nursing staff as to their care and progress. For example, one patient on Mersea ward told us the doctor in charge had discussed their progress and discharge plans with them.

Emotional support

- Surgical services had access to a hospital chaplain if patients or relatives requested this support and there

was information about the chaplaincy service displayed on the wards. There is chaplain on-site from 8am to 4pm Monday to Friday and a chaplain on-call 24 hours per day, seven days a week.
- Patients in the Elective Care Centre and Elmstead ward gave specific praise for the emotional support they had received from staff prior to and post-surgery.
- There was access to specialist bereavement services on-site for relatives if required.

Are surgery services responsive?

Requires improvement 🟠

We rated responsive as requires improvement because:

- The trust's referral to treatment time (RTT) data, between April 2016 and March 2017, for admitted pathways for surgical services had been consistently worse than the England average, and had remained relatively stable at around 60% over the 12 month period.
- Cancelled operations, not treated within 28 days, was higher than the England average at 12 %.
- Theatre utilisation had not shown any significant improvement in the 12 month period between April 2016 and April 2017, with the percentage of used sessions, late starts, early finishes and cancellations remaining relatively static and all below trust target. This issue was on the divisional risk register.

However:

- There were two dementia care nurse specialists (DCNS) within the trust. The DCNS are notified of every patient over 75 admitted as an emergency via the dementia assessment tool (DAT). All suitable patients are assessed as per FAIR (Find, Assess and Investigate, Refer) utilising the DAT tool for dementia and delirium.
- There was evidence of learning from complaints across the service.
- Between February 2016 and January 2017 the average length of stay for surgical patients, both elective and non elective admissions, was lower (better) than the England average.

Service planning and delivery to meet the needs of local people

Surgery

- Pre-assessment, situated within the elective care centre (ECC), was open from 7am to 7pm seven days a week. Most pre-assessment clinics were nurse led.
- There was an anaesthetist allocated to the ECC two days a week to review patients that might require a more complex medical assessment to reduce the need for additional appointments.
- There were clear processes in place for outsourcing patients to other providers. Certain specialties such as, pain, foot and ankle, and oral surgery are outsourced when a capacity issue is identified. A dedicated administration team organise and ensure completion in a timely manner, with procedure protocols in place.
- There were clear processes for planning ongoing care in the community for surgery patients post discharge from the hospital, for example arranging ongoing physiotherapy care from local community providers.

Access and flow

- The admissions team were responsible for prioritising workload and clinic letter administration. All patients were booked in order from the patient target list (PTL). There were medical secretaries responsible for two nominated consultants and the process was organised.
- Staff had appropriate knowledge of the access policy.
- Between February 2016 and January 2017, the average length of stay for surgical elective patients at the hospital was 2.7 days, compared to 3.3 days for the England average. For surgical non-elective patients, the average length of stay was 4.6 days, compared to 5.2 for the England average
- Between April 2016 and March 2017, the trust's referral to treatment time (RTT), within 18 weeks, for admitted pathways for surgical services has been consistently worse than the England overall performance. The trusts performance remained stable at approximately 60% over the 12-month period. Data provided demonstrated that Vascular surgery, Opthalmology and Ear, Nose and Throat (ENT) had the highest RTT with 79%, 72% and 64% with Trauma and Orthopaedics and oral surgery at the lowest with 39% and 42% respectively.
- A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient is not treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their

choice. For the period April 2015 to March 2017 the trust cancelled 684 surgeries. Of these, 85 cancellations (12%) were not treated within 28 days, this is higher (worse than) the England average. Last-minute cancellations were included on the agenda for discussion at governance meetings.
- Cancelled operations as a percentage of elective admissions for the period April 2015 to March 2017 at the trust were lower than the England average.
- Theatre utilisation (excluding unsued sessions) as of April 2017 was 81.7% with average utilisation between April 2016 and April 2017 of 86%, against a target of 90%. However the total percentage of theatre sessions used over the 12 month period averaged at 76%, which reduced end theatre utilisation to 59%.
- Data also demonstrated that, in April 2017, 75% of lists started late and 53% finished early against a trust target of less than 40% and less than 20% respectively. This was comparative to the 12 month reporting period (between April 2016-17) where on average 77.7% of operating lists started late and 54.8% finished early. This meant not all theatres were being utilised to full capacity with the situation remaining relatively static with little improvement seen.
- The percentage of theatre cancellations in April 2017 was 32.4%, again comparative to the reporting period where cancellations averaged 32.7% over the 12 month period against a target of less than 5%.
- The trust monitored elective theatre utilisation via a dashboard that was RAG rated. The only month that showed green, achieving compliance above 90% was February 2017, where 91.2% was achieved. The theatre manager and surgical general manager were not certain as to what the difference had been in February particulary to achieve the target.
- The theatre dashboard also demonstrated that in April 2017 there were 27% of patient arrivals to theatre were delayed and 32.4% of patient transfers from theatre were delayed. Both of which affect the optimisation of theatre utilisation. The number of late list finishes (theatre overruns) in April was 39.5%, with the average over the 12 months being 37.6%, against a target of 20%. This had the potential to negatively impact on access and flow as some patients may become overnight admissions due to late transfers to the ward,
- The trust had 229 occurrences of unscheduled overnight stays (between midnight and 7am) in theatres between April 2016 and March 2017.

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- Theatre recovery has capacity for one overnight patient within the staffing template. Patients who require overnight recovery are referred to the critical care consultant anaesthetist who is responsible for the overnight recovery patients and liaises with duty theatre consultant anaesthetist. Overnight Recovery patients are transferred to the ward in the morning following satisfactory review by the night duty critical care anaesthetist.
- The surgery service reported no mixed sex breaches in the 12 months prior to our inspection.
- Data showed a number of patients were allocated bed spaces on surgical wards but should have been on medical wards in the period reported between January 2017 and April 2017. These patients are called outliers. There was an average of 40 outliers a month in general surgery during the reporting period. Nurses and medical staff assured us that the admitting team reviewed outliers daily.
- The Elmstead day surgery unit had extended operating hours until 10pm. Staff said that this meant that if a patient was not fit for discharge the transfer often occurred late in the day, which meant staff staying late and patients being moved late in the day.

Meeting people's individual needs

- There were leaflets available on a number of different procedures and conditions. These were available in different languages and larger print on request.
- Patient toilets and bathrooms were large enough to accommodate wheelchairs.
- Staff knew of the availability of translation services for people who did not speak English as a first language. The trust had an "Accessing an Interpreter Policy". Translation serviced could be provided by telephone or face-to-face.
- The trust had a dementia strategy 2016-2019 and delirium pathway in place, which was developed to improve access to high quality diagnosis, treatment, support and advice for all people living with dementia and their carers
- There were two dementia care nurse specialists (DCNS) within the trust. The DCNS are notified of every patient over 75 admitted as an emergency via the dementia assessment tool (DAT). All suitable patients are assessed as per FAIR (Find, Assess and Investigate, Refer) utilising the DAT tool for dementia and delirium.

- The trust utilised 'Link' nurses and was developing new 'Link' nurses, who linked to specific specialism to offer support, guidance, and advice to staff, for example for patients with diabetes or dementia.
- People admitted to the hospital with a known diagnosis of diabetes are flagged up through the portal alert system. All patients have a Think Glucose assessment within 24 hours of admission, which includes their diabetes status, and foot assessment. 'Think glucose' magnets are applied next to patient names on ward boards.
- The staff had access to a learning disabilities hospital liaison nurse specialist (LDHLN) who was notified of patients attending the hospital with a learning disability by ward staff, care homes, parents, carers, social workers, and community health team members.

Learning from complaints and concerns

- Between April 2016 and March 2017, there were 181 complaints about surgical care. The trust took an average of 45 days to investigate and close complaints; this was the longest of the core services. The most common complaint theme was treatment plan with 41 complaints, followed by staff attitude with 28.
- Patient information leaflets detailed how to contact the patient advice and liaison service with compliments or complaints.
- All staff we spoke with knew how to report a complaint and that feedback from complaints would be shared on a one-to-one basis where necessary or at team meetings. Learning from complaints was also included in governance and learning folders that were kept on each ward.
- One member of staff gave an example of talking to a patient and their relatives as a result of a complaint in an attempt to resolve the issue quickly. Staff told us they can be asked to provide statements as a result of complaints to aid investigations.

Are surgery services well-led?

Good 🟢

We rated well-led as good because:

Surgery

- Staff were aware of the new vision for the trust of, "Delivering great healthcare to every patient, every day". This was evident through the renaming of medical outliers to guests and the increased accountability for these patients.
- There was a clear governance structure in place for the service.
- There was an open culture of sharing and learning around complaints and incidents.
- Staff felt supported and valued by their colleagues .

However:

- Staff at a local were uncertain as to the surgical strategy.
- Staff felt morale was improving, but nursing staff felt that the number of vacancies and subsequent pressure was still affecting staff morale.

Leadership of service

- There was a defined surgical divisional structure. The division of surgery, including cancer, is divided into four clinical delivery groups, each led by a clinical director, general manager and number of clinical leads
  - General surgery, urology and vascular
  - Trauma and orthopaedics and specialist surgery
  - Anaesthetics, theatres and critical care
  - Cancer including haematology
- At time of inspection the general manager position was vacant in two of the four divisions, trauma and orthopaedics and cancer.These were actively being recruited to, with support provided through the clinical leads, matron and clinical directors whilst recruitment was ongoing.
- Surgical services were consultant-led and surgical staff in all areas reported that they were well supported by consultant leads. Staff of all levels said that senior staff were approachable.
- Nursing leadership at a local level was good with the majority of staff confirming that their line manager and matron were approachable, responsive and involved staff in the ward development.
- In theatres and recovery, we observed good communication from team leaders with all staff involved in the relevant procedure or recovery care.
- There was mixed feedback from staff about the visibility and level of support from senior leadership in the trust. However, staff felt the director of nursing was more visible on the wards than other members of the senior leadership team.

Vision and strategy for this service

- A strategy document for the surgery division was in place, which aligned to the trusts 2015 clinical strategy. The document was created in September 2015 and was due for review in September 2017. It outlined four areas of focus, new leadership team, culture, embedding of governance structures and performance.
- Staff we spoke with were unsure or unaware of a specific vision and strategy for the surgery service and how this linked into the new trust vision that was launched in October 2016. Staff were aware of the new vision for the trust of, "Delivering great healthcare to every patient, every day".

Governance, risk management and quality measurement

- There was a governance structure in place. At ward level there was a "Two at the top" monthly meetings with a set agenda, generic template to complete and standards outlined. The meeting reports to the monthly service area governance meeting for upward reporting to the monthly divisional governance meeting.
- The clinical governance meetings were used for reviewing operational policies and procedures. The meetings included a broad mix of nursing, medical, and multidisciplinary staff amongst others and details of the meeting and minutes were circulated to staff
- The trust provided minutes from the last three clinical governance meetings (May – July 2017), which included a standard agenda that included discussion of current risks, complaints, patient's safety, and clinical effectiveness.
- The surgery divisional risk register was reviewed as part of clinical governance and risks were appropriately mitigated as far as possible. All risks identified by the inspection team were on the existing risk register and staff we spoke to were aware of the risks in their department. Current risks included theatre utilisation, nursing and allied healthcare professional and medical staffing.
- All risks on the register were rated as Extreme or High risk. Risks included a most recent review date. However, the data provided, did not include a target date for meeting the risk target and did not identify specific actions taken to mitigate and reduce the risks.

Surgery

- Internal monitoring was conducted through the surgery division performance dashboard, which is completed on a monthly basis. The dashboard includes reports on RTT performance, cancelled appointments and operations, and a quality scorecard for each surgery ward.
- We were not assured that local leaders in theatre were being fully engaged by the service managers to help drive improvement. Whilst theatre performance data was being collated to provide quality measurements, the theatre manager stated their involvement was to collate information into a report for more senior managers . The head of operations was identified on the risk register as the owner for the risk regarding theatre utilisation. During inspection we explored this with the theatre manager and general manager, who was relatively new in post, and it was evident that local responsibilty and ownership for helping drive improvement with utilisation could be strengthed.

Culture within the service

- There had been several changes at service manager level, especially in urology, which staff stated made it difficult to then raise and resolve any issues.
- Nursing staff felt that the number of vacancies and subsequent pressure on staff was still affecting staff morale. However, they did feel morale at the hospital in general was improving.
- Physiotherapy staff reported they felt well supported and morale was improving.
- Staff we spoke with spoke to inspectors honestly and frankly during the inspection.
- Nurses and healthcare assistants told us they felt valued and respected by colleagues. However, they felt that not all managers had the necessary skills or experience to perform their roles.
- There was an open culture of sharing and learning around complaints and incidents. Staff told us that learning from was shared at board meetings and by email.
- Senior nursing and medical staff we spoke with were all aware of the duty of candour process and had received training.
- There was increased focus on the culture of the service. This was evident through the renaming of medical outliers to guests and the increased accountability for these patients.

Public engagement

- Public engagement was primarily through the patient advice and liaison service (PALS), and the Friends and Family Test (FFT).
- The trust took part in the most recent uro-oncology clinical nurse specialist service inpatient survey in December 2016.

Staff engagement

- Staff we spoke with told us they attended regular team meetings with their managers and received information in a number of ways including face-to-face, email, and ward newsletters/bulletins. We saw two copies of the Fordham ward bulletin, which updated staff on 'Two at the top' meetings, any changes to trust leadership or governance structure and updates and reminders to staff on ward specific issues.
- The trust has also started a 'Staff Involvement Group', which is an executive led meeting that happens on a monthly basis. The purpose of the group is to allow staff to raise any issues, concerns and highlight good practice.

Innovation, improvement and sustainability

- One of the work streams within the 'Every Patient Every Day programme' is planned care. The planned care work stream aim to drive quality and productivity improvements and efficiency savings across capacity and demand, referral to treatment (RTT) and theatres/outpatients. The planned care work stream is responsible for the delivery of planned improvements to RTT waiting times for patients on admitted care pathways, diagnostic access, and waiting times, day case and inpatient theatre productivity and efficiency.
- This trust had begun a quality improvement project, which is monitored regularly with key performance indicators and actions.
- There was uncertainty about the future of the urology service since another trust had been chosen as the Essex urology specialist cancer centre, which had resulted in a fragmentation of urology services across both trusts.
- Senior staff raised concerns about the funding for the ICENI Centre, which is a joint venture between Colchester Hospital University Foundation Trust and a local university, which since 2011 has been housed in a purpose built Research and Education Centre. The university was withdrawing funding and the future of the

Surgery

centre was uncertain. Staff were concerned that if the centre were to close it would limit the sustainability and innovation within the trust, because the centre is a focus for surgical research and training.

- The trust was proactively looking to develop and support healthcare assistants on the pathway to the registered general nurse training, which would improve staff retention and help the trust in tackling the shortfall in nursing numbers.

Critical care

Safe	**Good**	🟢
Effective	**Good**	🟢
Caring	**Good**	🟢
Responsive	**Good**	🟢
Well-led	**Requires improvement**	🟠
Overall	**Good**	🟢

Information about the service

Colchester Hospital University NHS Foundation Trust's Critical Care Unit has14 beds (four side rooms and 10 open beds). However, they are only funded to have 13 beds operational at any one time. Between April 2016 to March 2017 care was provided for 671 patients.

The Critical Care unit delivers care to adult patients with life- threatening illnesses, postoperative patients and children who may require short term admission for ventilation and clinical stabilisation prior to transfer to a dedicated Paediatric Intensive Care Unit as soon as possible. All beds in the critical care unit can be used for high dependency care (described as Level 2 care) or critical care (described as Level 3 care) as defined by Levels of Critical Care for Adult Patient Intensive Care Society 2009.

Patients would be admitted following complex and serious operations and in the event of medical and surgical emergencies. The unit provided support for all inpatient specialities and tertiary services within the acute hospital, and to the emergency department, including major trauma patients. A critical care outreach team assisted in the management of critically-ill patients on wards across the hospital and was available 24 hours a day, seven days a week.

During the inspection we spoke with 17 members of staff including consultants, junior doctors, nurses, allied health professionals, health care assistants and housekeeping staff. We also spoke with three patients receiving care and four of their relatives. We examined ten sets of paper records and observed care provided within this service.

Summary of findings

We rated this service as Good because:

- There was a good culture of incident reporting and learning from incidents. Duty of candour was understood and discharged appropriately by staff, and we observed this directly during our inspection.

- There had been a significant improvement in the servicing and cleanliness of equipment since the last inspection. We found all equipment to be visibly clean and in date with electrical safety checking.

- Infection prevention and control practices were good as were compliance rates for internal audits.

- The critical care outreach team, provided outreach services into wards, proactively identifying patients who would benefit from closer monitoring, as well as monitoring patients discharged from the unit back into the wards.

- Nursing and medical staffing levels were in line with national guidance recommendations.

- Treatment and care was provided in line with best practice and recognised national guidelines.

- There were numerous examples of good team work across medical, nursing and allied health professionals. Staff worked collaboratively to provide the highest possible care for patients.

- Feedback from patients and relatives during our inspection was overall very positive.

Critical care

- The unit was very responsive to complaints and we saw evidence of where learning from complaints had occurred, as well as bespoke reflective learning and development for individual staff.
- There was a positive culture within the unit, and staff praised the leadership team for being supportive and approachable.

However:

- Whilst governance processes were in place, actions plans and some meeting minutes lacked detail. Governance recording processes and quality measures were yet to be embedded.
- Whilst the service had worked to improve attendance at the mortality and morbidity meetings, these were often poorly attended, with sparse minutes and no clear actions or learning from deaths recorded.
- Due to new staff taking over the nurse led follow up clinic, there had been a number of months in which data was not received in relation to numbers attended, patients referred to other services such as psychology, or feedback into the service from patients once they had been discharged.
- Data from the East of England critical care network showed that between April 2016 to March 2017 there were 179 delayed discharges (those between four to 24 hours). Discharges more than 24 hours were 239 from the same period. However it was noted that the unit was working to improve this by early identification of patients that could be discharged, as well as completing a business case to potentially expand the unit providing a high dependency/level 1 facility that could be used for step down. There was no evidence that delayed discharges impacted upon timeliness of admission to the unit.

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Are critical care services safe?

Good ●

We rated safe as Good because:

- Since our last inspection there had been a significant improvement in the servicing and cleanliness of equipment. We found all equipment to be visibly clean and in date with electrical safety checking.
- There was an open culture around incident reporting and evidence of learning from incidents.
- Staff were knowledgable of duty of candour and we saw evidence of this being discharged in practice.
- There was good compliance with hand hygine and infection control compliance in care bundles, such as management of line insertions.
- There was a good culture around medicine safety, which included evidence of reflection and learning when mistakes occurred.
- The critical care outreach team provided a good service in proactively identifying patients who would benefit from closer monitoring, as well as monitoring patients discharged from the unit back in wards.
- Medical staffing met the requirements of the Core Standards for Intensive Care (2013).
- Nurse staffing levels were sufficient to meet with the Faculty of Intensive Medicine Standards

However:

- Mortality and morbidity meetings were often poorly attended. Minutes were sparce and there were no clear actions or learning from deaths recorded, although cases were discussed at both governance and sisters meetings.
- Data for June 2017 showed that only 50% of medical staff had completed traning for adults safeguarding Level 1 and 2.

Incidents

- Between April 2016 to April 2017 159 incidents were reported.151 incidents resulted with no harm and were deemed as low risk. Eight incidents had been recorded as moderate.
- No never events were reported between May 2016 and April 2017.Never events are serious incidents, which are wholly preventable as guidance and safety

Critical care

recommendations are available that provide strong systemic protective barriers at a national level. Although each never event has the potential to cause harm or death, harm is not required to have occurred for an incident to be categorised as a never event.

- Between May 2016 and April 2017 no Serious Incidents (SI) had been reported.

- There was an open culture of incident reported throughout the unit. Staff knew how to report an incident and could give examples in which learning had taken place. A member of staff told us that they had received feedback when they made a report through the incident reporting system.

- We reviewed an incident that had occurred on the unit in relation to the management of a patients airway. An investigation had been completed with a number of learning action points. These actions had resulted in change of practice within the unit and additional training for staff. For example the introduction of white boards above each patient bed space which clearly identified the specific airway management, and any potential issues, such as difficult airway management and type of equipment to be used.

- We observed an incident occur on the unit during our inspection, which was not in direct relation to care on the unit, but that of care received elsewhere within the hospital. Staff responded appropriately and recorded the incident on the electronic incident reporting system.Duty of candour was considered and intitated.The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) ofcertain 'notifiable safety incidents'andprovides reasonable support to that person).

- We reviewed a Root Cause Analysis (RCA) in relation to a grade three pressure ulcer that had occurred prior to May 2017. The pressure ulcer had been appropriately reported and assessed by the Tissue Viability Nurse. Duty of candour had been clearly documented in the notes, which had been attached to the incident report. There was an action plan, which included ensuring staff were including assessment of patients skin integrity where equipment was secured with gauze or tape. This had been subsequently included on the care rounding documentation.

- We saw response to an incident that had occurred in a ward area with a patient who had been transferred from critical care. Although the incident occurred at ward level, there had been learning across both areas. This resulted in the critical care unit producing an information sheet that was sent with all patients who were discharged to the ward with a specific piece of equipment. The leaflet included advice and guidance on the equipment, and identified that the critical care outreach team took overall responsibility for removing the equipment following use.

- Mortality and morbidity (M&M) meetings were held monthly. We reviewed meeting minutes from February 2017, which reflected a low attendance (five members of staff). Minutes were sparse and it was unclear how and if learning was shared. Whilst learning points had been identified, there were no completion dates, or who the member of staff was who was required to take the action.

- The attendance rate at the M&M meetings had been identified during the East of England Critical Care Network peer review in which attendance had been identified as variable. Senior staff recognised that improvement needed to be made in both meeting attendance and reporting and learning process. Meetings times had recently been changed to encourage more staff to attend.There had been higher attendance in June 2017, with 14 members of staff attending.

Safety thermometer

- Safety thermometer data was displayed in the clinical area.The safety thermometer is a data collection tool to help orgnsisations understand the most commonly occurring harms in healthcare:pressure ulcers, falls, urinary tract infections and venous thromboembolism (VTE).

- Between April 2016 and April 2017 the unit reported one new pressure ulcer. We reviewed the root cause analysis. Learning had been disseminated to staff.

- Between April 2016 and April 2017 no catheter acquired urinary infections or falls had been reported.

Cleanliness, infection control and hygiene

- Between April 2016 and March 2017 there had been no reports of MRSA or C Difficile infection.

- Hand Hygiene audits were carried out on monthly basis. We reviewed data for audits completed in March and April 2017 and found 100% of all staff observed were compliant with hand hygiene principles.

Critical care

- Hand sanitizer was available throughout the unit and we observed staff using this appropriately.
- We observed nursing, medical and allied health professionals wearing personal protective equipment when delivering patient care. However we observed one member of staff not removing gloves when completing documentation and sorting through records.
- One patient was receiving care in a side room due to an on going infection. There was clear signage on the door instructing staff and visitors that personal protective equipment should be worn when entering. The patients records showed that the patient was on an appropriate pathway for the type of infection to ensure that appropriate infection control measures, communications and medication was prescribed.
- We reviewed data from the March and April 2017 Saving Lives, high impact intervention audit, which looked at compliance with standardised clinical practice to reduce infections. Audit data showed that those patients with line insertions such as renal catheters had received 100% compliance with the related care bundles, thus providing good infection control prevention.
- The unit was visibly clean and tidy, with the use of "I am clean stickers" on equipment that indicated it was clean and ready for use. Data from the cleaning audit from March and April 2017 showed that the unit achieved between 97-98% in the cleaning compliance audit.
- All patients receiving antibiotic therapy were reviewed daily by the microbiologist, to ensure that therapy being given was appropriate.

Environment and equipment

- The unit was compliant with the Health Building Notice 57, which included, but not exhaustive, sufficient space around beds to accommodate mobile equipment, as well as allowing a minimum of five members of staff to attend in an emergency situation.
- The unit had a difficult airway trolley, which was clean, accessible and daily checks between May 2017 and June 2017 had been completed.
- We checked a wide range of medical equipment, which included pumps, syringe drivers, machines to administer intravenous fluid and monitors. All were found to be visibly clean and were in date for electrical safety checking.

- The resuscitation trolleys were checked twice a day. We reviewed the two resuscitation trolleys, both of which had recived daily checks between May 2017 and June 2017. However, there were six times in which a second check had not been carried out.
- The unit had recently completed a business case to purchase new ventilators and was awaiting the outcome of this at the time of our inspection. The new ventilators would improve ventilator care, as they had a number of different clinical applications, including automated weaning.
- All patients were nursed on pressure relieving mattresses whilst in bed. Staff could also request pressure relieving chair cushions and gel pads were available for use on patients heels, to reduce the risk of pressure damage.

Medicines

- Between April 2017 to April 2017 31 medication incidents were reported. 29 were recorded as no harm with two recorded as low harm.
- We reviewed three incident reporting forms in relation to medication errors. Investigations had been completed and staff had received appropriate counselling and additional training where required. We also saw evidence of staff completing reflective learning summaries to help reflect on the incident and identify learning and the impact on the patient.
- The pharmacist would undertake monthly audits specifically looking at omitted doses of medication. The latest audit was completed on the 27 July and no omitted doses had been identified.
- Medicines were stored securely with secure access limited to nursing staff. Controlled Drugs (CDs) which require special storage and recording were stored following best guidance procedures including daily checks by two nurses on quantities and records. We checked the records between January 2017 and July 2017, however we found five days when CDs had not been checked.
- Medicines requiring cool storage were stored appropriately in locked medicine refrigerators. Daily temperature records for the medicine storage room and for the medicine refrigerator documented that medicines were stored within safe temperature ranges.

However we identified one fridge temperature record that did not have the correct ranges listed (although the fridge was in range). We escalated this to a member of staff at the time.

- The unit had recently worked with pharmacy and introduced "grab bags", which contained all essential drugs for emergency stabilisation, and could be taken out into other clinical areas for patients who were deteriorating. Staff on the unit were reviewing the impact of the grab bags at the time of inspection.

Records

- Records were paper based. However the trust was in the process of developing a new electronic patient management system to be used for record keeping, which would have automated prompts for the use of care bundles and would ensure a contemporaneous recording of all physiological and drug administration data.
- We reviewed ten sets of patient records. All records were completed appropriately and included a number of clinical assessments such as pressure ulcer risk, falls assessments and venous thromboembolism (VTE) assessment.
- Between April 2017 and April 2017 100% of VTE risk assessments had been completed.
- Clinical notes included daily documentation of ward rounds, assessment of fluid status, review of sedation and evidence of input from the multidisciplinary team

Safeguarding

- In April 2017 critical care achieved the target of 95% for nursing staff training compliance in adults safeguarding Level 1 and Safeguarding of vulnerable adults level 1 and 2. Child protection training Level 1 and 2 was at 94% and 92%. (Level 1 provides a baseline understanding, Level 2 provides greater knowledge for those working regularly with children). However, data for June 2017 showed that this had increased to 100%.
- Data for June 2017 showed that 100% of medical staff had completed child protection level 1 and 2, and 50% for adults safeguarding Level 1 and 2.
- There were policies, systems and processes for reporting and recording abuse in place. The policies described definitions of abuse and who might be at risk. The policies were linked with the provisions of the Mental Capacity Act 2005 in relation to deciding if a person was vulnerable due to their lack of mental

capacity to make their own decisions. The policies described the responsibilities of staff in reporting concerns for both adults and children, who were subject to different procedures within the policies.

- Staff were able to provide examples of when they had contacted or made referrals to the safeguarding team, for example in patients with complex mental health needs.
- Senior staff in CCU were aware of their responsibilities to investigate and report any concerns about children and vulnerable adults. Staff knew who within the hospital trust could be contacted for support and how to take matters further with other agencies.
- Patients between the ages of 0-18 years were admitted to the unit, for initial stabilisation and then would be transferred out to an appropriate tertiary centre. For all children admitted a paediatric nurse, paediatric consultant and paediatric lead anaesthetist would oversee the care. Between July 2016 and June 2017 20 paediatric patients had been admitted to the unit.

Mandatory training

- Mandatory training consisted of 18 modules, including fire safety, infection control, learning disability awareness and basic life support.
- In April 2017 nursing staff compliance for mandatory training ranged between 78-100% depending on the module. Basic life support was at 76%, and sepsis at 97%.
- Medical staff compliance ranged from 47-100% (however the total number of staff required to complete the training was three, which affected the % scoring if missing one attendee). The lowest module for compliance in medical staffing was in sepsis and conflict resolution, and 66% in basic life support.

Assessing and responding to patient risk

- The critical care unit operated a 24/7 outreach service. The service was based on the critical care unit. Between July 2016 and June 2017 the team carried out 359 assessments.
- There was a dedicated referral form used by ward areas to refer into critical care. This proforma used the Situation, Background, Assessment and Recommendations (SBAR) format, which is a tool to provide clear communication, and included the Airway, Breathing, Circulation, Disability and Environment (ABCDE) assessment of patients.

Critical care

- The proforma also included the clinical frailty index, to inform discussion prior to the transfer of patients. This is a tool which predicts adverse outcomes for older patients such as increased hospital stay and mortality.
- All patients who were deemed ready for discharge from critical care, would be assessed using the National Early Warning Score (NEWS) scoring system to determine the degree of illness which is based on a number of vital signs such as blood pressure, pulse and respiratory rate.
- Patients transferred from critical care into ward areas would be reviewed by the outreach service four hours post discharge. Once patients had a NEWS score less than five, they would be discharged from the care of the critical care team. However staff could re refer if there were any concerns or contact the medical team in the unit for advice and support.
- All patient receiving non-invasive ventilation therapy (NIV), (which supports a patients breathing without the need for intubation or tracheostomy), remained under the care of the outreach service.
- The unit would take patients of all ages, including children. Children admitted to the unit, would be initially stabilised and then transferred out to a local tertiary centre via the Childrens Acute Transport Services (CATS).
- A paediatric nurse would be released from the paediatric ward to attend critical care, and support staff in the management of any child admitted.
- All patients were assessed using the Richmond Agitation-Sedation Score (RASS- a tool to detect delirium in intensive care unit patients) to monitor signs of delirium.
- Patients who were identified as deteriorating or at end of life were captured on the trusts electronic data system. This meant that medical staff would be aware of patients who may require critical services, or at risk of deterioration, as well as the palliative care team being aware of patients who were at end of life.

Nursing staffing

- The nursing establishment was planned for seven level three patients (requiring advanced airway support or support of two or more organs) and six level two patients (requiring single organ support). The Faculty of Intensive Care Medicine / Intensive Care Society Core Standards for Intensive Care Units recommends that each level three patient should have one-to-one nursing, and level two patients should have one-to-two nursing
- In April 2017 there were 63.81 whole time equivalents (WTE) Registered Nurses (RN).Staffing rotas were reviewed for the months of April to June 2017.
- The critical care outreach team had 5.14 WTE staff in post.
- Between May 2016 and April 2017, the trust reported a turnover rate of 0% in Critical Care
- Recommended staffing levels had been met during these three months in line with patient acuity. Staff were redeployed to other areas within the trust to support other clinical areas if patient acuity allowed and this would be assessed continuously as the units acuity could change on an hourly basis. However, staff informed us that sometimes it was difficult to "recall staff" should the unit become busy.
- At the time of our inspection a new acuity tool was being trialled, which reviewed staffing levels three times during the day on an ipad, which was reviewed by the trust site team and would identify any "hot spots" in which extra staff was needed.
- The tool provided information on the number of Level 1, 2 or 3 patients. This was in addition to the six monthly "Safer Nursing Care Tool" (SNCT) assessment, which would assess patients acuity and dependency to ensure that nursing establishments reflected patient need.
- A critical care unit with over 10 beds, should have a supernumerary nurse, who is not rostered to patient care. The shift co ordinator was always supernumerary to the number of nurses per shift.
- The trust held a number of "honorary " contracts with the local army base, which meant that nurses from the armed services would work ad hoc shifts on the unit.
- Between May 2016 and April 2017, the trust reported a sickness rate of 0.5% in Critical Care.
- Between May 2016 and April 2017, the bank and agency usage was 9% in Critical Care for registered nursing staff.
- Nursing handovers were undertaken twice a day at shift handover, followed by a detailed handover at the patient bedside. At the time of our inspection the unit was planning to introduce a morning multidisciplinary handover, due to commence in July 2017.

Medical staffing

Critical care

- There were 10 consultants who provided cover, including one consultant on site from 8am until 10pm including weekends. This met the requirements of the Core Standards for Intensive Care (2013) for medical staffing, in which consultant range should not exceed 1:8 - 1:15 and the CCU resident patient ratio should not exceed 1:8.
- As of April 2017, the trust reported a vacancy rate of -3% in Critical Care, being over establishment for consultant grade or higher by 0.27 WTE.
- Between March 2017 and April 2017 the trust reported a bank and locum usage rate of 0% in Critical Care with the exception of February 2017 when the usage was 1%.
- One senior anaesthetic resident covered critical care during the night, with additional support if required provided by theatres and obstetric services.
- There was always a consultant in critical care who was available 24/7 and able to attend within 30 minutes.
- Handover consisted of a morning hand over from the night to day shift, an evening handover between 6-7pm and a trust wide medical handover at 9pm, in which a member of critical care medical staff would be present. In the night handover patients,such as those on a palliative care pathway, or those with ceilings of care, would be discussed to ensure continuity.
- We observed a consultant handover from night shift to day shift. This included details of discharges, deaths and admissions as well as any clinical concerns such as difficult airway management.
- The consultants on the unit also undertook a daily ward round on the medical high observation area (five beds) located on a medical ward , in which the overall responsibility for patient care was overseen by acute physicians, to provide assistance and support.

Major incident awareness and training

- The trust had a major incident plan, including plans for the provision of additional critical care beds should they be required.
- The major incident policy provided a flow chart for the critical care unit of stepping up the number of level 3 beds and the additional bed capacity utilsed in the theatre recovery area.
- There was evidence of shared learning by the trust lead for emergency planning, for example communication of learning points following recent emergency incidents and how other trusts responded. This was shared with staff via email.

Are critical care services effective?

Good 🟢

We rated effective as Good because:

- There were a number of audits carried out locally and nationally.
- Best practice guidelines and polices were reviewed and updated and changed in line with recommendations, for example the therapeutic hypothermia guidance had been amended in accordance with changes.
- All patients admitted to critical care received an assessment on rehabilitation requirements in line with National Institute for Health and Care Excellence (NICE) Clinical Guidance CG 83 – "rehabilitation after critical illness"
- The East of England Critical Care Network peer review carried out in February 2017, showed that the unit was meeting the seven East of England evidence based principles for critical care, known as the "magnificent seven".
- The Intensive Care National Audit Research Centre (ICNARC) data showed that for all patients the risk adjusted hospital mortality ratio was 1.1. This was within the expected range. The risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 0.8. This was within the expected range.
- The unit had recently invested in the purchase of a "simulation mannequin", which enabled simulation training experiences for staff as the mannequin would respond, for example in drug recognition, light sensitive pupils and body fluid excretion.
- We observed good examples of multidisciplinary working in ward rounds, handovers and multidisciplinary meetings. Staff worked collaboratively and supported each other in delivering care.
- Patients were assessed in line with the Mental Capacity Act 2005. Out of the 10 sets of notes reviewed every patient had an initial MCA assessment completed

However:

- There was no standardised or routine assessment form completed to assess mental capacity, for example if a patients condition changed. This would be reliant upon the consultant documenting in the patients notes.

Critical care

- Complaince with rehabilitation requirements in line with National Institute for Health and Care Excellence (NICE) Clinical Guidance CG 83 – "rehabilitation after critical illness" were not routinely audited.

Evidence-based care and treatment

- There were a number of local and national audits within the department such as participation of the National Emergency Laparotomy Audit (NELA) due for completion in December 2017and the local audit of central venous line (CVC) tips (end of the catheter that lies in part of the heart) sent for microbiology screening (routine practice in removal of CVC lines).

- The outcome from the CVC audit showed that the number of tips sent for screening was lower than that of the number of patients. This meant that not all tips may have been sent. At the time of our inspection the unit was re auditing this, following additional teaching to staff, to ensure that all tips were sent.

- As part of the NELA audit, all patients with a predicted preoperative mortality score of greater than 5% were admitted to the unit for peri operative care.

- We reviewed audit results for the "siting of tracheostomies", to ensure that practice was in line with the National Confidentiality Enquiry into Patient Outcome and Death (NCEPOD) guidelines. There was clear learning from the audit, which included use of variable length or extended length tracheostomy flanges that should be considered more often, especially in obese patients.

- All patients admitted to critical care received an assessment on rehabilitation requirements in line with National Institute for Health and Care Excellence (NICE) Clinical Guidance CG 83 – "rehabilitation after critical illness". We saw these in all of the 10 sets of notes we reviewed, however these were not regularly audited to ensure compliance.

- The Confusion Assessment Method (CAM) for delirium was used for assessment of patients, which included the Richmond Agitation Sedation Scale (RASS). Assessments would be carried out as per NICE guidelines every 24 hours.

- The East of England Critical Care Network peer review carried out in February 2017, showed that the unit was meeting the seven East of England evidence based principles for critical care, known as the "magnificent seven". These included ensuring that parental nutrition was only prescribed after authorisation from the critical

care pharmacist and multidisciplinary team, and the evening consultants review and direct what diagnostic tests are required as opposed to "routine regular intervals".

- There were a number of new practices that the unit was in the process of either trialling or reviewing. For example there was a trial at the time of our inspection being carried out into "blood conservation". This looked at the way in which patients blood tests were requested and clinical rationale, so that blood tests were not "routinely" carried out. The unit was also reviewing more "sutureless" invasive equipment to reduce the need for suturing in intravenous lines, which would potentially reduce the risk of developing infections.

- All clinical guidelines were kept at the end of each patients bed in a folder. We reviewed a number of guidelines including therapeutic hypothermia, delirium guidelines and sepsis screening. All guidelines were in date and had a date for review. We saw evidence of where updates had been made to guidelines for example the therapeutic hypothermia guidance had been amended in accordance with changes.

- The unit was in the process of developing a number of care bundles which would be available on the new electronic management system. These care bundles included kidney management and electronic prescribing.

- Sedation guidelines had been recently re written to reflect changes in the administration of certain drugs that enhance the weaning off of ventilators for patients.

- Physiotherapists used the Chelsea Critical Care Physical Assessment tool (CPAX) (a tool to measure physical morbidity), for the assessment of patients, which included respiratory function and mobilisation. Out of the ten records we reviewed every patient had received a CPAX assessment.

Pain relief

- Pain was assessed using a variety of methods in the until by staff involved in the patients care. This included speaking with carers and families, facial expressions and clinical observations.

- All patients who were receiving Patient Controlled Analgesia (PCA) or epidurals (pain relieving injection placed into spinal cord space were reviewed by the pain management team during the consultant ward round.

- Staff were able to refer patients directly to the pain team, if they felt patients pain was not controlled.

Critical care

- Staff were responsive to patients, and gave an example of where a patient wished to try an alternative pain relief, to what they were prescribed.
- We spoke with one patient who said that their pain had been well controlled and staff had responded promptly when their pain had increased.

Nutrition and hydration

- The unit had a designated dietician, who attended the daily ward rounds and saw all patients admitted to the unit.
- Patients had a nutritional assessment completed within 24 hours of admission. There was a feeding protocol in place which stated that all naso gastric feeds were commenced on admission unless clinically contraindicated.
- We observed that for patients that could eat and drink, drinks were available and within reach, and a variety of food was able to be ordered.

Patient outcomes

- The Critical Care Unit contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. The latest ICNARC data available at the time of our inspection was for the period from April 2016 to December 2017.
- ICNARC data showed that for all patients that the risk adjusted hospital mortality ratio was 1.1. This was within the expected range. The risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 0.8. This was within the expected range.
- The number of unplanned readmission with 48 hours between April 2016 to March 2017 was 0.7%.This was below the expected range (better than average).
- The service reported key performance indicators (KPIs) to the East of England Critical Care Network on a monthly basis.
- The unit achieved the target of the national threshold for avoidance of non-clinical transfers at 0.4%, as they only had one transfer in the last 10 months.
- The consultant lead had introduced a new initiative called "paralysis by pyjamas". This focused on the importance of staff supporting patients to get dressed, once they were clinically stable to encourage mobilisation and to focus on their rehabilitation.

- All patients that had received any length of stay in critical care were able to attend the physiotherapy sessions which were held twice a week. This enabled the on going rehabilitation of patients.
- Nurse led follow up clinics were held. Patients would be sent letters inviting them to attend a follow up clinic two weeks after discharge. There was a clear process for the on going assessment of patients following discharge at two, and then at six and twelve months. A post-traumatic stress disorder proformar was used during clinics and referral were made to appropriate services if required.
- At the time of our inspection, two recently designated nurses had taken over the follow up clinic role, hence there had been no quarterly report published to capture any data such as number of patients seen in the last quarter.

Competent staff

- There was a dedicated critical care practice educator with responsibility for coordinating the education, training and continuous professional development of staff.
- All new staff to the unit received four weeks supernumerary status followed by four week supervised practice.
- The unit had recently invested in the purchase of a "simulation mannequin", which enabled simulation training experiences for staff as the mannequin would respond, for example in drug recognition, light sensitive pupils and body fluid excretion.
- Since the purchase of the simulation mannequin, multi-professional training scenarios had been introduced. The first scenario based training had been for the management of patients airway, in which nursing and medical staffed worked through a scenario and were able to carry out clinical interventions on the mannequin.
- There was a staff equipment assessment register which detailed which staff required to complete training on a specific piece of equipment for example feeding pumps or ventilators.
- We reviewed training records and found that all qualified and unqualified staff were compliant and had received training on equipment such as blood glucose meters, pumps and monitors. Out of fourteen pieces of specialist equipment 95-100% of staff had received training and were deemed competent.

Critical care

- 68% of nursing staff held the post registration award in critical care nursing, which was above the 50% minimum standard.
- 65% of band seven nurses and 50% of Band six nurses had completed the Advanced Life Support training (ALS). This meant that senior nurses were trained in the management of the deteriorating patients and managing a cardiac arrest in an emergency situation.
- 100% of medical staff and 23% of nursing staff had completed the Acute Life-threatening Events-Recognition and Treatment (ALERT) course, which was a one day multidisciplinary course in the recognition and management of the critical ill patient.
- As of April 2017, 95% of staff within Critical Care had received an appraisal.
- Revalidation for nursing staff was recorded on the electronic staff rota system. Staff also received an email from the human resources department. There had been a number of workshops across the trust for staff to attend to support them in the process of revalidation.
- Any temporary working staff to the unit completed an induction checklist. We reviewed 10 checklists which were comprehensive and provided relevant key information about the unit.
- All new consultants had a programme of induction. Within the last three years there had been two new consultants, who had both worked on the unit before commencing their consultant posts.
- Staff could access a number of training sessions delivered by other teams. For example the pain team ran an acute pain study day four times during the year which covered epidurals, patient controlled analgesia and pain assessments, as well as providing training on the staff induction and ad hoc sessions if requested.
- The unit had recently introduced mental health training for Band six and Band seven nurses, to increase knowledge and awareness of mental health issues.
- All staff had completed "sepsis six" training. This meant that staff were competent in the recognising, assessing and treatment of patients with sepsis.
- The unit received a number of students including nursing, midwifery and operating department practitioner (ODP). The unit provided appropriate levels of mentors for students, and had a good relationship with the local university. We spoke to one student ODP during the inspection who reported that they had a positive learning experience and felt well supported.

Multidisciplinary working

- During the inspection we observed a morning ward round. The multidisciplinary team were engaged during the round and there was good communications and plans of care discussed for the patient. For example we observed discussion between the medical team and physiotherapist regarding patient airway management and the pharmacist regarding medication blood levels.
- We observed the diabetic nurse specialist join the ward round to provide specialist advice regarding a patients diabetic management.
- Each consultant was a key lead in a designated area and worked with other teams across the trust. For example the lead clinician was part of the end of life care working group, another consultant worked within the vascular working group which consisted of anaesthetists and surgeons.
- We saw evidence of good multidisciplinary working between the unit and the palliative care team, in assisting a patient with a legal matter, and how the patient was supported in requesting external support and how this was facilitated for them.
- The dietetic team provided nutritional advice for unit staff and could be called upon for support or guidance. The dietetic team would update unit staff of any changes in guidance, and the team felt valued as part of the team working in critical care.
- Referrals were made to the speech and language team, who would assess patients upon request, and they had a close working relationship with the dietetic team.
- The critical care outreach team were based in an office on the critical care unit. One member of staff from the unit rotated into the outreach team.
- The unit had a good relationship with the hospital liaison mental health nurse and mental health crisis team. Staff provided an example where they had worked with the mental health team in the management of a complex patient.
- The physiotherapist worked closely with the occupational therapy team, and gave examples of where they had referred patients that required specific aides such as specific splints or high to low rise beds.
- The team spoke positively of starting to build relationships with another trust and looking at ways to share best practice to improve patient care.

Seven-day services

Critical care

- Critical care services were consultant led seven days of the week. All patients were reviewed twice daily, on all days of the week.
- The dietetic team provided cover Monday to Friday 8.30am to 5.30pm.There was no on call weekend cover provided.
- The outreach team provided one dedicated nurse 24/7.
- Physiotherapy services were available daily from 08.30-16.30pm, with an on call system in the evenings.
- Radiology services, including access to urgent Computed Tomography CT scans were available 24/7.
- The specialist nurses in organ donations were available 24 hours per day, seven days per week via a bleep system.
- The speech and language team were available between Monday to Friday 08.30-4.30pm.There was no out of hours service, however if a referral was received on a Friday afternoon advice would be provided to the consultant in charge of the patients care.

Access to information

- All patient discharged from the unit had a detailed discharge summary completed, outlining key events on the unit and outstanding issues requiring management.
- All patients admitted on to the unit were offered a follow up appointment on discharge. Results from this review were shared with the general practitioner, including information regarding the psychological well-being of the patient in order to aide on-going management within the community.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- The Treatment, resuscitation and End of Life form (TREC), contained guidance for those patients who lacked capacity including reference to Mental Capacity Assessment, best interest decision, lasting power of attorney and advanced directives. The form was used in ward areas, for those patients being transferred into the critical care unit.
- All staff received restraint training as part of their mandatory Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) training. As of April 2017, MCA Level 1 training had been completed by 97% of staff. MCA training level 2 had a completion rate of 94% and level 3, 96%. DoLS Level 1 training had been completed by 96% of staff. DoLS level 2 had been completed by 95% of staff.

- Any patient requiring any form of restraint (such as the use of mittens in confused patients who may be at risk of pulling intravenous lines out), had a risk assessment completed and physical restraint checklist. This would always be sent to the safeguarding team.
- At the time of inspection the "use of mittens" protocol was in development.
- Patients were assessed in line with the Mental Capacity Act 2005. Out of the 10 sets of notes reviewed every patient had an initial MCA assessment completed. However there was no standardised or routine assessment form completed if a patients condition changed.

Are critical care services caring?

Good ●

We rated caring as Good because:

- Staff provided compassionate care to patients. We saw staff talking to patients and explaining procedures.
- Relatives gave praise and positive feedback to all of the staff involved in their loved ones care.
- Between December 2016 and February 2017 the critical care satisfaction survey showed out of 31 responses, 29 stated that they were satisfied with the care provided to themselves or a family member, and 30 feeling that their questions had been answered.
- We saw a number of thank you cards and letters from patients and relatives displayed in the unit, which praised the care that they or their family member had received.

However:

- One relative mentioned that they had one poor experience in which staff had been talking over the patient whilst providing care.

Compassionate care

- The unit completed a critical care satisfaction survey. We reviewed the data between December 2016 and February 2017 in which 31 patient/carers/families had completed the survey.
- Out of 31 responses, 29 stated that they were satisfied with the care provided to themselves or a family member, and 30 felt that their questions had been answered.

Critical care

- Staff were observed maintaining patients dignity by drawing screens when delivering care.
- Family members were supported if they wished to stay overnight.
- We spoke with four relatives. Overall visitors praised the staff in the unit with comments such as " nurses explain everything" and " we are kept well informed and staff are honest and supportive"
- One relative stated that "staff could not do enough" however did mention that they had one poor experience in which staff had been talking over the patient whilst providing care.
- We observed a member of the portering team speaking to a patient in a calm, acring manner explaining what they wanted them to do.
- The unit had recently introduced small boxes and jewellery pouches in which patients jewellery could be put into following their death, as opposed to a bag or envelope.
- We saw a number of thank you cards and letters displayed in the unit from patients and relatives, which praised the care that they or their family member had received.

Understanding and involvement of patients and those close to them

- Relatives and carers were kept informed and involved in decisions where appropriate.
- During the multidisciplinary ward round we observed good interaction with patients and their families, in relation to the plan of care, and observed staff seeking agreement regarding treatment plans.

Emotional support

- Staff in the follow up outpatient clinic could signpost patients to self-refer into external organisations that could offer counselling services.
- Patients could also be referred on to the hospital psychology services. The services supported patients and provided opportunities for patients to return to the critical care wards. This often helped in linking memories such as sound, to the patient's experience.
- There was a dedicated bereavement nurse, who would send information out to families approximately six weeks following the death of a loved one, offering the opportunity to come and meet with them for support.

Are critical care services responsive?

Good 🟢

We rated responsive as Good because:

- Patients discharged from critical care were followed up via an outpatient appointment. The appointments offered patients support and referral (if required) in relation to on-going rehabilitation needs as well as psychological support.
- The unit had recently completed a "critical guide for families and carers" booklet, which was going through ratification at the time of our inspection. The booklet gave key information about the unit.
- The Intensive Care National Audit Research Centre (ICNARC) data from the 2016 annual report showed that 4.1% of admissions were non delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. Compared with other units, this unit was within the expected range.There was no evidence that delayed discharges impacted upon timeliness of admission to the unit.
- Complaints were managed and investigated. Learning from complaints was shared with staff.

However:

- At the time of our inspection a new standardised operating procedure (SOP) was being developed in relation to the reporting of mixed sex accommodation. However, we were informed that only patients exceeding 24 hour stay would potentially be reported as a mixed sex beach, although none had occurred during the inspection period. This means the SOP would not be in line with Department of Health Guidance regarding mixed sex in critical care units.
- Patient diaries were routinely not being started until day five for those patients admitted to critical care. This is against recommendations by the critical care network .

Service planning and delivery to meet the needs of local people

- Bed Occupancy levels from November 2016 to February 2017 were below the England average, January 2017 saw the lowest occupancy rate at 45%.
- The unit had one critical care bed for every 11,150 adult population it served.

Critical care

Meeting people's individual needs

- There was a dedicated nurse lead for patients with a learning disability.
- Staff had access to a translation services, for patients or relatives.
- Patients could access the use of an ipad, which enabled patients to communicate through the use of a basic language tool, if they were unable to speak.
- The unit had recently completed a "critical guide for families and carers" booklet, which was going through ratification at the time of our inspection. The booklet gave key information about the unit, including the types of different monitoring equipment used, including pictures, to ensure that families and carers understood what was happening to their relatives.
- Patient diaries were used across the service. Staff filled in details of daily events, which patients got to take home. This helped patients orientate themselves with the care they were provided whilst on the unit.
- However we identified one patient who had been ventilated on the unit for five days with no diary commenced, which was not in line with guidance from the critical care network. The member of staff advised that diaries would not be started until day five. This showed a lack of understanding around patient diary objectives amongst staff.
- All patients were offered to attend a critical care rehabilitation outpatient exercise class through referrals from ward physiotherapists or at follow up clinics.
- In the relatives room there were a number of patient leaflets, for example leaflets explaining patient diaries and delirium. There was a separate room, which was used for breaking bad news.

Access and flow

- We followed a patients pathway who had been admitted into the resuscitation area, in the emergency department .The critical care outreach had been called by the ED consultant. We observed how the patient was assessed, plan of care decided and the commencement of respiratory management. A bed was identified and the patient subsequently transferred onto the unit.
- There were six cancelled elective surgery operations in the month of February 2017 due to non-availability of critical care bed.

- There was a local critical care plan in place to respond to capacity issues in times of surge. This included expanding capacity for level three and level two beds in the recovery area in theatres.
- It was identified that some patients (particularly vascular patients) who met level 2 criteria, were being cared for in recovery, which could provide overnight and longer term care to patients with certain clinical requirements such as non-invasive ventilation (NIV). The recovery area had been adapted to meet the individual needs of patients staying in this area. This was due to the on-going bed capacity demands within the unit, particulary for Level 2 patients as the trust did not have a high dependency unit facility available (HDU).
- During the period of June 2016 to June 2017 416 patients had been cared for by the critical care team post operatively in recovery. The staffing in this area were compliant with that required for level 2 care.
- We reviewed Intensive Care National Audit Research Centre (ICNARC) date from the 2016 annual report which showed that 4.1% of admissions were non delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 7.00am. Compared with other units, this unit was within the expected range.
- Data from the East of England critical care network reported that during the period of April 2016 and March 2017 there were 179 delayed discharges between four to 24 hours, and 239 delayed discharges above 24 hours.
- Delayed discharges were above the national threshold of 57.1%. Data from April 2016 to March 2017 from the East of England Critical Care Network showed that number of admission ranged between 46-67 patients per month. Out of these, delayed discharged (those between four to 24 hours) were 179. Discharges more than 24 hours were 239 from the same period.This had been identified in the peer review report published in February 2017 by the East of England critical care network. However it was noted the proactive response that the unit had taken in identifying patients early who were fit for discharge and the ongoing work with the trust site team to ensure that discharges from critical care were made a priority.
- ICNARC data from April 2017 to December 2017 reported there were 4392 available bed days. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 9.5%. This meant that the unit was not in the worst 5% of units nationally.

Critical care

- There had been no reported breeches of mixed sex accommodation. Patients requiring level 1 support would be moved accordingly into side rooms or within the unit to segregate and eliminate mixed sex breaches. During our inspection we observed during a morning handover that there were two Level 1 patients waiting for beds (one patient had been waiting for two days).Both patients were in a single side room. All Level 1 patient delays were reported through the incident report system.
- Patients requiring Level 1 care and required to be moved to ward areas were reported daily at the daily site meeting at trust level. At the time of our inspection a new standardised operating procedure (SOP) was being developed in relation to the reporting of mixed sex accommodation. However, we were informed that only patients exceeding 24 hours would potentially be reported as a mixed sex beach. This means the SOP would not be in line with Department of Health Guidance regarding mixed sex in critical care units, which states that that it is "not acceptable for any patients that do not require Level 2 or 3 care, but cannot be placed on appropriate ward". We raised this with the senior team and were told that they would review the SOP, However there were no mixed sex breaches occurring during the time of our inspection.

Learning from complaints and concerns

- Between April 2016 and March 2017 there had been one complaint for critical care.
- There was a visitors comment box in which family, carers and patients could make comments about the unit. A "we said you did" board was on display and we saw evidence on how the unit had responded to concerns such as patients finding it difficult to sleep because of light so black out blinds had been installed, and the changing of bins to silent close lids to reduce noise.
- The unit had introduced "listening ears" which were electronic devices fitted to the wall which recorded noise levels and turned orange colour if noise levels were too high. This was in a direct response to complaints regarding noise level on the unit. A member of the medical staff was in the process of completing an audit looking at the data collated at the time of our inspection.
- A member of staff had recently had a complaint made against them regarding communication in the

management of a patient. The unit had responded by ensuring the staff member had received additional supervision, completed a reflective piece and attended an external course in relation to communication.

Are critical care services well-led?

Requires improvement 🟠

We rated well-led as Requires Improvement because:

- The clinical strategy was in the early phase of development, with the first draft completed in June 2017. However the lack of clinical strategy had been identified in our previous inspection as an area for improvement in 2015.
- Whilst governance processes were in place, actions plans and some meeting minutes lacked detail. Governance recording processes and quality measures were yet to be embedded.
- Risks such as the potential of mixed sex accommodation (if patients could not be stepped down to a ward in a timely manner), of where discharging happened from critical care to home, had not been identified or recorded on the risk register.

However:

- There was a clear governance reporting structure in the division. Risk registers were reviewed and high risks were clearly identified.
- Staff told us of the positive leadership within the unit. Staff felt well supported and were proud of working in the unit.
- The unit management had recently introduced a quarterly newsletter for staff, with the first one published in April 2017. This provided staff with information on any updates, plaudits, concerns or risks within the unit, and staff told us that they found this newsletter very positive.
- Daily safety briefing sessions were held which discussed any incidents, feedback, complaints and staffing.
- There was a strong culture of innovation and improvement within the departments, with a number of new clinical practices and sharing of best practice with other units.

Leadership of service

Critical care

- The service was led by a clinical director, divisional head of nursing, head of operations and sat within the surgery and cancer division.
- At an operation level there was a senior clinical team, which consisted of the matron, clinical manager and clinical director, with the outreach team led by the sister and clinical lead.
- All staff we spoke to told us that they felt supported and able to raise concerns to the senior nursing and medical team.
- Staff told us that the senior nursing team for example, senior nursing staff, were visible and accessible and worked in the clinical environment, both providing nursing care, but also supporting staff.
- Medical staff told us that consultants were supportive and that they were well supervised in practice. One member of medical staff told us that "they had received the best learning experience" in the unit.
- We reviewed one file for a member of staff who had required performance management. The file was comprehensive and reflected that all relevant support had been sought through human resources and occupational health, as well as clear learning and development objectives set.

Vision and strategy for this service

- The unit had a mission statement, which staff were aware of, which was to provide high quality patient centered care. This was displayed within the unit.
- The strategy was in the early phase of development and had been led by the clinical lead. The strategy contained pertinent information such as education, staffing and vision for the unit in relation to capacity. However, the strategy had only been written in draft form in June 2017, even though this had been identified on our previous inspection in September 2015.

Governance, risk management and quality measurement

- There was a clear governance reporting structure in the division. Monthly governance meetings were held at ward and divisional level and subsequently fed into the overarching executive board.
- We reviewed three sets of divisional governance meeting minutes between January 2017 to March 2017. Minutes contained (but not exclusive) a running action log, discussion around mortality and morbidity, incidents and medicine management.

- However some of the minutes lacked detail. For example in the March 2017 minutes it was noted that there had been a rise in cancelled electives in February 2017. However no further information was given, reason or what, if any, actions would be taken.
- The risk register was divided into local level and divisional level risks. The risk register was in date, with a risk owner identified, mitigating actions and closed if resolved. For example, the local risk register had identified equipment as a risk, but since the new management of the equipment library, and the improvement of the management of equipment, this had been closed.
- As divisional level, delayed discharges had been identified as a high level risk. However risks related to this, such as the potential of mixed sex accommodation (if patients could not be stepped down to a ward in a timely manner), of where discharging happened from critical care to home, had not been identified or recorded.
- Quality was monitored through data submission to the Intensive Care National Audit Research Centre (ICNARC) and the East of England Critical Care Network as well as internal monitoring through the surgery division performance dashboard.
- We reviewed minutes from both the governance meetings and nursing sisters meeting from March 2017, in which quality review was embedded into these meetings. For example there was reference to the quality analysis in relation to activity and delayed discharges (which had seen an improvement), as well as reference to the change of equipment to improve patient outcomes.

Culture within the service

- There was good evidence of working relationships between medical and nursing staff and across other divisions.
- We spoke with the unit housekeeper who told us that they enjoyed working on the unit and felt like part of the team.
- Staff were able to access the occupational health department for support. We were provided with an example in which the unit manager had accessed the occupational health services to offer debriefing to staff who had been involved in the care of a patient with complex mental health needs.

Critical care

- We spoke with four members of staff who knew who the "freedom to speak up guardian" was. Contact details for the speak up guardian displayed in the staff room.
- Daily safety briefing sessions were held which discussed any incidents, feedback, complaints and staffing.

Public engagement

- The unit ran an "ICU STEPS" meeting every two months for patients and staff. This was a national intensive care patient support charity, which supported patients who had been discharged from the unit.
- The unit undertook internal satisfaction surveys, and used this feedback to make changes or service improvements.

Staff engagement

- The unit management had recently introduced a quarterly newsletter for staff, with the first one published in April 2017. This provided information on any updates, plaudits, concerns or risks within the unit. Staff told us that they had found the letter very beneficial and praised this initiative.
- The trust had recently introduced "Schwartz Rounds", that provided a forum in which all staff could come together to discuss the emotional and social aspects of working in healthcare. A number of staff from the unit had attended these rounds, and the manager had presented on the topic of receiving thankyous, and how that made them feel.

Innovation, improvement and sustainability

- The unit had a number of initiatives and plans that they wanted to introduce to improve patient care and ensure sustainability of the unit.
- The units vision for the outreach team was to develop the service into a "medical emergency team" which would incorporate nursing and medical staff and would enable immediate actions to be taken around patient clinical management decisions, as opposed to a soley nursing team who would have to contact medical staff.
- The unit was exploring the expansion of critical care into an empty adjacent ward to utilise as a "step down" , "step up "and level 1 facility, to support patients requiring higher levels of nursing care, and to provide a step down area for patients transitioning from a level 2/ 3 bed.
- The unit had recently received funding to train two Advanced Nurse Practitioners (ANP), which were due to commence in September 2017.
- The electronic patient system was in the process of being completed, which would provide electronic patient records, e prescribing and standardisation of care bundles. At the time of our inspection there was no set date for completion.
- The unit took part in research, for example to "Matching Michigan" which was a quality improvement study which looked at minimising central venous catheter blood stream infections.
- Lead staff from critical care and vascular specialists were due to visit another trust, as well as setting up a working group, to look at different techniques in the management of patients with aortic aneurysm repairs.

Maternity and gynaecology

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

Information about the service

Colchester Hospital University Foundation Trust (CHUFT) provides maternity and gynaecology services to the populations of Colchester, Harwich, Halstead, Clacton and the areas of north east Essex. The trust in addition provides community midwifery services across the north Essex area. In 2016, the service had a birth rate of 3,652, which was a decrease from 2015 with 3,719 births reported.

From 1 April 2017, women no longer had the option to give birth at Harwich midwife-led unit at the Fryatt Hospital. This decision followed public and staff consultation and was taken due to a low number of births having taken place at Harwich, just 23 babies in 2016. Clacton hospital was open from 8am to 5pm and additionally provided an out of hour's service. Colchester hospital was open 24 hours a day, seven days a week.

All of the maternity and gynaecology services Colchester Hospital are within the Constable wing. The maternity services consist of a maternity triage department and 28 mixed antenatal and postnatal beds on Lexden ward. The midwifery led birth centre on Juno ward has four rooms for women identified as being of low risk from complications in labour. The consultant led delivery suite has eight rooms and two fully equipped obstetric theatres.

The Colchester hospital maternity triage department had five couches/chairs and two single rooms. Lexden ward was under refurbishment during our inspection and women attended Aldham ward for their antenatal and postnatal admissions. The hospital had an early pregnancy assessment unit co-located within Stanway ward, which

provides gynaecological inpatient care for up to 16 women. There was also a six-bedded bay area between Lexden ward and Stanway ward used by gynaecology when the trust had increased activity.

During the inspection, we spoke with 41 members of staff including specialist nurses, midwives, health care support works, obstetrics and gynaecology staff and doctors. We also spoke with eighteen women, seven partners or family members and reviewed 18 records.

Maternity and gynaecology

Summary of findings

We rated maternity and gynaecology services as good because:

- Equipment that was in use throughout the department was serviced and calibrated.
- The midwife-to-birth ratio was in line with or better than the recommended England average.
- The number of consultant hours provided to the service was in line with guidance from the Royal College of Obstetricians: Safer Childbirth; Minimum Standards for Organisation and Delivery of Care in Labour, 2007.
- Outcomes for women who used services were in line with or better than expected when compared with other similar sized services.
- An external organisation provided the termination of pregnancy service unless there was a confirmed fetal abnormality. The trust would perform the termination under these circumstances. We were assured that in doing so that the trust followed all elements of national guidelines and legislation.
- The service took part in national and local audits as well as reviewing their service in line with nationally published recommendations.
- Feedback from people who use the service, those who are close to them and stakeholders was positive about the way staff treated women. Most women were positive about the care provided.
- The service had responded to the changing demand of its service users.
- Access to the service was through a simple route, which enabled the medical team to see women soon after arrival.
- Bed occupancy rates for the service were generally lower than the England average of 58% with 55% occupancy for 2016.
- Staff spoke positively about the clinical leads for the service with their involvement and approachability.
- Governance and risk management systems within maternity and gynaecology were well established.
- The service engaged well with the women who lived within the catchment area by linking up with the local mother and baby groups to seek feedback on services provided by the hospital.

- The Rosemary suite for mothers who had miscarried or delivered a stillbirth had undergone a refurbishment since our last inspection and provided a family room in addition to the delivery room and separate bedroom.

However:

- Whilst most staff attended mandatory training there were low rates of training complaince for conflict resolution level 2 (40%) and Immediate Life support for Adults was 25%.
- Staffing within the Clacton midwifery team was 11.2 whole time equivalent (WTE) midwives in post against an establishment of 14.5 WTE (April 2017). Increased bank staff and rotation of staff mitigated this when there was increased activity in an area.
- Medical staff training in safeguarding looked after children had a compliance rate at 53%.
- Several midwives expressed their concerns about feeling intimidated. They confirmed that the head of midwifery had completed a recent staff and student midwife survey, which had highlighted their concerns. This issue was being addressed by the management team at the time of our inspection.
- We received several comments through our comment cards about poor attitude of staff providing care to mothers on the postnatal ward.
- The waiting times for elective gynaecology for January to June 2017 showed a backlog of 642 women. However, this was less than the 2016 backlog of 744 cases. The midwifery co-ordinator for the delivery suite was supervisory but not supernumerary on the staffing roster. This meant that when they cared for pregnant women there was the potential for them to be unavailable to support colleagues as and when required.l

Maternity and gynaecology

Are maternity and gynaecology services safe?

Good ●

We rated the safety of maternity and gynaecology services as Good because:

- The midwifery service at Colchester hospital was fully recruited and had no vacancies which was an improvement since the last inspection in 2015.
- The Rosemary suite for mothers who had miscarried or delivered a stillbirth had undergone a refurbishment since our last inspection and provided a family room in addition to the delivery room and separate bedroom.
- There was a clear process for the reporting, recording and investigation of incidents with shared learning identified throughout the service.
- The staff implemented the duty of candour process where appropriate.
- The midwife-to-birth ratio was in line with the recommended England average. Staff numbers were sufficient to ensure women were cared for and supervised appropriately.
- The consultant hours met the recommended national guidance to deliver the maternity and gynaecology service. This meant that patient risk was lower because medical staff were available to offer advice and treatment.
- Maternity and gynaecology had processes in place to ensure staff adhered to infection control practices.
- Equipment was serviced, maintained and tested appropriately.

However

- Whilst most staff attended mandatory training there were low rates of training compliance for conflict resolution level 2 (40%) and Immediate Life support for Adults was 25%.
- The staffing vacancy rate at Clacton was 16.32 whole time equivalent (WTE) below the actual required staffing levels of 20.9 WTE for Clacton. Increased bank staff and rotation of staff mitigated this when there was increased activity in an area.
- Medical staff training in safeguarding looked after children had a compliance rate at 53%.

Incidents

- Staff understood their responsibilities to raise concerns, to record safety incidents and near misses and to report them. Staff used the trust's electronic reporting system and confidently gave examples of incidents which they had reported; for example, medication errors.
- Within maternity and gynaecology there had been no never events reported between May 2016 and April 2017. Never events are serious incidents that are entirely preventable as guidance or safety recommendations that provide strong systemic protective barriers, is available at a national level and should have been implemented by all healthcare providers). Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- Trust staff completed timely incidents on behalf of bank and agency staff, as they did not have access to the reporting system.
- Between May 2016 and April 2017, there were seven serious incidents in maternity and gynaecology at Colchester Hospital. Two of these were information governance based (confidential information leaks), two related to the clinical care of mother and baby, one related to the clinical care of a baby and another to the clinical care of the mother only.
- Serious incidents are events in healthcare where the potential for learning is so great or the consequences to patients, families and carers, staff or organisation are so significant, that they warrant using additional resources to mount a comprehensive response.
- We reviewed seven root cause analysis investigations for this service, two of which showed a comprehensive investigation completed by trained investigators who demonstrated shared learning with staff.
- There were various routes for sharing learning from incidents among staff. Staff discussed the "women's stories" monthly newsletter, which included details of learning and improvements in the service. The divisional governance teams also ensured learning filtered down to staff through safety huddles.
- Staff described their responsibilities regarding the duty of candour requirements. They informed women when things went wrong and were open and transparent relating to all incidents. The duty of candour is a

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regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust had a dedicated patient information leaflet for duty of candour.

- There had been one maternal death between March 2016 and July 2017; this was after postnatal discharge. Staff shared the three day fully completed review and further discussions assured us of this process. The statutory notification was submitted to Maternal New-born and Infant Clinical Outcome Review (MBRRACE-UK).
- There had been two deaths reported for gynaecology and both were reviewed by the clinicians as unexpected deaths with secondary symptoms.

Safety Thermometer

- Maternity services used the NHS Safety thermometer tool in conjunction with the maternity clinical dashboard. The maternity service monitored the key performance indicators from the maternity clinical dashboard monthly. This included the key areas of care, the clinical outcome indicators, staffing, risk management and patient safety.
- The NHS safety thermometer is a monthly audit of avoidable harms such as perineal (an area the pelvic diaphragm) or abdominal trauma. Post-partum haemorrhage (heavy bleeding after birth), infection, separation from baby and psychological safety. The results for the period March 2016 to March 2017 demonstrated that 8.9% of women had a moderate post-partum haemorrhage (between 1000 and 1999mls of blood loss) and 2.3% had a severe blood loss (over 2000mls of blood loss). Only 0.6% of women had an gone on to have maternal sepsis. 4.3% of women suffered a 3rd or 4th degree tear as a result of delivery although there was improvement in this across the year with only 2.7% of women experiencing a tear in March 2017. The gynaecology inpatient ward displayed the NHS safety thermometer for viewing by women and their relatives.
- The Apgar scores are a simple assessment of how a baby is doing at birth, which helps determine whether the baby requires additional medical assistance. If a

baby presented with a score of less than seven at five minutes old or was admitted to the neonatal unit then this was monitored as part of the safety thermometer. There were 0.8% of babies at Colchester general hospital that had an apgar score of less than 7 between March 2016 and March 2017.

- The maternity and gynaecology service scored 100% for the "Saving lives" audits completed for hand hygiene, peripheral venous catheters and urinary catheters insertion and continuing care and surgical site infections.
- On the gynaecological ward staff continued to display patient safety crosses within the office area, which showed monthly patient activity such as the number of days since the last patient fall, healthcare acquired infections (HCAI), medicine errors and safe staffing numbers. This information was readily available for staff but not displayed for people who use the service.
- Staff confirmed their awareness of sepsis pathways and the focus on sepsis was included within the every patient every day programme. Sepsis was reviewed monthly on the maternity dashboard with 47 (1.2 %) women identified and treated from March 2016 to March 2017. The risk management midwives reviewed all cases and shared learning at handovers and staff huddles.

Cleanliness, infection control and hygiene

- The maternity and gynaecology service areas we visited were visibly clean and tidy. There were cleaning schedules in place and completed. We observed the carrying out of cleaning during the inspection.
- Infection prevention and control policies we reviewed were in date. Staff could access the policies easily via the hospital computer system.
- All equipment that required regular decontamination had 'I am clean stickers' which were dated and signed. This meant clean equipment was easily identifiable.
- Staff maintained hand hygiene prior to and following patient care, and were compliant to "bare below the elbows" guidance. Staff used personal protective equipment appropriately such as gloves and aprons.
- The "Saving Lives" audit (to monitor improvement in infection prevention and control practice) results for June 2017 showed an overall compliance rate of 100%
- Staff were observed to be compliant to hand hygiene during the inspection.

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- Information provided by the trust showed that there had been no reported occurrence of known infections such as Clostridium difficile or MRSA (methicillin resistant staphylococcus aureus) in maternity and gynaecology services between January and July 2017.
- The management of waste and clinical needles and syringes was appropriate with all sharp boxes labelled, dated and signed.
- There was a conflict in audit data provided to the CQC as it stated in the summary that the "women and children' service was the lowest performing area for hand hygiene." This was mainly attributed to student midwives in radiology" who scored 40% (from 6 out of 15 student midwives). However, the information provided to the CQC for the women services and radiology, stated that students all scored 100%.

Environment and equipment

- The maternity and gynaecology services were located in the Constable wing of the hospital. The maternity and gynaecology service was in the process of major refurbishment. At the time of inspection the refurbishment of the bereavement and delivery suite had been completed and the refurbishment of the antenatal and postnatal wards was nearing completion.
- Staff showed us the newly landscaped reflective garden area for families to spend time together away from the ward environment. Feedback we received from women on the inspection included the comment, "The garden area is so beautiful, it's a relaxing area".
- The antenatal and postnatal (Lexden) ward was in the last stages of refurbishment, which included the ward's entrance corridor area. The new area provided women with an upgraded and private environment for the time they were within this service.
- The flooring in the wards was non-slip and was in good condition on all wards visited. Window restrictors used on the wards reduced the risk of falls from windows and the blind cords were not a ligature or strangulation risk.
- The two obstetric theatres were located within the delivery suite, which meant that there was quick and easy access to them in cases of emergency.
- The new two-bed recovery area was adjacent to theatres and provided women with privacy and one to one care while recovering from a caesarean.
- The Rosemary suite for mothers who had miscarried or delivered a stillbirth provided a family room in addition to the delivery room and separate bedroom.

- All equipment had electrical safety tests completed within the yearly checking date. This is an examination of electrical appliances and equipment to ensure all equipment is safe to use.
- The cardiotocography (CTG) completes monitoring of a baby's heart rate and a mother's contractions while the baby is in the uterus. CTG equipment within the service was checked daily and all monitors had a label with the date of the maintenance check. Staff informed us that an information technology upgrade had allowed CTG's to be linked to the woman's electronic records. This improvement meant there was a reduced risk of loss of the CTG tracing record.
- On reviewing the maintenance records for equipment across this service, we saw that equipment checks were within date.
- All adult and newborn resuscitation equipment across maternity and gynaecology services reviewed during inspection confirmed no issues with the completion or recording of daily checks.
- Close circuit television (CCTV) monitored the service and all areas were secured.

Medicines

- We reviewed twelve completed medication records from across the service. The drug charts included appropriate documentation with full patient details, identified allergies, signatures of prescribing staff and courses of antibiotic treatment.
- There were arrangements in place for managing medicines and medical gases. Staff maintained the controlled drug registers and the storage of controlled drugs within the delivery suite and Stanway ward. All records seen showed controlled drugs were maintained appropriately.
- Medications that required refrigeration were stored appropriately. There was a process of daily checks to ensure acceptable temperature limits were not exceeded
- Intravenous (IV) medicines were securely stored in a locked room, which meant that the risks associated with tampering of IV medicines were managed appropriately.
- Between January 2016 and June 2017 there were 31 medication errors within maternity service, seven related to frequency of drug administration, for example the delay of required antibiotics to more than four babies on the postnatal ward. The errors included:

failure to follow guidelines, prescribing errors, incorrect dose, medication omitted, medication not signed, and wrong route, for example oral medicines given instead of IV antibiotic.

- These medication incidents were discussed at the risk management and governance meetings and changes were taken to reduce the risk of reoccurrence. For example, midwifery staff updates and additional training to support midwifery second checkers for neonatal antibiotics (to reduce medication delays).

Records

- Record keeping guidelines were available on the intranet for all staff to access.

The record keeping guidance defined the responsibilities for all staff, when recording events and securing records within hospital hard copy patient files.

- The trust's Maternity Services used an electronic facility for the storage of records. The compliance with record keeping was monitored by auditing of hard copy records monthly.
- We saw medical paper records kept on the clinical areas behind reception areas in a secured trolley and in secured rooms near the antenatal and gynaecology clinics. Of the 18 sets of records reviewed from the gynaecology clinic and wards, all included relevant information such as health assessments, learning difficulties screening tool, assessments of social circumstances, and information about referrals to other agencies such as mental health services.
- We examined the risk assessments for women admitted for delivery which included, weight and pregnancy history. The records clearly documented the women's care pathway and had been completed appropriately.
- Women's records reviewed showed appropriate antenatal test results with all discussions documented.
- All trusts are required to submit a form (HSA4) to the Department of Health when they undertake a termination of pregnancy in accordance with the Abortion Act 1967. The HSA4 notification data between January 2016 and December 2016 showed that 53% of forms met the required deadline (369 cases out of 690) with 47% (321 cases out of 690) submitted following staff reminders.

Safeguarding

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements with a flagging system to highlight any known concerns.
- There was a full time safeguarding specialist lead midwife and a vulnerable women's and teenage pregnancy specialist lead midwife.
- There were up-to-date safeguarding policies and procedures in place, which incorporated relevant guidance and legislation. The Safeguarding Children, Young people and the Unborn policy was ratified in October 2016 and included guidance for those under 16 years of age and identified high risk areas; for example female genital mutilation (FGM) and child sexual exploitation. Staff demonstrated that they could access these via the hospital intranet and understood their responsibilities in relation to adherence to these policies.
- At the previous inspection, there was a concern that there was no abduction policy available for staff. Since then, the Infant Abduction Policy (from Maternity Services or Neonatal Unit) version one was ratified in October 2015 and reviewed. Staff were aware of the policy and described the practice drill held in November 2016, which had been completed successfully with three failed attempts at abduction.
- Staff described with confidence, how to escalate a safeguarding concern and knew whom they needed to speak to for information or advice. All staff could name the specialist midwifery lead for safeguarding.
- The training records, showed that within maternity and gynaecology services 95% of midwifery and nursing staff had received safeguarding adults training level one and 94% of staff had received safeguarding level two. However, safeguarding level three training was only completed by 70% of nursing and midwifery staff against the trust target of 95%.
- The medical staff did not achieve the trust target for any safeguarding training with 88% safeguarding adults training level one and 85% of staff had received safeguarding level two. Safeguarding looked after children had the lowest compliance rate at 53%.
- The Trust provided the Daisy programme, which looks specifically at the risks associated with domestic violence. Domestic violence training is part of the

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mandatory safeguarding training provided. There is also the Rose programme, a local initiative providing support for patients with learning disabilities, which is supported by the specialist lead midwife for vulnerable women.

- The specialist vulnerable women lead midwife was accessible for staff when they dealt with women in vulnerable situations including female genital mutilation (FGM) and child sexual exploitation. Staff said they had an awareness of and knew how to escalate concerns and how to contact the lead midwife and had attended training. The FGM policy remained in draft form and was for ratification within the next month.

Mandatory training

- Mandatory training rates for both medical and nursing/midwifery staff in maternity and gynaecology showed improvement from the last inspection, however both medical and midwifery staff attendance rates were below the 95% trust target. Medical staff achieved 85% overall attendance rate for mandatory training. Midwifery and nursing staff overall attendance was 77%. Immediate life support for Adults training had lower attendance rate at 25%.
- Maternity staff received additional mandatory training led by the practice development midwives. Topics included obstetric emergencies, breastfeeding and CTG training. Mandatory training in respect of skills and drills training was at 95%. The trust has a SIMMUM simulator for the PPH training and have workstations for shoulder dystocia, breech and neonatal resuscitation.
- At the previous inspection there were several serious incidents reported relating to the misinterpretations of CTG results. All staff had since attended an annual CTG training day. At this inspection there were no reported incidents relating to misinterpretation of CTG between January 2016 and June 2017.
- Staff had a buddy system in place for review of cardiotocograph (CTG) interpretation, with a protocol for escalation if concerns were raised. All senior staff had been trained in the review system and escalation protocol.
- Staff told us about the 'Fresh eyes' reviews of CTGs that identified areas for escalation and were completed for each CTG. The CTG guideline was implemented with handover teaching for all staff who reviewed CTGs.

Assessing and responding to patient risk

- Maternity staff confidently discussed how they dealt with a Code blue incident and there was a Code blue guidance policy. However, the policy was out of date with the policy was last amended in October 2012 with a review date of October 2015. Code blue is the system used in cases of major haemorrhage associated with clinical shock, collapse or rapid ongoing blood loss of more than 1500mls at or after delivery.
- For gynaecology patients the service used the National Early Warning Score (NEWS) system to monitor the risks of deterioration to a patient's condition. We reviewed eight charts and found that these were completed and calculated correctly. The training records showed that 97% of nursing staff had received training on the NEWS system.
- The service struggled to manage women admitted from other specialists on the gynaecology (Stanway) ward, as the women did not always have the criteria risk assessment fully completed before admission. Documentation showed the criteria risk assessment remained incomplete during the admission for three out of eight notes reviewed. The ward log confirmed 120 uncompleted risk assessments between December 2016 and July 2017 from approximately 320 women.
- Guest patients within the gynaecology ward saw the medical doctors in the early afternoon after the completion of medical rounds. However, staff said they called the speciality medical teams earlier if required and that the team responded and completed a medical review.
- On Stanway ward there was a standard operating criteria admission checklist for the admission of non-gynaecology women to the ward. During the inspection, we observed uncompleted checklists; for example, on reviewing the criteria three women out of eight did not have a completed checklist.
- In maternity services, the Maternal Early Warning Score (MEWS) and Neonatal Early Warning Score (NnEWS) system were in place for women and babies. We looked at eight records on the postnatal ward and found the MEWS completed appropriately with action taken as necessary.
- All babies had non-invasive pulse oximetry at 4 hours and 12 hours to detect earlier recognition of congenital defects.
- The 'World Health Organisation (WHO), Five Steps to Safer Surgery checklist' was in place in maternity and gynaecology. The maternity dashboard showed 100%

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compliance between March 2016 and June 2017. We examined the records of women where safer surgery checklists were required and found that they were appropriately completed.

- We observed a morning handover between maternity and medical staff. The handover covered key risk information in sufficient detail to alert the team and identify any increased risk factors

- Within maternity and gynaecology, the training records for adult basic life support showed that 97% of nursing and midwifery staff and 88% medical staff had received training. However, only 25% of nursing and midwifery staff had immediate life support for adults training. There were no records of staff receiving advanced life support training submitted. The trust target was 95%.

- Training records submitted did not include Newborn Life Support (NLS) and Paediatric Basic and Paediatric Advanced Life Support which we were informed staff had attended.

- The service had a named sepsis champion with monthly cases presented and included on the maternity performance dashboard. We saw 48 confirmed cases on the correct pathway between March 2016 and March 2017, an increase from 23 cases reported for 2015-16.

- The maternity triage area assessed all pregnant women on arrival to prevent women arriving on the delivery suite when not in established labour. It is open 24 hours a day, seven days a week and staff respond to queries and concerns, for example, reduced fetal movements.

- Risk assessment audits undertaken showed women were appropriately assessed and treated for venous thromboembolisation (VTE) (blood clots in the vein). On average 97% of women on Lexden had VTE assessments undertaken between March 2016 and March 2017. In March 2017 this figure rose to 99%. Records included hourly observations, medicines administered and CTG records. All records seen had the appropriate signature and date.

- All Cardiotocography (CTG) records were reviewed through a "Fresh Eyes" programme. Staff were trained to undertake this procedure and there was effective monitoring to ensure that women were safe.

- We reviewed the records of women attending the early pregnancy assessment unit, which included discussions regarding contraception and the risks of VTE. This was in line with best practice guidelines.

- The second obstetric theatre met the service needs for planned and emergency caesarean sections.

- The service held monthly perinatal morbidity meetings. A review of the minutes for May 2017 showed attendance from medical, diagnostic, and midwifery staff with actions identified and timescales for completion. The neonatal team led the monthly mortality and morbidity monthly audit and governance meeting.

Nursing/Midwifery staffing

- Between March 2016 and January 2017, the maternity service had a ratio of one midwife to every 28 births which is compliant with NICE guidance (clinical guidance 190). In February and March 2017 this increased to one midwife to every 29 births. This was in line with the national guidance from the Royal College of Obstetricians "Safer Childbirth; Minimum Standards for organisation and delivery of care in labour, 2007" standards state that, "The minimum midwife-to-woman ratio is 1:29 for safe level of service to ensure the capacity to achieve one-to-one care in labour".

- The service assessed the midwife to birth ratio monthly and reported to the board. The trust used the nationally recognised (Birth-rate plus system report) matrix to assess staffing requirements.

- Midwifery staffing levels at Colchester had improved since the last inspection with no vacancy rate at time of the inspection.

- To maintain staffing levels on Stanway ward when the ward supported medical guest patients (a specialist patient placed in another ward) the service used bank and agency staff.

- In the Clacton midwifery team there were 16.32 whole time equivalent (WTE) midwives employed against an establishment of 20.9 WTE. In the Harwich midwifery team, there were 4.74 WTE employed against an establishment of 10.29 WTE in April 2017. However, the recent staff review completed in December 2016 supported the staff numbers based on the reduced activity at the sites.

- The staff sickness ratio for maternity services from May 2016 to April 2017 was 4.5%. This was above the trust target of 3.5%.

- Ward managers were not supernumerary for all shifts but were able to support clinically as required. Student midwives were supernumerary and supported by a qualified midwife during the clinical experience.

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- Newly qualified midwifery staff rotated across all areas of the maternity service, including the community service and some experienced midwifery staff rotated from the community to the hospital site.

Medical staffing

- The trust employs 31.5 WTE doctors including 10.4 WTE consultants to work in the obstetrics and gynaecology service. There was a good skill mix on duty at all times. However, the number of consultant staff working at this trust was lower than the England average as of January 2017. Although the proportion of junior doctors working at this trust was higher than the England average.
- In April 2017, the trust reported a vacancy rate of 13% in maternity and gynaecology. Non-consultant grade staff had the highest vacancy rates with an average of 15% compared to consultant grade and equivalent of 9.2%, which was below the trust target.
- Between May 2016 and April 2017, the trust reported medical staff turnover rate of 7% for this service. Bank and locum staff usage for gynaecology was 7% in March 2017, which raised concerns with patient continuity and did not reflect the trust target.
- The trust stated that patients should receive 87.5 hours consultant cover each week on the delivery suite. The monthly maternity dashboard reported that between March 2016 and May 2017 the consultant cover on the delivery suite was 78 hours. However, this met the guideline issued by "The Royal College of Obstetricians: Safer Childbirth; Minimum Standards for organisation and delivery of care in labour, 2007" which requires that they provide at least 40 hours a week of consultant time.
- Medical and midwifery staff confirmed that consultants provided out of hours cover and responded to requests for help at weekends.
- Consultant ward rounds took place daily for all patients under the care of the consultant or any referrals identified by the midwifery team. Doctors we spoke with said that support was good, consultants were accessible and approachable, including out of hours.

Major incident awareness, training and security

- Maternity and gynaecology services followed the trust's major incident and escalation policy. Major incident information was available for all staff to access on the trust's intranet.
- Maternity and gynaecology achieved a 98% completion rate for local major incident training with nursing and

midwifery staff at 100% and medical staff at 27% completion (11 trained of 41). Staff had been involved in emergency drills workshop as part of the mandatory training update and there were records of training attendance which we were shown during the inspection.
- Midwifery staff supported the evacuation of mothers from the birthing pools with hoists located in an adjoining room to the birthing suite.
- In May 2017 a "cyber-attack" to the information technology systems was declared and immediate action taken as part of business continuity plans, resulting in no data being compromised.

Are maternity and gynaecology services effective?

Good ●

We rated the service as good for effective because:

- Women's outcomes were similar or in line with the England average, with monthly monitoring evidenced on the maternity dashboard.
- Staff provided care according to national guidance and evidenced based practice.
- There was good evidence of multidisciplinary team working practices in place.
- Women were encouraged and supported to deliver naturally and commence breast-feeding post birth.
- Seven-day services were available in the hospital as well as in the community.
- The service took part in national and local audits as well as reviewing their service in line with nationally published recommendation through the Kirkup report (an independent investigation to review the management, delivery and outcomes of care provided by a maternity and neonatal service).
- A variety of pain relief methods available to all women during labour included free hypnobirthing and birthing pools.
- The service completed consent to termination of pregnancy in line with national guidance.

However:

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- The Maternal New-born and Infant Clinical Outcome Review (MBRRACE) audit was higher than the average comparator by 10%.
- The service did not monitor or submit data for emergency maternal admission within 30 days of delivery.
- The service did not monitor or record data of women who had planned to have a vaginal birth after having a caesarean during a previous birth (VBAC).
- The staff appraisal rate was 56%, which was below the trust target of 77%.

Evidence-based care and treatment

- Policies and procedures used within gynaecology and maternity were in accordance with the National Institute for Health and Care Excellence (NICE) guidelines or those from the Royal College of Obstetrics and Gynaecology (RCOG). The monthly governance meetings discussed standards and newly issued guidelines, which were minuted to demonstrate how the service met the minimum national standards.
- Multiple pregnancies and maternal diabetes during pregnancy are supported by the lead specialist midwife who work closely with the neonatal team to promote the optimum care throughout the care delivery.
- The maternity performance dashboard was in place and was part of the process for monthly audit activity for stillbirth, antenatal records, post-partum health records, antenatal management of reduced fetal movement, management of multiple pregnancies, management of 3rd and 4th degree perineal tears (laceration of the skin and other soft tissue) and unplanned admissions to intensive care.
- The trust's Cardiotocography (CTG) policy reflected the NICE "Intrapartum care 2014" guidelines. Staff described how they were familiar with this guidance, their practice and how it was in line with trust policy.
- The maternity service adhered to and closely monitored the NICE standard number 32 for caesarean sections. The hospital was below the England average (12%) for elective caesarean sections with a rate of 11% between January and December 2016. However, the emergency caesarean section rate of 16% was above the England average of 15% between January and December 2016.
- Data submitted between March 2016 and March 2017 showed the total lower segment caesarean section rate at 26.8% compared to the national benchmark target of 26.20%.

- The service held monthly audit meetings. Staff shared learning from the audit, at the multidisciplinary handover and governance meetings held within the service.
- The trust had identified audit activity around NICE guidelines and senior midwives or consultants had projects allocated to this work, for example reducing the term of infant admissions to the neonatal unit.
- The directorate participated in the "GROW" assisted protocol programme to help minimise the number of stillbirths. It included all women who had a customised growth chart and offered extra ultrasound scans to check the baby if the growth fell outside of the normal range.
- During the inspection, eight women received post-natal care. The care received was in accordance with 'The NICE quality standard number 37: post-natal care'.
- We examined the notes of six women who had received antenatal care and specifically looked at the compliance with 'The NICE quality standard number 22: Antenatal care.' The service had a clear process for booking women into the antenatal service and checking them at the required phases throughout their pregnancy, which was in line with these standards.
- The gynaecology ward staff described how they assessed patients and provided care and treatment in line with recognised guidance, legislation and best practice standards.
- We spoke to the specialist infant feeding midwife who described how new mothers were supported to breastfeed, demonstrating that the trust adheres to NICE guidelines on encouraging new mothers to breastfeed.
- The service had reviewed and completed the external 'Kirkup review' into the management, delivery and outcomes of care provided by the maternity and neonatal services. Learning from this review had taken place across the service that included a comprehensive action plan with a timeline and responsible individuals for each action.
- The service demonstrated how it met the requirements of the Abortion Act 1967 and associated guidelines through the recording of care. The care records documented discussions clearly and legibly with identified signatures and dates. From April 2016, the

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only medical terminations completed in this service were following confirmation of fetal abnormalities. Medical and surgical terminations are completed by another contracted organisation.

- The trust participated in the Perinatal Institute GROW programme and included customised growth centile charts in the records. The charts are used to plot both symphysis fundal height measurements (a measure of the size of the uterus used to assess fetal growth and development during pregnancy) obtained during clinical examination and estimated fetal weight following an ultrasound examination. The customised charts take into account the height, weight, ethnicity and parity of the woman. Birth weights of any previous children are included to identify previous problems with growth. The information technology midwife audited the compliance of Maternity Medway entries and as a result of these reviews, had discussed at risk management meetings the use of making certain fields mandatory.
- The gynaecology service had very clear processes for the delivery of a safe service across all recognised gynaecology pathways.

Pain relief

- Women had access to information about the different types of analgesia (pain relief) available, which included pain management in labour. This was also available as a download mobile application. This was in line with the RCOG guidance.
- Women spoken with confirmed the assessment and management of their pain was timely and effective with staff offering a choice of pain relief when required.
- Three women confirmed that they delivered their babies at Colchester Hospital three years ago and they felt the service had improved. They described how during their previous admission they had to ask for pain relief but on this admission, the staff asked them if they needed any pain relief and anticipated their needs.
- Medication administration records showed women across the service received pain relief when they required it and that pain relief was given in accordance with the prescription.
- Birthing plans in maternity care records, included discussions with the woman about their preferred pain relief options during labour.

- The weekly hysteroscopy service was accessible through the clinical nurse specialist and doctor in the gynaecology clinic. Staff administered pain relief alongside an anaesthetic after patient discussion and consent.
- Anaesthetists responded promptly to staff requests for specialist pain relief, such as epidurals. Specialist anaesthetists trained in obstetric care were available 24 hours each day. However, we saw no monitoring on the maternity dashboard of the number of women who received regional anaesthesia for elective and emergency caesarean in line with safer Childbirth.
- A variety of pain relief methods available to all women during labour included free hypnobirthing and birthing pools.
- Hypnobirthing is an antenatal program that teaches simple but specific self-hypnosis and relaxation techniques for an easier, gentler birth that can often be accompanied by a significant reduction in pain.

Nutrition and hydration

- There were regular mealtimes with a variety of food choice. Patients had a jug of water beside them and told us that food choice and availability was good throughout the service. Women confirmed snack boxes were offered between meals when requested. The menu choice included diabetic, gluten free, vegan, kosher, halal and other special dietary foods.
- Records showed that staff discussed infant feeding choices and included the start of feeding by time and type, for example breast feeding or formula milk.
- The service monitored mothers who had chosen to breast feed within the first 48 hrs after delivery. Results averaged 78% between March 2016 and June 2017 above the trust's target of 75% and higher than the England average of 66%. The postnatal women told us they had received good support with breast-feeding.
- The service had access to a specialist dietician, diabetes lead nurse and midwife who supported women with personalised diabetes plans. This provided an effective service for women.
- On Stanway ward support was offered to patients who required assistance with eating and drinking. Malnutrition Universal Screening tool (MUST) was used to assess and record patient nutrition and hydration

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when applicable. We examined six records on Stanway ward, which evidenced that malnutrition assessments were undertaken and the recording of food and fluid intake.

Patient outcomes

- There were no active outliers relating to maternity and gynaecology care, as of 31 May 2017. An outlier is an indication of care or outcomes that are statistically higher or lower than expected. They can provide a useful indicator of concerns regarding the care that people receive.
- In the National Neonatal Audit Programme (2015), the trust performed better than the England average in three out of four measures. The measure not achieved was babies born below 33 weeks receiving mother's milk exclusively or as part of their feeding at the time of their discharge from the neonatal unit. The department scored 53% against this measure, which was below the national average of 58%.
- Audit results for antenatal care demonstrated that 93% of women received antenatal screening at 12 weeks compared to the required standard of 90%.
- Of the 3,652 births in 2016, 2,218 (61%) were normal (non- assisted) deliveries and 392 (10.7%) were elective caesarean deliveries.
- Community midwifery staff told us they were working hard with the service to improve the choice of home birth, out of hours and at weekends.
- There was an effective process for the review of stillbirths and post-delivery bereavement. Between March 2016 and March 2017, there were 15 stillbirths. There was only one still birth above 24 weeks 0.05% of all births. The maternity audit meeting reviewed each stillbirth as part of the annual audit on stillbirths. The meeting identified clear reasons for all stillbirths and the lessons learned.
- Between March 2016 and March 2017 there were 3,895 deliveries, of which 87 (2.2%) had a severe postpartum haemorrhage (PPH) above 2000mls.The service monitors the number of PPH's, which take place in the service through the maternity dashboard and assess themselves against the RCOG Management of PPH (No. 52) 2009.
- The service remained accredited as a Level 3 baby friendly initiative (BFI) maternity service.

- The ventouse (vacuum-assisted vaginal delivery) delivery rate at 4% was lower than the last inspection and better than the England average of 5%.
- Between March 2016 and March 2017 there were eight unplanned or unexpected admissions of new mothers to intensive care. These were reviewed within the maternity services clinical audit meeting as serious incidents that required investigation.
- Between March 2016 and March 2017, the service recorded 48 cases of maternal sepsis with cases investigated by the clinicians and risk management team and presented at the maternity clinical audit meeting for learning.
- Between March 2016 and March 2017, there were 285 unexpected admissions to the neonatal intensive care unit (NNU) for term (36 weeks and 6 days) babies which is below similar sized hospitals.
- Staff from other directorates confirmed that they worked well with maternity and gynaecology services and described the recently introduced "Avoiding Term Admissions in Neonatal Units" (ATAIN) programme. ATAIN has an objective to reduce the number of term (over 37 weeks) babies admitted to the neonatal unit.
- Staff told us of the red boxes given to the new mothers provided information to reduce the risk of neonatal hypoglycaemia (low blood glucose levels). This was part of the "ATAIN" programme.
- Another part of the ATAIN programme was babies receiving antibiotics. Previously they would have been separated from their mother and taken to the NNU but now all antibiotics are given to the baby who remains on the postnatal ward with their mother, which avoided unnecessary separation.
- Of the eleven quality indicators set by the Royal College of Obstetrics and Gynaecologists this service performed in line with or better than the England average on nine of the eleven indicators. The emergency caesarean section rates were 16% compared to the England average of 15%, the elective caesarean rate was 11%, which was just below the England average of 12% while instrumental deliveries was equal to the England average at 12%. There were 4% of reported third and fourth degree perineal tears which was higher (worse than) the England average of 2%, with monthly monitoring and extra staff training or support provided to reduce this occurrence.
- The trust did not monitor emergency maternal readmissions within 30 days of delivery.

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- The trust did not monitor or record data through the maternity dashboard for women who had planned to have a vaginal birth after having a caesarean during a previous birth (VBAC).
- The service took part in the 2016 Maternal New-born and Infant Clinical Outcome Review audit (MBRRACE). The perinatal mortality rate (per 1,000 births) was up to 10% higher than the average comparison group in this study. Staff informed us that this was being reviewed in line with any additional health concerns.

Competent staff

- Records submitted for April 2017 showed that 56% of staff currently working in this service had completed an appraisal within the past 12 months. This was the lowest appraisal completion rate of the hospital's core services and below the trust average of 77%. Managers informed us that dates were booked for staff who had not completed appraisals to increase compliance.
- Practice development midwives (PDM) provided evidence of completed midwife training including emergency skills and drills training, multi-disciplinary root cause analysis training which was in line with the trust target.
- The practice development midwives maintained the electronic staff competencies for the use of equipment such as CTG machines and infusion pumps for the maternity unit and gynaecology ward.
- The two-bedded recovery room was supported by trained dedicated recovery staff who support the midwifery team allocated to the high dependency area.
- The clinical nurse specialist provided procedures in the gynaecology clinic; for example in family planning and administering termination of pregnancy medication.
- The trust provided support to staff to gain additional qualifications and to maintain revalidation with the Nursing and Midwifery Council (NMC) and professional development.
- Community midwives provided cover for the wards when required. This meant that community midwifery staff maintained their skills and knowledge when working within the hospital environment.
- Midwifery staff had completed training for extended roles which included new-born infant physical examination (NIPE), neonatal antibiotic therapy and second checkers for antibiotic therapy (to prevent babies leaving the maternity environment and avoiding admissions to the neonatal unit).

- Junior doctors received a comprehensive induction for obstetrics and gynaecology. They told us that teaching and learning opportunities happened weekly and they felt supported. They additionally completed neonatal life support training before starting their placement within maternity and neonatal services.
- All staff that care for women in labour undertake an annual training and competency assessment on CTG interpretation and use of auscultation (listening to sounds from the heart, lungs, or other organs, typically with a stethoscope as a part of medical diagnosis.)
- The service used the International Federation of Gynaecology and Obstetrics (London, UK) (FIGO) interpretation and a two-hour workshop runs each month as mandatory training for the multidisciplinary team, where the classification of CTGs and fetal physiology is taught and assessed. All obstetricians and midwives attend this training annually.
- New midwives joining the trust undertake a CTG assessment as part of the interview process.
- There was an induction programme for all new staff including agency staff and student midwives on the ward or birthing units. Student midwives confirmed this was completed and they had attended.
- A one-year preceptorship programme for newly qualified midwives followed a competency package to ensure midwives are able to undertake specific tasks relevant to their role.
- Staff competencies were reviewed across the service to maintain development and support revalidation.
- Stanway ward is used for gynaecology outpatients when required. Stanway ward is predominantly a gynaecology and breast surgery ward with a bay that accepts medical and surgical outliers. Staff attempt to place patients from the various specialties together in separate bays. Nursing staff working on Stanway ward have clinical competencies in place that match with the surgical wards to ensure clinical care is appropriate and nurse have the necessary skills for the various specialties.

Multidisciplinary working

- Staff described how they worked effectively together, both internally and in the community to assess and plan ongoing care and treatment in a timely manner. There were detailed multidisciplinary team meetings, which ensured effective care and treatment plans when women with complex requirements moved between teams or services, including referral and discharge.

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- A multidisciplinary handover observed on the delivery suite supported patient care and included comprehensive discussions, for example, arrangements for a preterm delivery anticipated later that day.
- Staff reported to us that their working relationship with the Clinical Commissioning Group (CCG) was supportive and established.
- Senior managers described working well with other trusts and community services to promote the best care for the women.
- The specialist lead midwife team included specialities such as diabetes, infant feeding and midwife and information technology.
- NICE QS46 states: Women with a multiple pregnancy are cared for by a multidisciplinary core team, which included midwifery and neonatal staff according to the number of expected babies. The service provided care in line with this guidance.
- Maternity and gynaecology services had access to the critical care outreach team and intensive care services should a woman's condition deteriorate.
- There was 24-hour availability in obstetric units of senior paediatric colleagues, who have advanced skills for immediate advice and urgent attendance.
- Staff confirmed that women were discharged once they were confident and had successfully fed; had a full postnatal check and received any identified parental support.
- Schwartz rounds were introduced from September 2015 to provide all the multidisciplinary team members with a confidential environment and opportunity to talk about the emotional challenges they had experienced.
- Agency or bank nurses were able to review the individualised care plans that identified the women's planned care requirements. This meant the trust had processes and procedures in place ensuring that agency and bank staff had the relevant information to care for the women.

Seven-day services

- The midwife led birthing unit was open seven days per week and was located within the main maternity service.
- Community units and home births were also available at weekends and out of hours dependent on community staff availability.
- Medical staff provided an on call service 24 hours per day. Junior medical staff and midwifery staff confirmed

the availability of consultant advice out of hours. There was an on-call rota for consultant of the week. Staff stated that all emergency admissions seen had a thorough clinical assessment by the consultant as soon as possible but at the latest within 14 hours from the time of arrival at the hospital. However, the service did not collect this data and therefore we were unable to confirm the information provided was correct.
- Anaesthetic cover was available 24 hours a day seven days a week for both maternity and gynaecology services.
- There was an obstetric trained anaesthetist available on site seven days per week and on call out of hours.
- Antenatal services were available Monday to Friday. Outside these hours the emergency triage assessment unit was open seven days per week with support from the emergency department.
- Diagnostic services, including scans and x-rays, were accessible to patients seven days per week.
- Pharmacy was available on weekdays and weekends on reduced hours. Outside of these hours, there was an on call pharmacist to dispense urgent medicines.

Access to information

- All nursing and medical staff, including bank and agency staff, had access to computer systems including test results, diagnostics and records systems.
- Staff told us that when women moved between teams the services shared the information for their ongoing care, in a timely way and in line with relevant protocols.
- The service used whiteboards across the service to provide information about the women to staff. We saw staff maintained patient confidentiality with the position of the boards within staff rooms and secure areas.
- IT access included access to policies and procedures for internal staff.
- Electronic and paper records were readily available to staff to refer to during the time of a woman's admission.
- The service had a different electronic record system to the trust wide system but the woman's hand held records provided additional information for other specialities, allowing for an effective coordination system across the trust.
- General practitioners received electronic care summaries and discharge letters with a hard copy given to women to promote continuity of care within the community.

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Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Women spoken with confirmed they had received clear explanations and guidance about their required surgery. They also confirmed that they understood what surgery they had consented to.
- Staff understood their roles and responsibilities regarding the Mental Capacity Act (MCA 2005). Staff we spoke with had awareness of the MCA and the Deprivation of Liberty safeguards (DoLS).
- Training on consent, the MCA, DoLS and learning disability was part of mandatory training for all staff. The training records showed an improvement from the last inspection with 91% of medical staff and 97% of nursing staff having received level one training in learning disability and autism.
- Both MCA and DoLS training records showed that 88% of medical staff and 95% of nursing and midwifery staff had completed their training. The trust had policies in place regarding these subjects and they were accessible to staff via the intranet.
- We reviewed eight records and saw fully completed, signed and dated consent forms.
- The HSA 1 form is a document for practitioners to certify their opinion on the grounds for an abortion. We reviewed two HSA 1 forms on inspection; these both complied with the Abortion Act 1967 and were completed appropriately with two legible doctor signatures.

Are maternity and gynaecology services caring?

Good ●

We rated the maternity and gynaecology service as good for the care provided to women who used the service because:

- Feedback from people who use the service, those close to them and stakeholders were positive about the way staff treated women.
- We observed that women received care in a dignified and respectful manner. Women told us how staff kept them involved in all their care decisions and that they were provided with written information or access to download information about those choice options.

- The maternity survey results were in line with the England average in most areas of the Friends and Family Test. The service has received positive comments and feedback from women. However, the response rate for the test was significantly lower than would be expected, particularly in antenatal and community areas.
- Staff on Stanway ward provided care in a manner that was compassionate and delivered the best experience possible for the women in their care.
- Women, their partners and families were active participants in their care and were encouraged through education and support to plan and prepare for their pregnancy, birth and their post birth experience.
- The processes for emotional support available to women who terminate pregnancies or miscarry babies was robust with clear process, systems and there was access to specialist support services available, including the chaplaincy team.

However:

- We received feedback from our comment cards about poor attitude of staff providing care to mothers in the postnatal period.

Compassionate care

- There were mixed results for the Friends and Family test (FFT) for Colchester hospital maternity and gynaecology departments, with good results for performance on delivery wards but poor results for antenatal care.
- Between April 2016 and March 2017, FFT for birth performance was similar to the England average. In the latest month, March 2017, the trust's performance for delivery wards was 100% compared to the national average of 97%.
- Between April 2016 and March 2017, the FFT for postnatal ward performance was generally similar to the England average of 94%. In the latest month, March 2017, the performance for postnatal ward was 96%, which was above the national average of 94%.
- Between April 2016 and March 2017, the FFT for postnatal community performance was generally worse than the England average. In March 2017, the trust had no responses and this response rate reoccurred across the reviewed data.

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- Between April 2016 and March 2017, the FFT for antenatal care was generally worse than the England average of 94%. In the latest month March 2017, the trust had a low response rate with just five people included in the results.
- The Care Quality Commission (CQC) maternity survey results for 2015 showed that the trust performed about the same as other trusts for all 16 questions.
- Women who used the maternity services told us that staff were caring, respectful and friendly.
- Women we spoke with were positive about all clinical staff and felt staff respected their privacy and dignity. Staff maintained women's confidentiality with the use of first names only above bed areas, together with appropriate documentation at the bedside.
- Most women spoke of an excellent and caring experience during labour. Comments included: "My experience this time was so different to the last time and staff were wonderful" and "This time was really good and staff anticipated my needs the last time I needed to ask"
- However, another woman told us that "staff attitudes within postnatal were not good but I do recognise they are all so busy."

Understanding and involvement of patients and those close to them

- Partners and their families said they had been fully involved and felt included in caring for their family member.
- Birthing partners were included throughout all stages of pregnancy and encouraged to stay overnight.
- We spoke with women within the service who were able to identify their named midwife and confirmed that they had been accessible throughout their pregnancy.
- Patients said that the doctors had kept them fully informed.
- We observed doctors and nurses introducing themselves to patients using the "my name is" approach.
- A woman within gynaecology was waiting for surgery and told us that staff had explained what would happen and had checked that she had understood everything. We observed staff repeating the information to the woman's husband who arrived at the end of the discussion.

- Staff had access to language interpreters, as well as staff trained in the use of sign language or Makaton (the use of signs and symbols to help people communicate).

Emotional support

- Staff understood the impact that a person's care, treatment or condition would have on their wellbeing and on those close to them, both emotionally and socially. We observed staff delivering kind, compassionate care, aimed to provide the best experience possible to all women attending the service.
- Staff discussed with women the options available prior to them making decisions about their preferred treatment or birth choices.
- The perinatal mental health team provide assessment and support for women at risk of postnatal depression or anxiety. Staff had thought and considered all aspects of emotional care and support that would be required to women who lost a baby.
- The bereavement specialist midwife is also a trained counsellor and supported families who had lost a baby. The service had established the butterfly bereavement group to support parents following the loss of their baby up to one month after the birth.
- Support was provided with individual and cultural practices respected in relation to the bereavement.
- A counselling service was available for all staff and patients. Staff trained in counselling techniques helped women in making decisions about fertility treatment and/or terminations of pregnancy.
- There was a list of chaplaincy services for staff to contact to meet patients spiritual needs when required, with an on call support rota to cover times outside of the normal working hours (Monday to Friday, 9am until 5pm). The chaplain provided a taped recording of special multi faith services held if women were unable to attend the multi faith chapel.
- There was a trust wide zero tolerance policy in place to support staff against violence and abuse.

Are maternity and gynaecology services responsive?

Good ●

We rated the maternity and gynaecology service as good for being responsive to the needs of women because:

Maternity and gynaecology

- Services were planned, delivered and responsive to the demands from within and outside the service.
- Specialist lead midwives and consultants supported women with more complex requirements, with good access to specialist nurses available to support patients with learning disability and mental health needs.
- Bed occupancy for the service was consistently lower than the England average.
- A range of birthing options were offered and included free hypnobirthing technique which offered natural birthing with limited medicinal input to pain relief, as well as water births and home births.
- There was a newly developed fast track "tongue tie" service to care for the new-born and assist with breast feeding. Staff had worked together with surgeons and the neonatal teams for earlier treatment.
- The service had improved the process for investigating, responding to and managing complaints. Staff now viewed a complaint as an opportunity to improve the service in a positive manner. The service monitored its complaints and offered a response that was personalised and showed a level of care and understanding to the concerns raised.
- Performance against the referral to treatment time (RTT) was in line with the national average.

Service planning and delivery to meet the needs of local people

- The service monitored its birth rates monthly through the maternity dashboard.
- Women had a choice of planned care, which met the needs of the local people. This included for example: community services on the coastal areas, the traveller communities as well as urban areas to reach those groups defined as 'at risk'.
- We spoke with women who confirmed they knew their named midwife and contacted them for advice during their pregnancy.
- Women wishing to give birth at Colchester hospital had the choice of giving birth at the midwife led delivery suite on Juno ward or the consultant led delivery suite for higher risk pregnancy. Women additionally had the choice of giving birth at the midwife led delivery suite located at Clacton hospital.

- Women no longer had the option of giving birth at the midwife led unit at the Fryatt hospital in Harwich. This decision was taken following public and staff consultation, which was initiated due to a low number of women giving birth at the hospital in 2016.
- A home birth service was available for women who were risk assessed and met the criteria for a home delivery if this was their preferred choice.
- The recently refurbished Rosemary suite provided an area for bereaved women and their families to receive support away from the ward environment.
- A choice of memory boxes and 'when a baby dies' and 'Goodbye' parent information leaflets were available within the Rosemary suite.

Access and flow

- Between quarter three (October to December 2015/16) and quarter four (January to March 2016/17) the bed occupancy levels for maternity were lower than the England average, with the trust having 55% bed occupancy in quarter four compared to the England average of 58%.
- Between October 2016 and March 2017, the maternity unit at Clacton closed for 56 days due to a risk identified with the fire alarm system. During this time, women delivered their babies at either Colchester hospital or Harwich Hospital.
- The early pregnancy unit (EPU) received women who presented through the emergency department out of hours. The gynaecology service provided support 24 hours per day. Stanway ward admitted women who required gynaecological or early pregnancy care.
- The head of nursing and matron attended operational bed meetings to raise concerns from this service.
- The service had two obstetric theatres, which meant that should an emergency occur during an elective procedure, there was capacity to complete both caesarean sections. Maternity and gynaecology services had access to the critical care outreach team and intensive care services should a woman's condition deteriorate.
- Performance against the referral to treatment time (RTT) was in line with the national average. RTT means that patients should wait no longer than 18 weeks from GP referral to treatment. The national target is that at least 92% of people should spend less than 18 weeks waiting for treatment.

Maternity and gynaecology

- The percentage of women who had operations cancelled for non-clinical reasons but were offered another date within 28 days with 94.6% against a trust target of 100% between April 2016 and March 2017.
- Data submitted for discharges from the maternity service showed that during 2016 only six women were discharged between 10pm and 7am, compared to three from January 2017 to June 2017.
- In 2016, the gynaecology ward had 73 discharges (between 10pm and 7am) while between January 2017 and June 2017 there had been 50 discharges. We were assured that discharges occurred when the woman was confident to go home and where ongoing care was in place.
- During the refurbishment of Lexden ward women used Aldham ward for their antenatal and postnatal admissions.
- Stanway ward provided care to women with gynaecological conditions as well as female medical patients who were guest patients to the ward during times of increased capacity pressures within the hospital. During our inspection, we noted there was between seven and eight patients from other specialities on the ward.
- Staff informed us about women who had miscarried in the corridor waiting area of the ward. However, we saw no evidence or incident reporting to verify this.

Meeting people's individual needs

- The service offered a range of birthing techniques, which included free dedicated classes and birth pathway for women using 'hypnobirthing' techniques. Hypnobirthing is an antenatal program that teaches simple but specific self-hypnosis and relaxation techniques which support pain management with minimal medicinal input.
- Staff described when a patient's first language was not English that they had access to a telephone interpretation service which they could access twenty-four hours per day.
- We saw patient leaflets displayed throughout the maternity service and on the gynaecology ward; however they were only immediately available in one format. When we asked staff about this, they informed us that alternative formats including large print and different languages were available upon request.

- There were registered midwives with sign language and Makaton (a language programme using signs and symbols to help people to communicate) skills to support those patients and relative with communication difficulties or disabilities.
- The specialist midwifery team supported women with particular complex needs. The team included a perinatal mental health maternity lead midwife and a vulnerable women lead midwife. There was also a bereavement specialist midwife.
- Staff spoken to demonstrated an awareness of "this is me" scheme where patients with a learning disability brought with them a document, which outlined their care needs, preferences and other useful information.
- The Rosemary suite within Stanway ward provided privacy for women who had miscarried.
- We reviewed the processes for the disposal of remains of pregnancy as part of this inspection. The service had a clear protocol to ensure that the remains could be disposed of in line with national guidance and ensured that women were informed of and consented to the process for the disposal of pregnancy remains.
- Staff wore coloured, role-specific lanyards to assist women in recognising the different roles of staff providing them with care.
- All six medical records we reviewed of women over 65 showed that when admitted to Stanway ward the women had a completed assessment for dementia.

Learning from complaints and concerns

- We found at the 2015 inspection that the service addressed complaints with a standard response, however on this inspection we found that an individual response was sent to the complainant. This improved approach resulted from staff participating in the interactive "in your shoes" sessions. This experience ensured staff had learnt from bad patient experiences and provided solutions to prevent reoccurrence. Since the implementation of these sessions, there had been an increase in positive patient feedback received and a reduced number of complaints.
- We saw literature displayed across the service that advised women and their families how they could raise a concern or complaint with details on how to contact the patient advice liaison service (PALS). Staff directed complainants to PALS if they were unable to deal with concerns outside of the service; for example, car parking access.

Maternity and gynaecology

- The service handled complaints in line with the trust's complaints policy in an open, timely and transparent manner.
- Between January 2016 and June 2017, the service had received 37 complaints which related to staff attitude, patient information poor communication and delays in treatment.
- We saw that complaints were reviewed weekly, investigated and responses were written and sent. If the complaint related to staff attitude the individual was required to write a reflection on the complaint and their involvement and learning.
- The trust took an average of 30 days to investigate and close complaints. The longest complaint we viewed took 82 days to close, however this was due to another organisation's involvement. At the time of the inspection, three complaints remained open while still under review.
- The service's governance team maintained all complaints and managed them. The team chased staff for a response if one had not been received. This ensured compliance with responding to the complainants in line with trust policy.
- Learning from complaints was shared through the directorate by the risk management newsletter and women's stories which included the use of the woman's own language.
- We observed, staff interactions with women with a genuine desire to provide high quality care and address any concerns before they escalated to complaints.

Are maternity and gynaecology services well-led?

Good 🟢

We rated well led as good because:

- There was a clear leadership structure within the service and the senior staff demonstrated strong leadership skills.
- There was a clear vision and strategy for this service, known by staff across the service.
- Staff described management as being "visible and approachable". Staff within the inpatient teams stated that areas of poor behaviour, identified via the staff survey, had been addressed.

- There was an established governance and risk management system in place. Which identified, monitored and reviewed clinical risks.
- There was a strong drive to improve services with the well-led recruitment programme and "licence to lead" development for staff.

However:

- The head of midwifery described how the recent staff survey had given the service an increased awareness of staff intimidation and bullying within some areas of the service. This issue was being addressed by the management team at the time of our inspection.
- Staff confirmed that morale was low in some areas across the service. However, actions were taken to address these concerns by a working group with an objective to improve working behaviours in conjunction with the Royal College of Midwifery
- Several members of community staff spoke about how they felt bullied or intimidated by senior staff. They said they had no confidence when asked that concerns raised would be addressed in a fair and consistent manner.
- At the time of inspection, there was no consultant midwife in post. Managers told us of plans to convert an identified budget to support this post.

Leadership of service

- The maternity and gynaecology service was part of the women's children and clinical services division which was led by the " four at the top", the medical clinical divisional lead, divisional head of operations, head of midwifery and a recently appointed interim head of nursing for gynaecology.
- The "four at the top team" confirmed that they worked well together. Staff working within the service recognised the leads for the service and the clinical leads for specialties.
- The service reported to the trust board through the "four at the top" divisional team members, who demonstrated a clear understanding of the service challenges. They discussed actions taken and what was needed to deliver a good quality of care to the women, for example when dealing with women with high complex needs.
- The senior team confirmed there was a clear information pathway from ward to board. Information was fed back to local teams through the divisional leads.

Maternity and gynaecology

- Staff we spoke with felt that the executive team were visible and most staff felt well supported within the service and through their local leadership team.
- Each clinical area had a senior lead nursing or midwifery staff member who reported to the matron for midwifery and gynaecology. Staff told us the head of midwifery supported, inspired and were driving the service forward.
- The leadership for gynaecology had recently changed with the responsibilities of gynaecology now lay with the head of nursing for gynaecology. At a local level, staff stated they felt well supported by the ward manager who oversaw the gynaecological ward.
- Senior staff spoke about the "Licence to Lead" development programme. This programme-supported staff in understanding their roles as leaders and helped them develop competencies and skills including managing difficult situations.
- A national programme for advocating and educating for quality improvement had been developed in collaboration with NHS England, higher education institutions, the Royal College of Midwives, A-EQUIP pilot sites and other key stakeholders to replace traditional midwife supervision. Supervisors of midwifery had continued to support through supervision until this programme had been embedded.
- Community staff were aware of the service links to the hospital and held the same values of delivering "the best care to every patient, every day". The community midwifery staff confirmed that they rotated into the maternity hospital as required by the service.
- However, the community midwives were less positive about the support they received from senior staff and in a focus group confirmed that they felt intimidated by a member of the management team who they would not approach and that staff morale remained low.

Vision and strategy for this service

- The trust launched, in October 2016, the "Delivering great healthcare to every patient every day" vision and strategy. This included:
  - acting in the best interests of every patient, every day
  - Supporting our workforce to look after every patient, every day
  - Achieving clinical, operational and financial resilience every day
- Staff spoken with were aware and felt that the service had embedded the trust's vision and strategy.

- Maternity services had benefited from investment to the in-patient environment since the last inspection.
- The maternity services objective of "the best care to every patient, every day" linked into the trust's quality improvement strategy.

Governance, risk management and quality measurement

- A member of the trustwide patient safety team attended the service's monthly governance meetings and discussed quality issues such as complaints, incidents and audits. For example, the monthly team meeting minutes for March and April 2017 showed that staff shared learning from identified incidents and demonstrated improvement actions taken.
- The service maintained one ongoing action plan, which was regularly reviewed and updated to ensure continual oversight and improvement. The monthly directorate governance meeting met and agreed the actions relating to the improvement service plan, which ensured continual progress within the service.
- The service held a weekly risk management meeting, which reviewed the clinical risk register with senior staff. The risk register for July 2017 identified 12 current risks, which included the risk of service closures. Staff members were identified as leads for each risk.
- Risks were included in the maternity services risk management newsletter for all staff awareness.
- Staff communicated any identified key learning with staff members at team meetings and at handovers.
- Staff told us they understood their role and responsibilities in relation to risk. The risks that staff identified reflected the risks we identified during the inspection; for example, the hot environment on Lexden ward with no air conditioning system.
- There was a systematic programme of clinical and internal audit used to monitor quality and systems (to identify where action should be taken). The service had a clinical performance dashboard which was colour rated to clearly demonstrate areas of concern (red), areas where work continued (amber) and where agreed targets or standards (green) had been achieved.
- The service had developed a message of the week which was risk related, a short sentence communicated to all staff at staff team meetings or handovers.
- On Lexden ward, the weekly message of "child health red books" (which should be given to women after the

completion of the new-born and infant physical examination screening and placed in boxes as appropriate) was seen and known about by staff we spoke with.

- Inspectors attended the serious incident review investigation panel meeting for July 2017. We observed the presentation of each case on the agenda. Investigations are completed by a team rather than one individual and the number of investigators trained in completing full root cause analysis had increased from the last inspection.

- The maternity service employed an information technology midwife who worked closely with the trust wide information technology group to promote an effective system. One example of an improvement was the CTG uploaded to the woman's electronic records.

- There was a conflict of information reported to the CQC. In the information submitted by the trust to the CQC, the trust did not report any closures of the maternity unit in the last six months, however the maternity dashboard stated there were six closures between March 2016 and March 2017.

Culture within the service

- The culture within maternity and gynaecology services was open and promoted supportive relationships between staff and women and their families. Most staff praised the work of the senior management team who they felt were the driving force for recent successes.

- The head of midwifery and head of nursing had an open door policy and encouraged staff to be open about any concerns. They attended staff team meetings and held monthly meetings with staff.

- Staff informed us that they were 'passionate' and 'driven' to provide good care for all women.

- We heard a clear change of language used by staff which we were told by staff was based on the women's feedback; for example staff no longer referred to as a failed induction but as an ineffective induction, and a ward outlier or boarder were now referred to as guest patients.

- We spoke with members of staff about the culture and they told us that they believed the staff worked well together as a team.

- Doctors were positive and said they had good working relationships with supportive colleagues. However one member of medical staff stated that a senior clinician had intimidated them in an unfair manner in front of colleagues.

- The head of midwifery commissioned a local staff survey in May 2017 that demonstrated that not all staff adhered to the values of the service. Staff from the community midwifery said they felt intimidated by senior staff and had observed colleagues being "bullied". We raised this concern with the head of midwifery who confirmed engagement with the Royal College of Midwives to improve working relationship and build an open culture for staff.

- There was a whistleblowing policy for the trust but we saw no whistleblowing incidents reported from staff within the inpatient service.

- Several staff spoke about how they felt bullied or intimidated by senior staff. They felt concerns addressed would not be looked at fairly or consistency. Five out of twelve staff that attended a focus group stated that the staff morale remained low in some areas and those same five staff stated they did not feel respected or valued.We received a number of concerns particularly from community midwives. We raised this with the senior team who were aware of a meeting with community midwives and the head of midwifery in the week following our inspection. The senior team were aware of the importance of addressing the concerns of community midwives and the chief executive would personally take an interest in their concerns.

Public engagement

- The maternity services used a variety of communication methods, for example a virtual tour and procedure film on the trust website. The service also used social media, the friends and family test and maternity services liaison committee or "maternity voices" to encourage involvement and feedback from women who used the services.

- The service had two active "projects" with an objective to encourage, inspire and support new parents and obtain feedback to help shape the service of the future. The MaMa project is a maternity collaboration, enabling women to share their experiences of pregnancy and birth. The PaPa project aimed to support and listen to new father's and to build a network in order to receive feedback to directly influence and ignite change.

Maternity and gynaecology

- The maternity services liaison committee is a multidisciplinary meeting forum that includes patient representation and works to develop the service to meet the needs of women in the local area.
- The midwives had continued to obtain service users' opinions by holding off-site monthly supportive sessions for woman. Feedback given included "I would like to say a huge thank you to the midwives who gave amazing support and stopped longer than planned to provide me with additional reassurance".
- Midwives were actively reaching out to pregnant women to promote the midwife led unit (Juno suite) through online information and social media. For example, the website had a virtual tour of the delivery suite.
- Lexden ward's refurbishment was currently near completion and women and staff had been listened to regarding the requirements of the area.

Staff engagement

- The head of midwifery had involved staff with the strategy and recent changes within the service. Staff told us they were encouraged to participate in the improvement of service delivery and make suggestions.
- Staff discussed how they felt the service had improved with the current head of midwifery. Most staff said they could share their observations from other trusts and felt they were encouraged to share their experience.
- Two members of staff described how they left the service to work in another organisation but had returned and saw positive changes in place on their return.
- Staff told us they had regular monthly team meetings and the service shared information in different ways, such as email, one to one meetings or newsletters.
- Staff described positively how the service supported them when handling a sensitive matter which may affect them.
- Staff confirmed they had attended development days, team meetings, case review meetings and national conferences, which were supported by their managers.
- The head of midwifery had commenced two surveys for staff and students in May 2017. We saw plans in place to address the feedback and support staff involved.
- Three members of midwifery staff told us about the "speak up" guardians who supported staff who felt unable to raise concerns. The speak-up guardians also supported staff when they required support outside of this service.

- Across the service and on the performance dashboard, staff could see the number of complaints and plaudits received for the service. Individual staff members received a letter of acknowledgement from the head of midwifery or head of nursing when they were the subject of positive feedback.
- Staff demonstrated how they acted in the best interests of every woman every day. After the last inspection staff listened to feedback, which stated that women wanted their partners to support them overnight during their first days as a new mother. As a result, partners were encouraged to stay overnight. Several staff mentioned a colleague who had opened their garden to raise charitable funds for suitable overnight bed/chairs.
- Staff discussed and felt proud of the developments completed within this service, for example, the two-bedded quiet area for women following caesarean section. Staff had been involved in the refurbishment design.
- Lexden ward refurbishment was near completion and staff had been listened to regarding the requirements of the area. This included an air cooling system in each room to prevent overheating in the summer months.

Innovation, improvement and sustainability

- The trust launched the "Baby box" scheme in October 2016 where every new or expectant woman received a baby box that included a high quality mattress and free baby equipment and information. The research associated with the use of the baby box scheme had demonstrated that sudden infant death syndrome rates have dropped when baby boxes are used.
- Staff introduced the innovative "gentle caesarean" delivery, which creates a relaxing atmosphere, with dimmed lights, music and allows the woman and their partner to witness the birth with no separation drapes at the delivery of the baby's head.
- As an area of innovative practice, the service introduced a hypnotherapy birthing service, which is a complete antenatal programme focussing on a combination of education, self-hypnosis and deep relaxation to help achieve a more comfortable birth. Medical staff attended this training with the service being free to all women.
- In April 2017, "quick response" (QR) codes were introduced to provide a shortcut to patient information, for example, diabetes in pregnancy, common problems

in pregnancy and domestic violence awareness. They are a series of squares that when scanned by a mobile phone reads the information the woman or her family require.

Services for children and young people

Safe	**Requires improvement**	🟠
Effective	**Good**	🟢
Caring	**Good**	🟢
Responsive	**Good**	🟢
Well-led	**Good**	🟢
Overall	**Good**	🟢

Information about the service

Children's and young people's services at Colchester General Hospital consist of a children's unit, a neonatal unit, children's outpatients department, and children's and neonatal community outreach services.

The children's unit is comprised of three separate areas: the children's assessment unit (CAU), an elective care unit (ECU) and a children's ward.

The CAU receives patients from the accident and emergency (A&E) department. It has the capacity for ten patients, with eight beds and two side rooms and has one consulting room. The ECU has ten beds. The children's ward has 24 beds in total, four of which are reserved as contingency beds, and 10 side rooms. There is a level two neonatal unit for babies requiring short-term intensive care with 17 cots, including one cooling cot, four high dependency cots and 12 special care cots.

During the inspection, we inspected all areas where children and young people were treated. We spoke with five parents and one child, and 34 members of staff including consultants, registrars, junior doctors, nurses, student nurses and specialist nurses, health care assistants, allied health professionals, play specialists and administrative staff. We observed one theatre case and attended three children's outpatient clinics, and reviewed 13 patient records. We also reviewed data provided by the trust before, during and after the inspection, such as audits, policies and procedures.

Summary of findings

We rated this service as good because:

- Nursing and medical staffing levels and skill mix were generally appropriate to meet patient needs.
- There was a comprehensive local audit schedule to monitor performance, and participation in national audit, with actions for improvement following audits.
- Policies and procedures were up-to-date, and based on national guidance and best practice.
- Staff were well supported to develop their skills and competencies. For example, the transition nurse lead was on a degree pathway to complete an adolescent health course.
- Multidisciplinary team (MDT) working was strong both internally and externally. MDT meetings involved all relevant staff and everyone had an opportunity to contribute.
- All observations of staff interaction with patients showed compassionate care and staff tailored their communication to suit the needs of each child.
- Parents and families were actively involved in the care of their child and staff took time to ensure they understood information given to them.
- There was a dedicated community nursing team working in schools and the wider local area to meet the needs of the local population.

- Discharge planning was integral to patient care plans throughout the patient's stay in hospital. The NNU had implemented a 'discharge passport' aimed at involving parents more centrally in discharge

Services for children and young people

planning. There was a focus on nurse-led discharges in straightforward cases, meaning nursing staff did not have to wait for a doctor to approve the discharge.

- There was a team of specialist nurses to provide support for patients with diabetes, epilepsy and asthma, gastroenterology, urology and oncology.
- There was a dedicated transition team for adolescents approaching their transfer to adult services. They worked with other teams to meet the more complex individual needs of patients at the age of transitioning to other services. For example, they ran a joint clinic with the epilepsy specialist nurse three to four times a year. There was a gradual, long-term approach to transition starting around the age of 14, which included a 'transition passport' system, where staff from both paediatric and adult services documented changes and progress.
- Complaints were discussed as part of the patient safety group which took place weekly as part of the medical handover.

- There was a comprehensive strategic vision for the service for the next three years.
- The risk register was closely monitored and up-to-date, and matched the areas of risk we saw on inspection. Risks were reviewed at a weekly risk management meeting by the service leads. This fed into the monthly 'two at the top' risks, which were circulated among staff and escalated up to the trust clinical governance team.
- The clinical and nursing leads showed strong leadership and oversight of the service. Staff said they were well-supported by the leads.
- There was a positive, supportive culture in the service.
- The service had initiatives to engage the local population and service users; for example, there was a support group called 'Little Miracles' for mothers who had previously had their children treated in the neonatal unit.

However:

- We were not assured that staff were consistently reporting all incidents through the electronic incident reporting system, or that formal systems to ensure actions from incidents were not shared consistently among all staff.
- There had been an increase in medicines incidents between March and May 2017. This was due to inconsistent checking of drug charts by theatre staff when children were taken for surgery, and different types of documentation used by the paediatric and theatre teams. However, the service had recently introduced red stickers in the patient notes as an action to address this.
- The 13 sets of patient records we reviewed were variable in their content and completion. For example, one set of notes did not include the time of review or why the patient was reviewed, and a discharge summary did not indicate whether there were any medications allergies.
- The policy for safeguarding children was not in line with best practice; for example, it did not set out who was responsible for completing body maps, and it was not trust policy or procedure to have all child protection cases overseen by a paediatrician.
- Children undergoing surgery had to be transported through the adult recovery area to reach the children's recovery area.

Services for children and young people

Are services for children and young people safe?

Requires improvement ●

We rated safe as requires improvement because:

- We were not assured that staff were consistently reporting all incidents of any severity through the electronic incident reporting system.
- We were not assured that formal systems to ensure actions from incidents were not shared consistently among all staff. Staff received feedback from incidents they had personally reported, but wider feedback and learning from incidents reported by other staff or from other departments was inconsistent. Service leads confirmed it was a challenge bringing all staff together to share important learning and updates.
- Staff did not all show an understanding of the duty of candour.
- The checklist for maintaining cot mattresses in the neonatal unit was not consistently carried out; for example, there were no cot mattress checks documented for the month of June 2017.
- One fridge on the children's ward was overfilled with items including antibiotics and creams. The temperature of the fridge had been recorded as higher than the safe range on 15 days out of the previous 25 days due to an issue with the thermometer used for recording. However, the matron had arranged to order and install a new fridge.
- There had been an increase in medicines incidents between March and May 2017. This was due to inconsistent checking of drug charts by theatre staff when children were taken for surgery, and different types of documentation used by the paediatric and theatre teams. However, the service had recently introduced red stickers in the patient notes as an action to address this.
- The 13 sets of patient records we reviewed were variable in their content and completion. For example, one set of notes did not include the time of review or why the patient was reviewed, and a discharge summary did not

indicate whether there were any medications allergies. This was not good practice, particularly as elsewhere in the notes it was highlighted that this patient had multiple reactions to medications.
- Mandatory training compliance rates for medical and dental staff was variable across the 19 training modules. The lowest was adult basic life support at 45%.
- Medical staff compliance rate for safeguarding children training level three was 41%.
- The policy for safeguarding children was not in line with best practice in some areas. For example, it stated that consent was required before medical examinations for child protection can be undertaken, which is not the position for cases falling under section 47 of the Children Act 1989. It also did not set out who was responsible for completing body maps.
- It was not trust procedure or policy to have all child protection cases overseen by a paediatrician, which was not good practice.

However:

- All areas where children were treated were secure, spacious and well laid out.
- The resuscitation trolleys on both the children's unit and the NNU contained appropriate equipment for a range of ages and sizes, and the checklists of equipment on the trolley were completed and signed off daily with no gaps.
- There was appropriate paediatric equipment in theatres.
- There was a comprehensive equipment maintenance schedule in place.
- All medicines, including controlled drugs, were stored securely and appropriately. We checked the CD register for May-July 2017and saw it was signed off daily with no gaps.
- The neonatal unit had recently introduced 'focused care charts' which gave a 24-hour documentation of each aspect of the care plan; for example there were individual documents for ventilation, pain scoring and nutrition. We saw these charts showed a clear picture of the patient's condition. All five we reviewed were clear, complete, and provided all information required.
- Nursing staff within children's services achieved the 95% safeguarding training compliance level for all training

courses, except for Safeguarding Children Update level three. All members of the community nursing team were up-to-date with level three training in safeguarding children at the time of our inspection.

- There was a named nurse and named doctor for safeguarding children and staff said they were able to obtain advice and support from them promptly.
- We observed staff using the paediatric early warning system (PEWS) to assess patients' risk of deterioration. PEWS scores were consistently and clearly documented in individual records. There was a monthly PEWS audit, which identified areas of good practice and actions for improvement, such as refresher training sessions and updating the existing PEWS by piloting four age-specific charts intended to be clearer and easier to use.
- Nurse staffing levels and skill mix were usually sufficient to safely meet patient need, although notably the children's assessment unit had significant vacancies. The service mitigated this by being flexible with their workforce between different areas. The NNU was meeting standards set by the British Association of Perinatal Medicine (BAPM) for nursing staffing levels, and there was always a band six nurse or above leading the shift.
- Medical staffing levels and skill mix were appropriate to meet patient needs.

Incidents

- Between June 2016 and May 2017, the trust reported no never events for children's services. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Between May 2016 and April 2017 there was a total of 251 incidents in CYP services reported through the electronic reporting system. This included three patient deaths due to cardiac arrest, which had been reviewed appropriately by the child death review panel and outcomes documented. 205 incidents resulted in no harm. We reviewed the incident reporting log, which included evidence of actions taken and lessons learned.
- In accordance with the Serious Incident Framework 2015, the trust reported four serious incidents (SIs) in children's services that met the reporting criteria set by NHS England between June 2016 and May 2017. Two of

these were categorised as sub-optimal care of the deteriorating patient; one was a diagnostic incident including delay (including failure to act on results); and one was categorised as abuse/alleged abuse of child patient by third party.

- SIs were discussed at the weekly patient safety meeting and at nursing and medical handovers and the matron was involved in the investigation and report of any SIs that occurred in their department.
- We were not assured that staff were consistently reporting all incidents of any severity. Two members of staff we asked had both been working at the service for over a year and had each only reported one incident using the online reporting system. Some members of staff said they would report an incident verbally to their manager rather than through the electronic system.
- We were not assured that the formal systems to ensure actions from incidents were used consistently among all staff in the service. Staff said there were email updates of learning from incidents, but they rarely had time to check these when they were on the ward. Staff received feedback from incidents they had personally reported, but wider feedback and learning from incidents reported by other staff or from other departments was inconsistent. Two members of staff said they did not routinely receive feedback unless they asked specifically. Two others said feedback was shared by the service leads about incidents within the children's ward, but they did not hear about any learning from incidents in other areas.
- Service leads in both the NNU and on the ward acknowledged that it was a challenge bringing all staff together to share important learning and updates and that they relied on the team study days which took place four times a year. Staff confirmed that the study days were where the majority of learning from incidents took place.
- However, incidents were escalated for discussion at monthly governance meetings. For example, the minutes from the May 2017 meeting identified a theme from incident reports, namely delays to theatre due to inconsistent notification on the porter tracking system. It was documented that this had been discussed with the relevant staff members.
- Staff understanding of the duty of candour was variable. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or

other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Two members of nursing staff we asked said the duty was about being an advocate and providing a voice for the patient and were unable to give examples of where they had used it. However, service leads showed clear understanding of the duty of candour.

- We reviewed mortality and morbidity meeting minutes from February, March and May 2017. These minutes included appropriate discussion of mortality and morbidity cases and causes. There were actions from discussion such as looking into management of pre-term labour conditions and additional teaching sessions. Actions were allocated to owners. We saw there was attendance and contribution from staff at all grades.

- Mortality and morbidity were also discussed at the weekly patient safety group which followed the morning medical handover at 9am. At the handover we attended there had been no cases from the past week to discuss.

Safety thermometer

- The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care.

- Data from the children's and young people's patient safety thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new catheter urinary tract infections between April 2016 and April 2017 for children's services.

Cleanliness, infection control and hygiene

- All areas we inspected were visibly clean.

- There was a lack of hand gel dispensers at appropriate places in the children's ward. In particular, there was no dispenser immediately outside each side room. This meant there was a short delay between a member of staff leaving the side room and disinfecting their hands afterwards with hand gel. This was not best practice as patients presenting a high infection risk were treated in side rooms, including one patient at the time of our inspection.

- However, hand hygiene audit results showed 100% compliance among nursing staff for each month between April 2016 and March 2017. Among medical staff, results were 100% in each month except for one month where it was 88%.

- Availability of personal protective equipment (PPE) was inconsistent. There were aprons at the entrance to each side room which we saw staff using appropriately. However, there were no gloves available before entering. Protective gloves were stored inside the side room and staff put them on only after entering the room. When we asked about this we were told this was the usual procedure, unless the patient in the side room presented a risk of airborne infection. In that event, we were told there would be no PPE stored in the side room as it would all be at risk of becoming contaminated. Instead, the staff would disinfect their hands and put on an apron, mask and gloves all before entering the room. We saw staff following this on site as there was a patient with a severe chest infection in the side room at the time.

- In the CQC children's survey 2014 the trust scored 9.34 out of ten for the question 'How clean do you think the hospital room or ward was that your child was in?' This was about the same as other trusts.

- Cleaning and housekeeping audits were carried out once a month in individual areas across children's services. In April 2017, the neonatal unit scored 100%; children's outpatients achieved 98.06%; children's elective care scored 97.81%; For February 2017, the children's ward scored 99.1% and the children's assessment unit scored 98.84%. However, the audits did not state what the target percentage was.

- During our inspection, we were assured that cleanliness and infection control was well managed and actions for improvement were taken when necessary. For example, the NNU matron told us that the IPC audit carried out in February 2017 had highlighted areas of concern, such as missed cleaning underneath intravenous drip stands and inconsistent secure closing of sharps bins. They had discussed these with staff and designed a poster to improve staff awareness around filling and closing sharps bins. The audit that took place the following month showed improvement in these areas as a result.

- We saw a cleaning rota in the playroom displaying which toys and equipment were required to be cleaned weekly or fortnightly. All members of the play team were responsible for this. We checked the signing off sheet to document this and saw it had been completed with no gaps for the period May – July 2017. Any toys used by patients presenting an infection risk would be cleaned immediately afterwards.

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- Service leads were supported by the trust IPC link nurse for any specific concerns if required.
- Between April 2016 and March 2017, there were no instances of MRSA recorded in the service.
- Between April 2016 and March 2017, there was one instance of C.difficile recorded in the service.

Environment and equipment

- CYP services consisted of the main ward, neonatal unit, children's assessment unit (CAU) and children's outpatients department.
- The children's ward and neonatal unit were both secured with buzzer and intercom entry and throughout the inspection we saw that doors were not left open and staff used the buzzer system appropriately to ensure a safe environment for children.
- The ward comprised 20 beds separated into bays of four beds, which were spacious and free from clutter. There were an additional four beds, which were used as contingency beds. There were eight beds on the CAU and ten beds in children's elective care.
- The NNU was a level two unit with one level three bed, four high dependency beds and 12 special care beds.
- There were two dedicated paediatric recovery beds for children post-surgery, although these could only be accessed by going through the adult recovery area.
- There was a toilet in each bay on the ward. However, when we were carrying out observations of the ward area, we saw there was a bottle of cleaning fluid left on the floor of one of the toilets, which posed a potential health and safety risk to children using the toilet. The nurse in charge immediately removed it and replaced it in the appropriate store cupboard.
- There was a playroom accessible for children admitted to the children's assessment unit and the elective care unit that contained many play items such as games consoles, books, and train sets.
- Facilities in the CAU included six beds, two side rooms, a consulting room, a clean utility room, sluice room, parents' lounge, nine clinic rooms and a treatment room. The treatment room was often used for phlebotomy clinics.
- There was a garden, which could be accessed only from the children's ward for children and parents to enjoy outdoor space. This was secure all the way around with outdoor toys and seating areas.
- We checked the resuscitation trolley on the children's unit, which was sealed with a security tag. The checklist

of equipment on the trolley was completed and signed off daily for the period May – July 2017. However, there was an ampoule, which was in date but stored in the incorrect box displaying an out of date label. We informed the nurse in charge, who removed it immediately.
- The resuscitation trolley on the NNU was checked daily with no gaps in the checking history for June and July 2017. The contents matched the equipment checklist and were all in date.
- There was appropriate paediatric equipment in theatres for a range of ages and sizes, including resuscitation equipment.
- We reviewed the checklist for maintaining cot mattresses in the NNU to ensure there was no damage and that they were fit for purpose, which was meant to be completed and signed off weekly. This was not consistently carried out; for example, there were no cot mattress checks documented on this for the month of June 2017.
- In the CQC children's survey 2014 the trust scored 9.5 out of ten for the question 'Did you feel safe on the hospital ward?' This was about the same as other trusts.
- The trust scored 9.6 out of ten for the question 'Did you feel that your child was safe on the hospital ward?' This was about the same as other trusts.
- The trust scored 8.9 out of ten for the question 'Did the ward where your child stayed have appropriate equipment or adaptions for your child?' This was about the same as other trusts.
- One fridge on the children's ward was overfilled with items including antibiotics and creams. We checked the fridge temperature recording sheet and saw it had been recorded as a temperature higher than the safe range on 15 days out of the previous 25 days. There were also 10 instances of it being too high in June 2017. When we raised this with the matron, they looked into the issue and realised it was the recording equipment that was faulty so the fridges were at a safe temperature. However, they acknowledged that the fridge was too small and arranged to order and install a new one.
- We checked the milk storage fridges on the NNU and in the ward and saw they were within the safe range for June and July 2017, with daily checks documented.

Medicines

- All medicines we checked across all children's areas were in date and stored securely and appropriately.

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However, there were two bags of IV fluids in a drawer in the medications preparation room on the ward that were five months out of date. We alerted the nurse in charge who immediately removed these. Controlled drugs (CDs) were locked away securely and staff had to request the keys from the nurse in charge to access them.

- We checked the CD register on the ward for May-July 2017and saw it was signed off daily with no gaps.

- Medicines incidents, changes and updates were discussed at the medical handover we observed on the children's ward. This included a review of an incident of delayed antibiotic administration, which had occurred the week before as a result of miscommunication about the means of administering the antibiotic. This caused a delay of half an hour to administration but with no harm to the patient. This had been reported as an incident.

- The matron told us there had been an increase in medicines incidents between March and May 2017. This was due to inconsistent checking of drug charts by theatre staff when children were taken for surgery, and different types of documentation used by the paediatric and theatre teams. To address this, the matron and consultant lead had met with the lead anaesthetist and introduced red stickers in the patient notes to highlight that the medication had already been administered. This change had only been implemented two months before so it was too early to fully assess whether this had resolved the issue, but the leads told us there had not been any incidents of accidental double doses since. Staff we asked were aware of this new system.

- Drugs charts we reviewed had weights recorded for children to ensure the correct dose of medication was prescribed.

- The matron for the neonatal unit told us about a 'check the chart' campaign they had initiated to encourage more thorough checking of drug charts before starting the administration process. They said this had been well received by staff, leading to an improvement in medicines errors. Staff we spoke with on the unit were aware of the campaign and we saw posters for this on the unit.

- There was a dedicated pharmacist for children's and young people's services. They reviewed patients' medicines and checked drug charts daily. They attended medical handovers to provide input on medicines as required and to flag up any prescriptions to take away (TTAs) for patients nearing discharge.

- Nursing staff consistently reported they could get doctors to prescribe medicines promptly, even at night. There was no nurse prescriber on the ward but there was one in the children's assessment unit to help ensure prescriptions were made in a timely manner.

- In the neonatal unit there was a new system for the administration of gentamicin (an antibiotic) whereby the neonatal nurse was the first checker for the dose and the midwife was the second checker. This new system had been in place for around 12 months and was innovative for meeting the needs of mothers and babies as it meant the baby did not have to be apart from the mother and could stay on the postnatal unit for the whole process to avoid admissions onto the NNU.

Records

- Records were entirely paper-based and on the children's ward were stored in a trolley behind the nurses' station. Although we saw this left unlocked, the trolley was not in a thoroughfare.

- We reviewed 13 sets of patient records, which were variable in their content and completion. For example, one set of notes did not include the time of review or why the patient was reviewed, and medical notes following height and weight measurements were not consistently completed. Another set did not include the patient's name and NHS number on every page. One discharge summary we reviewed did not indicate whether there were any medications allergies. This was not good practice, particularly as elsewhere in the notes it was highlighted that this patient had multiple reactions to medications. The notes also lacked information on what their reactions involved.

- The neonatal unit had recently introduced 'focused care charts' which gave a 24-hour documentation of each aspect of the care plan; for example there were individual documents for ventilation, pain scoring and nutrition The matron told us this had made records clearer and better-organised. Staff spoke positively about the ease of use of these records. We reviewed five sets of records in the NNU, which were clear, complete, and provided all information required.

- Daily notes for patients in the NNU were kept by each baby's bed.

- In the CAU staff used a 'part one admission sheet'. When the child was later admitted to the ward nursing staff

used separate documentation and used a new page for each day of the child's admission. Referral and arrival times were not consistently documented in the part one records.

- Records of all appointments where patients did not attend (DNAs) were kept in a folder and sent to patients' GPs. The service kept copies of the records for one month and then destroyed them as per trust policy.

Safeguarding

- Between April 2016 and March 2017 the trust made 491 safeguarding referrals for children to the local authority.
- Medical staff within children's services did not achieve the trust target of 95% for any of the safeguarding courses. Safeguarding children update level three had the lowest compliance rate at 41%. However, by the time of our inspection, training compliance rates had improved as staff had completed refresher training.
- Nursing staff within children's services at Colchester General Hospital achieved the 95% safeguarding training compliance level for all training courses, except for Safeguarding children update level three, which had a compliance rate of 87%.
- All members of the community nursing team were up-to-date with level three training in safeguarding children at the time of our inspection. The community matron told us they had good links with the local safeguarding board and had worked with them on additional face-to-face training.
- There was a named nurse and named doctor for safeguarding children and staff said they were able to obtain advice and support from them promptly. There was also a named midwife and safeguarding children adviser, who formed the safeguarding children team. This team attended quarterly meetings for the safeguarding children management group and the trust-wide safeguarding children committee.
- There was an up-to-date policy for safeguarding children, which included guidance for those under 16 years of age and identified high risk areas such as female genital mutilation (FGM) and child sexual exploitation.
- However, the policy was not in line with best practice in all areas. For example, it stated that consent was required before medical examinations for child

protection can be undertaken, which is not the position for cases falling under section 47 of the Children Act 1989. It also did not set out who was responsible for completing body maps.

- There was an infant abduction policy in place, of which staff were aware. This was an improvement from the previous inspection, where there had not been an abduction policy.
- We discussed recent child safeguarding incidents within the last six months with the safeguarding leads. While there was evidence of referral to the local authority in appropriate cases and investigation, we were concerned that it was not within procedure or policy to have all child protection cases by a paediatrician. Safeguarding leads confirmed that such cases would not always be overseen by a paediatrician. This was not best practice. We were also concerned that in one incident of a baby with an unexplained injury, there had been no body map or further investigations carried out prior to discharge.
- Staff we spoke with in children's outpatients said that where there had been two missed appointments, they would raise it with the consultant to be aware of any potential safeguarding concerns and make further enquiries as they saw fit. This was good practice and a section on missed appointment was included in the Safeguarding children, young people and the unborn policy, (16) 180, October 2016..
- Two health care assistants (HCAs) we asked gave examples of feedback the team had received from previous safeguarding concerns raised in the department. A nurse also showed good awareness of the missed safeguarding concern in the department and explained the feedback and learning that had been shared on a team day.
- Staff reported to have good links with the safeguarding leads in the trust.
- There was a pink marker next to children's names on the board at the nurse's station which indicated any child known to social care or who were potential safeguarding concerns.
- An information folder on display at the nurses' station in the NNU contained a child protection action flowchart to advise staff who to contact and how to respond to any potential concerns. It also included guidance on recognising abuse, including a body map of common sites for non-accidental injuries.

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- We reviewed the annual safeguarding children report for 2016-17, which included discussion of key concerns, examples of safeguarding incidents, and actions for improvement. For example, the report highlighted that safeguarding 16-17 year olds was an ongoing challenge for the trust due to a lack of dedicated adolescent unit or treatment area. To mitigate this, the safeguarding team were working towards increased visibility in clinical areas and improved joint working with other departments including outpatients and A&E in relation to awareness of concerns with 16 and 17 year olds.

Mandatory training

- Mandatory training consisted of a combination of online and face-to-face learning. The programme included, but was not limited to, health and safety, hand washing and conflict resolution.
- Medical and dental staff within the service were not meeting the trust target of 95% compliance for any of the 19 mandatory training modules, as of April 2017. The lowest was adult basic life support at 45%.
- Nursing and midwifery staff within the service had achieved the trust target of 95% compliance for 14 out of 19 mandatory training modules, as of April 2017. The lowest compliance rate was 86% in paediatric basic life support.
- All staff we spoke with on inspection were up-to-date with mandatory training or were booked onto the next refresher training course for any modules that were overdue.
- Responses were variable when we asked staff whether they felt they had sufficient time to complete or update their mandatory training. Some nursing staff said it was difficult to get the time away from the ward to do this.

Assessing and responding to patient risk

- The service used the Paediatric Early Warning System (PEWS) to monitor a childs condition and detect early signs of deterioration. The neonatal unit used the neonatal early warning score system to assess and monitor for deterioration. During our inspection, we observed staff using PEWS competently and effectively. PEWS scores were consistently and clearly documented in individual records.
- The service carried out a monthly PEWS audit. We reviewed the results of the audits from February to June 2017. The results identified areas of good practice; for example, in February, the PEWS score was accurately

calculated in 100% of cases in the sample; vital signs were accurately plotted in 99.6% of cases, and the appropriate chart relative to the child's age was used in 98% of cases.

- However, the audit also identified areas for improvement in using the tool to assess and respond to patient risk. For example, overall assessment of level of consciousness using the 'Alert, Voice, Pain, Unresponsive' (AVPU) tool was inconsistent when patients were sleeping, with staff either scoring amber or not scoring at all. This early/false triggering of an amber score when no action was required was raised as a concern in the audit as it increased the risk that a genuine trigger would be ignored. It was also identified that none of the escalation conversations following red or amber PEWS scores were documented using the 'Situation, Background, Assessment, Recommendation' (SBAR) tool.
- The audit included actions to address these areas of concern, such as refresher teaching on SBAR on team training days; and updating the existing PEWS by piloting four age-specific charts intended to be clearer and easier to use.
- We reviewed the compliance audit for the World Health Organisation (WHO) 'Five Steps to Safer Surgery' checklist for the five theatres where surgery on children and young people was carried out. The audit showed good compliance, with the lowest score being 96% in May 2016.
- The service had a 'consultant of the week' who was on call to respond to any concerns over patient risk or deterioration. There was always a registrar on call for all children's areas, either in the local area or on site so they could respond promptly to any patient deterioration. On the NNU there was a SHO available 24 hours a day, seven days a week.
- There was always a doctor with advanced paediatric life support (APLS) or European paediatric advanced life support (EPALS) on each shift.
- There was appropriate paediatric resuscitation equipment in the adult critical care unit because under 18s sometimes had to be stabilised there in the event of their condition deteriorating, before being transferred to an appropriate paediatric facility. If an under 18 was being treated in the unit, a paediatric specific risk assessment would be carried out.

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- The service worked closely with the Acute Neonatal Transfer Service (ANTS) and the Children's Acute Transfer Service (CATS) to transfer critically ill patients out to more suitable critical care facilities.
- The service used the 'sepsis six' pathway and we saw this was appropriately documented within patient records. Training on recognising and responding to sepsis was included in mandatory training

Nursing staffing

- Data showed that as of April 2017, there were 133.45 whole time equivalent (WTE) nursing staff in post across CYP services. This was slightly lower than the planned level of 152.47 WTE staff.
- There was a vacancy rate of 13% in children's services. The children's assessment unit had the highest vacancy rate with 7.7 WTE posts unfilled out of an establishment of 25.1 WTE (-29%). During our inspection, we saw that the actual nurse staffing levels in the CAU did not match planned levels.
- However, other areas within the service had appropriate staffing levels and skill mix to safely meet patient need when we inspected, which was confirmed by the matron and nursing staff. On the day of our inspection, planned staffing on the ward was six registered nurses and one HCA for the long day shift, and five RNs and one HCA for the night shift. The actual levels were five RNs and two HCAs on the long day shift, and the night shift met planned levels.
- The risk of understaffing was on the service's risk register. The service mitigated the risk of low nurse staffing, notably within the CAU, by being flexible with their workforce between different areas. During our inspection, a member of staff had moved from the NNU to the ward to improve staffing levels in accordance with acuity.
- The NNU was meeting standards set by the British Association of Perinatal Medicine (BAPM) for nursing staffing levels, namely one nurse to one baby for babies requiring intensive care; one to two for babies requiring high dependency care; and one to four for babies requiring special care. The unit had also achieved an average of 73% in their skill mix, against a BAPM target of 70% and the matron and staff said they felt staffing and skill mix was sufficient to safely meet patient needs. There was always a band six nurse or above leading the shift.

- On the day of our inspection the planned staffing levels on the NNU were six registered nurses and two nursery nurses for the long day shift, and the same for the night shift. The actual staffing levels were five registered nurses and three nursery nurses for the long day shift and six registered nurses and one nursery nurse on the night shift. The discrepancy was due to a sudden increase in patient acuity, however this was still a safe level.
- The matron for the NNU showed us the NNU staffing tool which they accessed on the intranet. This was an acuity tool which showed at a glance when they were or were not meeting BAPM staffing guidelines. This showed there had only been one occasion across June and July where the service had not met the BAPM guidelines.
- Between May 2016 and April 2017, the trust reported a turnover rate of 11% in children's services. Service management and senior nurses had the highest turnover rates at 40% and 18% respectively.
- Between May 2016 and April 2017, the trust reported a sickness rate of two per cent overall across children's services. Sickness rates were four per cent in the neonatal unit and one per cent in both the children's ward and the children's assessment unit.
- As of October 2016, the trust reported a bank and agency usage rate of 6% overall in children's services. This equated to five percent bank use and nine per cent agency use in the children's ward; and one percent bank use and no agency use on the neonatal unit.
- There were two agency nurses working on the children's unit who were an established part of the rota and has been working there for 12 months and 18 months respectively.
- Twelve months prior to our inspection, the service had increased HCA staffing on the ward from one to two HCAs on each shift. The two HCAs we spoke to said this had noticeably improved their workload on the ward.
- There was a team of 13 community nurses led by the community matron.

Medical staffing

- As of April 2017, the trust reported a vacancy rate of 2% overall in children's services for medical staff. The largest vacancy rate was within neonatology which had a vacancy rate of 28% (under establishment by one WTE)
- Between May 2016 and April 2017, the trust reported a turnover rate of 0% in children's services.

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- Between May 2016 and April 2017, the trust reported a sickness rate among medical staff of 2% in children's services.
- Between April 2016 and March 2017, the trust reported a bank and locum usage rate of between 0% and 8% in children's services. Neonatology reported a 0% bank and locum usage for the entirety of the period. Bank and locum use in acute paediatrics was variable, peaking to around 8% in June 2016 and February 2017. During our inspection there was no bank or locum medical staff.
- There was a 'consultant of the week' rota to ensure 24-hour access to a paediatrician if required.
- In January 2017, the proportion of consultant staff was reported as lower than the England average and the proportion of junior (foundation year 1-2) staff was higher than the England average.
- During our inspection, we found the skill mix among medical staff and the overall staffing levels to be appropriate to meet patient needs. Junior doctors felt well supported by consultants and registrars and reported that the skill mix was adequate to meet patient needs and to support their own learning and development.
- However, two SHOs we spoke with on the post-natal ward told us they were often left by themselves to do the ward round without help from the registrar. They said that the ward was challenging for junior doctors in general because it was SHO led and there was poor registrar presence.
- Medical handovers took place three times a day at 9am, 4.30pm and 9pm, and were consultant led. We observed the morning medical handover on the children's ward, which involved a comprehensive review of each patient including specific medications and changes to conditions or care plans. The handover also included updates on staffing, infection prevention and control and any safeguarding concerns.
- We also observed the morning medical handover on the NNU which provided a detailed review of each patient. For example, in the case of a baby who was going to be discharged to a hospice that day, the team discussed their feeding and pain relief arrangements and the do not resuscitate status of the baby.
- There were twelve consultants employed by the service. The NNU was covered by four neonatal consultants. Medical staff and service leads were proud that this had improved continuity of care for patients and families.

- Junior doctors rotated between the NNU and the ward, with nine working on the ward and six on the NNU alongside an advanced nurse practitioner.

Major incident awareness and training

- There was an up-to-date and appropriate major incident policy and procedure, which staff knew how to access via the intranet.
- The service had recently been impacted by a widespread cyber attack lasting three days. Staff explained how they had ensured they could safely maintain the service during this event. This included service leads informing everyone to turn off computers and other equipment such as photocopiers immediately; calling in extra staff to help manage the increased workload; and writing discharge letters by hand.

Are services for children and young people effective?

Good 🟢

We rated effective as good because:

- There was a comprehensive local audit schedule to monitor performance, and actions for improvement following audits. There was participation in national audit including the Epilepsy 12 national audit, the National Neonatal Audit Programme (NNAP), a children's and young people's asthma audit, a national paediatric diabetes audit and the Patient and Parent Reported Experience Measures for diabetes.
- The service had a nominated clinical lead for audit. There was a monthly audit meeting to discuss audit performance and recommendations.
- Policies and procedures were up-to-date, and based on national guidance and best practice. Staff were aware of how to access policies and procedures either in hard copy or via the intranet.
- Pain was assessed on arrival, and was age appropriate. There were up to date pain management policies in place, based on the Faculty of Pain Medicine's Core Standards for Pain Management (2015). Pain assessment charts were completed appropriately.
- A choice of meals was available and catering staff worked with dieticians and nurses to ensure

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appropriate provision of food for children with special requirements, such as high-calorie, low bolus meals. There was dietetic input into the neonatal and children's ward rounds.

- All staff we spoke with on inspection were up-to-date with their appraisals and reported they had the appropriate training and skills to carry out their roles.
- Staff were well supported to develop their skills and competencies. For example, the transition nurse lead was on a degree pathway to complete an adolescent health course.
- Multidisciplinary team (MDT) working was strong both internally and externally. MDT meetings involved all relevant staff and everyone had an opportunity to contribute.
- There was an up-to-date and appropriate consent policy and the two consent forms we reviewed were complete and comprehensive. Consent was discussed at the medical handover we attended.

However:

- CHIMP care plan audit results were variable and in one month there was a 33% compliance rate. In two other months there was a 67% compliance rate.
- Compliance in the consent audit was 83.3%, compared to a trust overall score of 92.4%

Evidence-based care and treatment

- There was a comprehensive local audit schedule to monitor performance, including, for example, audit of referrals to community paediatric clinic and antenatal diagnosis of congenital heart disease. We saw that key findings from local audits were documented with actions for improvement. For example, following the congenital heart disease audit in October 2016, it was recommended that new local electronic congenital screening database were to be used to record all congenital abnormalities.
- The service used national guidelines such as those published by the National Institute of Health and Care Excellence (NICE) to inform their own local policies and protocols; for example, the NNU was continuously monitoring their performance and quality against the standards set by NICE Quality Statement 4: neonatal specialist care. The transition team had also used the NICE guidance on transition services to carry out their work and develop the transition service.

- There was participation in national audit including the Epilepsy 12 national audit, the National Neonatal Audit Programme (NNAP), a children's and young people's asthma audit, a national paediatric diabetes audit and the Patient and Parent Reported Experience Measures for diabetes.
- The service had a nominated clinical lead for audit. There was a monthly audit meeting to discuss audit performance and recommendations. This reported into the service governance meeting and trust wide quarterly audit meetings.
- Policies and procedures were based on national guidance and best practice. However, there were some exceptions to this, such as aspects of the safeguarding policy, which we have explained fully in the 'Safe' section of this report.
- Staff were aware of how to access policies and procedures either in hard copy or via the intranet.
- The service had a revised PEWS audit system in place as of February 2017. Previously the audit had aimed to ascertain compliance with national guidance such as the Royal College of Nursing (RCN) Standards for Assessing, Measuring and Monitoring Vital Signs in Infants, Children and Young People (2007). The aim of this revision was, in addition to compliance with the above national guidance, to provide more detailed information about whether the PEWS was triggering appropriate actions in a timely way and was fit for purpose, using a larger scope and sample size in line with the NEWS audits taking place in adult services.
- We reviewed the NNU's latest Bliss baby charter audit. The Bliss baby charter is a practical framework for neonatal units to self-assess the quality of family-centred care they deliver against a set of seven core principles. The audit included appropriate actions for any criteria with red or amber ratings, with a responsible person allocated to each action. Actions included improving documentation of 'how baby responded to touch and social interaction' by highlighting this at training days; submitting a business plan to the trust board for an extension to the unit; and auditing care plans to identify any change in practice.
- The theatre case we observed showed staff working in accordance with best practice and national standards including constant monitoring by the anaesthetist.
- The NNU took part in a regional lead nurse forum, which met three times a year to discuss issues in different NNUs in the region and share learning and best practice.

- The handover we attended on the NNU included an update by the consultant about a change in national hypoglycaemic guidelines.

Pain relief

- Pain was assessed on arrival, and was age appropriate.
- Children's services had up to date pain management policies in place, including the use of intravenous pain relief and epidural management and care. These were based on Faculty of Pain Medicine's Core Standards for Pain Management (2015). Staff were aware of these policies and how to access them.
- Nursing and medical staff we spoke with showed good awareness of assessing pain and responding appropriately to manage and limit it as much as possible.
- We were shown a pain assessment chart and a nurse explained they assessed the patient's pain every four hours, and would check half an hour after analgesia was administered. Nursing staff told us that the play team helped to distract children experiencing pain or when administering pain relief.
- There was an NNU-specific pain relief chart which we saw was completed comprehensively in patient notes.
- During the recovery period of the theatre case we observed, the child required additional analgesic and we saw the nurse check that this had not already been administered in theatre. The analgesic was checked by two nurses in accordance with trust policy and good practice.
- Parents we spoke with reported they felt their child's pain was managed well by staff.

Nutrition and hydration

- A choice of meals was available and patients completed two menu choices a day. In addition to set meals, snacks were provided at 3pm and fruit was always available on the unit.
- Catering staff worked with dieticians and nurses to ensure appropriate provision of food for children with special requirements, such as high-calorie, low bolus meals. The team also provided all snacks required to fulfil the care plan requirements for the Children's Malnutrition Screening Tool (CHIMP).
- There was a dedicated chef in the catering department for those requiring specialist diets.

- There was dietetic input into the neonatal and children's ward rounds to ensure that children's nutrition and hydration were appropriately assessed and managed and that medical and nursing staff were aware of any particular needs.
- The service was carrying out monthly CHIMP audits for both screening and care plans. Between April 2016 and May 2017, there were eight months where CHIMP screening was carried out in 100% of admissions. There were two months where screening was carried out in 78% and 80% of admissions. There were two months where the audit had not been carried out. CHIMP care plan audits within the same period had been carried out 100% of the time in five of the 12 months. In two of the months the rate was 67% and in one month it was 33%. For the other four months there was no data available. However, there was no target compliance rate set by the service, although the data was red, amber, and green (RAG) rated to indicate level of compliance. The audit did not indicate any reasons for missed or lower results.

Patient outcomes

- The National Paediatric Diabetes Audit 2015/16 showed that the trust performed the hospital performed at or around the national average in the majority of the key performance indicators. There was also a slight improvement in performance within the service in comparison to the 2014/15 report.
- Between February 2016 and January 2017 there were no children readmitted following an elective admission.
- Between February 2016 and January 2017 there was a lower percentage of under ones readmitted following an emergency admission compared to the England average and a higher percentage of patients aged 1-17 years old readmitted following an emergency admission compared to the England average.
- Between March 2016 and February 2017 the trust performed worse than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for all of the long term conditions. For asthma, the multiple admission rate was 21.6% compared to the England average of 16.5%. For diabetes, the multiple admission rate was 29.5% compared to the England average of 13.3%. For epilepsy, the multiple admission rate was 34.2% compared to the England average of 27.1%. When we discussed these with the service leads they were able to explain mitigating factors for the high readmission rates,

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including the fact that children with these conditions would be included in the data even when admitted for something unrelated to their long-term condition. Also, there was a high proportion of children with these conditions using the service due to the open access system.

- The service participated in the annual national neonatal audit programme (NNAP). Results from the most recent audit in 2015 showed the service was performing better than average in some areas but worse in others. For example, the trust was conducting the first retinopathy of prematurity (ROP) screening on 97% of babies weighing less than 1501g or at a gestational age of under 32 weeks at birth as recommended by national guidance. This was comparable to the national average of 98%. However, the trust scored reported documented consultation with parents by a senior member of the neonatal team within 24 hours of admission in 100% of cases, which was better than the national average of 88%.

Competent staff

- All staff we spoke with on inspection were up-to-date with their appraisals and reported they had the appropriate support, resources and skills to carry out their roles effectively.
- Nursing staff were supported in their revalidation by a dedicated practice development nurse. There were four study days a year to help them in the revalidation process.
- Student nurses received local induction to all areas of CYP services on their first day and were allocated a mentor to work alongside. We spoke with a student nurse, who praised the support they had received and were hoping to continue at the service once qualified.
- Two SHOs we spoke with told us that although their paediatric training gave them the appropriate skills and competencies and they were well supported, e-learning training during the induction period had to be done in their own time, which was a challenge.
- Each doctor had an online portfolio for their professional development, which they were supported to complete by their mentor and given sufficient time and opportunity to do this.
- Staff were well supported to develop their skills and competencies. For example, the transition nurse lead was on a degree pathway to complete an adolescent health course. The matron for the children's ward had

undergone a six-month development plan to support her in taking on additional responsibilities in this role, which included, for example, shadowing experienced matrons in other departments.

- The community matron wanted to ensure that the community team maintained and developed their skills in the acute hospital setting so had arranged with the leads for the staff to come onto the wards for refresher learning sessions on assessment of the acutely unwell child and to spend a week on the CAU twice a year. Community staff fed back that this had been beneficial for their competencies.
- The diabetes nurse told us they were currently running a training programme for ward staff on treating hypoglycaemic patients and using pumps.
- Junior medical staff received one day of trust induction and two to three days of local induction, covering resuscitation; safeguarding; drug prescribing; and pathways, among other areas.
- Appraisals of junior medical staff were carried out by the deanery. Each junior staff member had a named educational and clinical supervision support. The service had performed the best in the region in the 2017 General Medical Council (GMC) National Training Survey.

Multidisciplinary working

- Nursing and medical teams worked well together as one team and we saw positive communication and interactions between them to deliver an effective and efficient service to patients. For example, in the clinical handover we attended on the children's ward, a nurse raised concerns about a child with dysmorphic features and made a suggestion about their care, which was listened to and well received by the medical staff. All nursing staff we spoke with said they found consultants very approachable and accessible.
- There was a team of play specialists and assistants, who supported nursing and medical staff. MDT meetings involved all relevant staff and everyone had an opportunity to contribute. One play assistant said they were asked to attend MDT meetings for children with whom they had a lot of interaction and that doctors asked for their input because the play team often had more of an insight into the wider family and social context of the patient.
- Staff consistently reported effective MDT working internally. For example we were told the physiotherapists, who worked on six-month rotations,

were 'very responsive'; and there were three dedicated paediatric dieticians who ran their own clinics. The play assistant we spoke with gave an example of working closely with a physiotherapist in the case of a child with a fabricated illness.

- In the theatre case we observed, we saw that all members of staff were involved in the discussion, for example in the discussion of allergies and post-operative care.
- The community nurses were an integral part of the team and worked closely with staff based in the trust day-to-day to ensure care outside of the hospital setting, for example in schools, was effective.
- Staff reported good MDT working with external services to improve care and outcomes for their patients. For example, the transition team worked closely with schools and GPs in the local community, and also met with paediatric staff at other trusts to share learning and best practice regarding effective care for children at transition age.

Seven-day services

- Paediatric consultants were available on site between 9am and 10pm daily, with an on call rota for out of hours.
- There was no on-call service from the consultants for diabetes specifically; however, there was access to the on-call system of the East of England network for families and children with diabetes at home. This meant that families of children with urgent diabetes needs could contact the regional diabetes consultant via the trust switchboard. The diabetes nurse told us the on-call service was very responsive and supportive.
- A pharmacist was available for advice seven days a week and over the phone if required. There was pharmacy access on weekends from 10am to 2pm.
- Physiotherapists were available seven days a week, from 8am to 8pm.
- The community nursing team worked seven days a week.
- The play team worked seven days a week, covered by a team of six staff.

Access to information

- On the CAU staff could access information electronically about children who were currently being assessed or treated in A&E. Information included name, age, hospital and NHS numbers, waiting time in A&E and the

reason for attendance. The system allowed staff to digitally admit, transfer and discharge patients to and from wards. This meant that staff had access to information they needed about patients in advance.
- An electronic system enabled staff to see blood test results and clinical correspondence. Patients' GPs also had access to this system, which enabled timely access of information between both primary and secondary care.
- The neonatal unit staff had access to an electronic system that was used in the community and in local primary care settings. This allowed neonatal staff to identify certain issues in advance such as parents with mental health or substance misuse issues. This enabled the unit to prepare appropriate care and support for families of babies admitted to the unit.

Consent

- There was an up-to-date and appropriate policy on obtaining consent for treatment on children and staff showed good understanding of the principles of consent.
- We reviewed two consent forms on the ward. They were complete and comprehensive with documentation of explaining the risks and benefits, details of the surgical integrated pathway, and a pain assessment record included for post-operative review. This was signed by the parent and the relevant member of staff with date and time.
- Consent was discussed at the medical handover we attended on the children's ward. This was good practice as it meant learning was shared about potentially complex consent cases and encouraged medical staff to be alert to this. For example, there was discussion about a patient who had been admitted to the ward while in the care of family friends while their parents were away, and another who was under the parental responsibility of social care.
- Staff were familiar with Gillick competence (a legal principle for assessing a child's capacity to consent to medical treatment) and Fraser guidelines and how these were applied in practice when caring for children.
- We reviewed the trust consent audit from November 2016. Within paediatrics, overall compliance was 83.3%. However, specific aspects of the audit were variable in their results. Compliance of staff who could give consent was 40%; compliance with the correct consent form for the procedure was 100%; and compliance of

information was 83.3%. Overall trust compliance was 92.4%. Actions for improvement were included, although these were trust-wide rather than service-specific, such as a reminder to registrars that they must hold the consent competency and be registered on the consent register. The consent procedure was also updated as a result of the audit.

Are services for children and young people caring?

Good ●

We rated caring as good because:

- All observations of staff interaction with patients and parents or relatives were compassionate and kind.
- Staff tailored their communication to best suit the age and needs of each child.
- All parents we spoke with were positive about the care from nursing staff.
- Parents and families were actively involved in the care of their child and staff took time to ensure they understood information given to them.
- There was access to emotional support, for example a midwifery bereavement counsellor, and a locum consultant in the community with a specialism in child psychiatry.

However:

- One parent we spoke with described one doctor as 'disregarding'.

Compassionate care

- All observations of staff interaction with patients and parents or relatives were compassionate and kind.
- We saw examples of where staff had 'gone the extra mile' to make patients' experiences easier. For example, there had been a nine-year-old oncology patient on the ward who said they wanted to be a writer when they were older. Staff arranged a 'book signing' day where medical and nursing staff in the unit took photos with the child and received 'signed copies' of a story book the child had made.
- Staff tailored their communication to best suit the age and needs of each child.

- All parents we spoke with praised the care from the nursing staff, describing them as 'friendly' 'polite' and 'respectful'. A mother in the NNU said 'staff could not do enough' and offered them tea and coffee regularly.
- However, one parent described one doctor as 'disregarding'.
- In the theatre case we observed, the play team were highly involved in preparing the child for theatre as the child had been assessed as very anxious. We saw they helped to distract the child and alleviate their anxiety.

Understanding and involvement of patients and those close to them

- In the three outpatients clinics we attended, staff ensured parents were involved and kept informed. They checked whether parents were happy and if they had any questions.
- The parents of a child who had been treated at the service had recently donated a 'my treatment is over' bell, which staff encouraged children to use to commemorate the end of their treatment.
- Feedback from parents and families was displayed on a patient experience board on the NNU. Comments included 'the staff made sure we had what we needed and answered our concerns' and 'they look after your little ones and yourself as one family'.
- In the theatre case we observed, the parents were informed politely and promptly that the theatre list was delayed due to the consultant ear, nose and throat (ENT) surgeon attending an emergency in A&E.

Emotional support

- There was no dedicated counsellor for CYP services. However, the neonatal unit had access to a midwifery bereavement counsellor who was very responsive and supportive. We were also told that the health visitor could help facilitate GP visits for families to be referred to counselling.
- The service worked with a locum consultant in the community with a specialism in child psychiatry. They had arranged to come in for several teaching sessions with two nurses on the ward with an interest in paediatric mental health to improve direct support for the emotional and psychiatric needs of patients.
- There was access to a chaplain for children and parents.

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Are services for children and young people responsive?

Good ●

We rated responsive as good because:

- There was always a paediatric consultant and nurse in the children's recovery area for elective patients.

- The neonatal unit had a community outreach team providing support at home for neonatal babies.

- The local Emotional Wellbeing and Mental Health Service (EWMHS) for Southend, Essex and Thurrock was accessible for patients admitted to the unit with mental health problems and also provided a seven day crisis team.

- There was a dedicated school room in the children's ward which ran from 9am to 12pm during term time.
- There was a dedicated community nursing team working in schools and the wider local area to meet the needs of local patients and help minimise hospital admission where possible.
- Flow through the service was smooth and well managed.

- Discharge planning was integral to patient care plans throughout the patient's stay in hospital. The NNU had implemented a 'discharge passport' aimed at involving parents more centrally in discharge planning. There was a focus on nurse-led discharges in straightforward cases, meaning nursing staff did not have to wait for a doctor to approve the discharge.
- The children's ward used a green/red system to flag when delays were expected so they could plan for this as far as possible.
- There was a team of specialist nurses to provide support for patients with diabetes, epilepsy and asthma. There were also specialist nurses for gastroenterology, urology and oncology. The children's urology service was the only dedicated one in the county.
- There was a dedicated transition team for adolescents approaching their transfer to adult services. They were able to provide examples of how their work had helped meet individual needs; for example they had a teenage patient who relied on oxygen cylinders and the team had worked closely with their school to try and make

school life as normal as possible for them. There was a gradual, long-term approach to transition starting around the age of 14, which included a 'transition passport' system, where staff from both paediatric and adult services documented changes and progress.
- The transition team worked with other teams to meet the more complex individual needs of patients at the age of transitioning to other services. For example, they ran a joint clinic with the epilepsy specialist nurse three to four times a year.
- There was an adolescent room on the ward and age-appropriate facilities.
- Play specialists and assistants provided therapy and distraction techniques to minimise childrens stress during interventions for example patients with needle phobias and preparation prior to surgery. They also led a variety of play room sessions.
- There was a 'hospital passport' system for patients with learning disabilities. Staff displayed understanding of responding to the needs of these patients.
- Complaints were discussed as part of the patient safety group which took place weekly as part of the medical handover.

However:

- Children undergoing surgery would have to be transported through the adult recovery area to reach the children's recovery area.

Service planning and delivery to meet the needs of local people

- Children and young people were rarely seen and treated in adult areas. This was in because of the children's ward reserving four contingency beds meaning they could increase their capacity when needed. However, children would be treated in the critical care unit to be stabilised before being transferred out to a regional paediatric critical care unit. In this case the patient would always be overseen by a paediatric consultant or registrar, plus a senior nurse or critical care coordinator who was paediatric trained. During our inspection, there was a patient under 18 in the critical care unit awaiting transfer, and we saw this precaution was followed.
- However, Children undergoing surgery would have to be transported through the adult recovery area to reach the children's recovery area. We saw that staff in recovery tried to make this as child-friendly as possible

and separate it as much as possible from the adult area, for example with the use of screens. Service leads told us they had submitted a business case for a separate paediatric recovery area but had been unsuccessful. .

- There was always a paediatric consultant and nurse in the children's recovery area for elective patients. At the time of our inspection there was an emergency paediatric theatre case admitted through A&E and in that instance the staff in theatre were not paediatric trained (as it was an emergency).

- The neonatal unit had a community outreach team providing support at home for neonatal babies, in line with national neonatal service specification published by NHS England. The team worked with the East of England neonatal network.

- The local (EWMHS) for Southend, Essex and Thurrock was accessible for patients admitted to the unit with mental health problems and also provided a seven day crisis team. There was a single point of contact for consultants to refer patients directly to this service.

- There was a dedicated school room in the children's ward which ran from 9am to 12pm during term time.

- The children's outpatients department had a 'who's who' board displaying photographs of all staff with their names. This meant that children and their parents or carers could identify and know in advance who was treating them.

- Visiting hours on the children's ward were 2pm to 7pm and one parent or carer could stay overnight.

- Staff were able to offer basic life support to parents prior to discharging their child. This information was displayed on a board in the NNU.

- There was a dedicated community nursing team working in schools and the wider local area to meet the needs of local patients and help minimise hospital admission where possible.

Access and flow

- The children's assessment unit received children directly from GP referrals, A&E transfer, and open access to children in the community. This meant that external care providers across the community could help patients access the service.

- Babies were admitted in a timely manner from delivery suite to the NNU. The NNU was located next to the delivery suite for efficiency.

- From the theatre case we observed, we saw that flow was well managed and smooth from pre-operation to recovery. The patient was accompanied by a nurse from the ward alongside their parent and checked into the anaesthetic room with their name band checked. Following the procedure, the child remained in theatre until sufficiently awake to remove the breathing tube from the airway. They were then accompanied by the nurse to the paediatric recovery area, where the parent could then join them.

- Discharge planning was integral to patient care plans throughout the patient's stay in hospital and was reviewed comprehensively at the medical handover we attended on the ward. A&E admissions were discussed by the registrar so staff had awareness of patients who would later be admitted to the ward and prioritisation was discussed based on paediatric early warning system (PEWS) scores.

- The NNU had implemented a 'discharge passport' aimed at involving parents more centrally in discharge planning. It included a checklist of tasks to cover before their child could be discharged, such as arranging any take-home medications.

- There was a focus on nurse-led discharges in straightforward cases. Service leads told us this helped ensure discharges as it meant nursing staff did not have to wait for a doctor to approve the discharge. The service leads confirmed they did not have concerns about delayed discharges.

- The children's ward used a green/red system to flag when a patient had received care that would progress their discharge, or when no acute care had been given, so the service could plan for discharge and delays appropriately. This information was displayed on the board at the nurse's station

- The children's outpatients department reserved some rapid access slots for consultants at the beginning of their clinics, which were filled one week ahead of the clinic. The service was also looking to develop more outpatient clinics in Clacton to reduce demand on the department here and improve timeliness for patients.

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- Staff we spoke with in children's outpatients told us that where patients did not attend (DNA) their appointment, they would inform the patient's consultant to make further enquiries if they felt it was appropriate. The advanced practitioner told us this was a frequent issue for blood tests in particular. The service was trying to reduce DNAs by giving the patient's parent(s) a courtesy call four to five days ahead of the planned appointment to check they were still available to attend.
- We looked at DNA rates for June 2017. There were 91 scheduled appointments for the urology clinic, of which 67 attended and three cancelled prior to the appointment, meaning there were 21 DNAs. For the gastroenterology clinic, there were 61 scheduled appointments, of which 50 attended, two cancelled prior to the appointment, meaning there were nine DNAs.
- The integrated care pathway included comprehensive pathways for asthma, diabetes and surgical patients. There was also a comprehensive care pathway in place for children under the age of one year attending hospital. This meant that established and structured care could be expected for children with specific conditions.

Meeting people's individual needs

- There was a team of specialist nurses to provide support for patients with diabetes, epilepsy and asthma. There were also specialist nurses for gastroenterology, urology and oncology.
- There were weekly epilepsy clinics run by a consultant and two epilepsy specialist nurses. Patients could be referred directly to the service by their GP, to access services such as electroencephalogram (EEG) and magnetic resonance imaging with anaesthesia if appropriate. There was open access available for epilepsy patients if appropriate.
- The diabetes team consisted of four nurses supported by two dieticians and two consultants to meet the needs of around 190 children with type one diabetes in the local area.
- The children's respiratory service was led by a respiratory consultant supported by one full time senior nurse. The caseload was approximately 70% allergy cases and 30% asthma cases.
- Asthma clinics were held three times a month in a local tertiary centre for families that had difficulty accessing the clinic within the trust.

- The children's urology service was the only dedicated one in the county. They held clinics to help with conditions including constipation, soiling, and night time wetting.
- There was a dedicated transition team for adolescents approaching their transfer to adult services. They acknowledged the importance of treating each patient in this age range individually, as some felt more suited to adult services at the age of 15, whereas others preferred to remain in children's services until 18 or 19 because they were familiar with the staff and environment. They were able to provide examples of how their work had helped meet individual needs; for example they had a teenage patient who relied on oxygen cylinders and the team had worked closely with their school to try and make school life as normal as possible for them.
- We spoke with the transition lead who told us that patients were referred to the service at 14 or 15. This was a recent improvement within the past 12 months, as previously, patients had only been referred at 16. This change meant the transition process could be more gradual for those in this age range requiring more support. There was a 'transition passport' system, which included a replica of the patient's records, to help with their transition. Staff from both paediatric and adult services documented changes and progress in here.
- The transition team worked with other teams to meet the more complex individual needs of patients at the age of transitioning to other services. For example, they ran a joint clinic with the epilepsy specialist nurse three to four times a year. They had run a gastroenterology clinic for adolescents in March alongside a specialist consultant, which had a 100% attendance rate and had booked a second date for October 2017. The transition team also held ad hoc renal clinics with a specialist renal consultant for patients around the age of transition with complex renal conditions.
- There was an adolescent room on the ward and age-appropriate facilities such as table football, air hockey and a DVD player. The matron told us that a volunteer group had arranged to come in and refresh the adolescent room in August 2017 to bring it more up-to-date. However it was a concern for the unit that the adolescent room was frequently used for staff meetings due to a lack of alternative private rooms.
- There was a team of play specialists and assistants consisting of six whole time equivalent staff who worked

across CYP services. They supported nursing and medical staff for example by comforting and distracting patients with needle phobia. The play specialists could also help prep children for surgery by using therapy and distraction techniques to calm them down. They also led a variety of play room sessions such as arts and crafts, music and movement and a movie afternoon.

- The play specialists had recently fundraised for an 'interactive carpet', which was projected onto the floor and included hundreds of different games and activities for a variety of ages and interests. They had also recently acquired a new sensory unit which contained a range of multi-sensory equipment and sensory toys used for play, therapy and distraction. This was portable and the play assistant we spoke with gave examples of bringing it to patients in isolation rooms, particularly patients with learning disabilities who responded well to it.

- Staff could access a locum child psychiatrist in the community to provide support for children experiencing mental health difficulties.

- There was a 'hospital passport' system for patients with learning disabilities. Staff displayed understanding of responding to the needs of these patients; for example, we were told about a patient with severe autism who became anxious in the bay and preferred to be in the main ward area. The staff had safely accommodated sleeping facilities by the nurses station to meet their preferences and help them remain calm, which was well received by the patient and their family. A parent of another long-term patient with learning disabilities had painted a window on the ward with the child's name incorporated into it.

- The service leads raised a concern that they did not have access to a clinical psychologist. This was on the service's risk register and it was a known challenge recruiting to this post.

- Staff could access an interpretation service for children and parents whose first language was not English. However, we were told the service was not consistently effective and prompt. One member of the community nursing team explained they were currently having difficulties obtaining translation for one of their patients.

Learning from complaints and concerns

- Complaints were discussed as part of the patient safety group which took place weekly as part of the medical

handover. At the handover we attended on the children's ward, it was shared that there had been no formal complaints raised about the service that week. However, there had been a concern raised informally by a parent. This had been responded to appropriately by staff

- Staff had changed the display boards on the CAU in response to a parent who raised that they were negative as they had a very clinical focus and were not family-oriented. As a result, they had included a board with comments from patients about their experiences and a board displaying thank-you cards and letters.

- A board on the NNU displayed areas they were striving to improve. These were improving their at-home IV medications service; closer working links with GPs; and better recording of loaned equipment.

Are services for children and young people well-led?

Good 🟢

We rated well-led as good because:

- There was a comprehensive strategic vision for the service for the next three years. There were clear plans and year-by-year steps documented to achieve targets and the service leads were able to explain these.
- There was a clear process of clinical governance oversight from ward to board level.
- The risk register was closely monitored and up-to-date, and matched the areas of risk we saw on inspection.
- Risks were reviewed at a weekly risk management meeting by the service leads. This fed into the monthly 'two at the top' risks, which were circulated among staff and escalated up to the trust clinical governance team.
- The clinical and nursing leads showed strong leadership and oversight of the service. Nursing and medical staff we spoke with at all levels consistently praised their support and leadership.
- Staff said they were supported and encouraged by the leads to suggest changes to improve the service and gave examples of this such as additional training days to improve skills and competencies.
- There was a positive, supportive culture in the service, which was confirmed by all staff we spoke with.

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- The service had initiatives to engage the local population and service users; for example, there was a support group called 'Little Miracles' for mothers who had previously had their children treated in the neonatal unit, and the local Brownies and Cubs groups visited the ward once a week for group play and activity sessions with the patients.

- There were examples of innovation; for example, in the neonatal unit there was a new system for the administration of gentamicin (an antibiotic) whereby the neonatal nurse was the first checker for the dose and the midwife was the second checker. This meant the baby did not have to be apart from the mother and could stay on the postnatal unit for the whole process.

However:

- Staff did not all show awareness of the documented strategic vision, although they were aware of particular plans to develop the service.

Leadership of service

- The service was led by a consultant clinical lead and nursing leads for the ward, CAU and NNU, alongside a consultant community lead and matron for children's community services.
- We spoke with the clinical and nursing leads for the service and found they showed strong leadership and oversight of the service. Nursing and medical staff we spoke with at all levels consistently praised their support and leadership.
- Staff said they were supported and encouraged by the leads to suggest changes to improve the service and gave examples of this such as additional training days to improve skills and competencies.
- Service leads reported that the senior leadership team of the trust were approachable and very involved in work going on at a departmental level; although there was mixed feedback about the visibility of the senior leadership team from more junior staff.

Vision and strategy for this service

- There was a document setting out the strategic vision of the service for the next three years. This was split into different areas of focus, such as harm-free care, carers' support and workforce development. There were clear plans and year-by-year steps documented to achieve targets within this strategy, which the clinical and nursing leads were able to explain. For example, one target was to improve services for children with learning disability, who were deaf or blind, or had a cognitive impairment. Actions to achieve this included developing individualised care plans and pathways for children with specific and complex needs similar to a learning disability passport; promoting the use of the sensory room; and working with commissioners to re-establish 'team around the child' meetings for pre-school children with learning disabilities.

- Although staff we asked did not show awareness of the contents of this document, they were aware of particular plans to develop and improve the service. For example the service leads had developed a plan for a dedicated young persons' unit.

Governance, risk management and quality measurement

- There was a clear process of clinical governance oversight from ward to board level. There were daily handover and ward rounds; and weekly safeguarding and patient safety meetings where clinical governance issues or updates were discussed. These all reported into respective monthly meetings. Clinical governance issues for assurance and escalation were then reported into the monthly CYP and divisional (women's and children's) clinical governance meetings and then on to the board.

- We reviewed the risk register for the service and saw the risks matched what we had seen on inspection. Each risk had an appropriate person allocated to overseeing it and appropriate actions in place to mitigate them as far as possible. They also had target risk levels to help drive improvement, and target dates for addressing the risks.

- Risks were reviewed at a weekly risk management meeting by the service leads and the risk level re-assessed to consider whether it needed to be changed. This was comprehensively documented within the risk register. This would then be compiled into the monthly 'two at the top' risks, which were circulated among all staff and escalated up to the trust clinical governance team.

- We reviewed governance meeting minutes for March to May 2017. They included assessment of current risks, incidents from the past month and patient safety

concerns, such as learning from and outcomes of the recent cyber attack. The minutes showed good oversight of the current activity and concerns in the service.

- The nursing and clinical leads for the service were able to explain the current risks and the actions being taken to mitigate them. For example, a current risk was being unable to carry out Autism Diagnostic Observation Schedule (ADOS) assessments within a reasonable timeframe. This was because of the high number of referrals in the area and shortfall of appropriately trained staff, resulting in delays. This was a risk as delays in assessment could have a potential impact on the learning and development of those children. They explained that, in order to reduce the risk, they had booked additional assessment sessions with the medical teams to support the reduction of the backlog for June to August 2017 and had asked the medical teams to validate each patient on the waiting list.
- The neonatal unit had two specific risks on the risk register, namely the shortage of accommodation and facilities for parents and a concern over chlorhexidine skin preparation. The matron for the unit was able to explain the reasons for these and actions to mitigate them, such as putting beds up in side rooms to accommodate parents if required; and joint working with the pharmacist for chlorhexidine skin preparation.
- Previously the service had concerns over nurse staffing levels and had addressed this by keeping four beds for contingency purposes only which they were confident had mitigated the risk. This matched our observations of nurse staffing to patient numbers on inspection.

Culture within the service

- Staff described the culture in the service as 'supportive' and 'team-based'. One doctor said they enjoyed it so much they returned after working briefly elsewhere as a student. One nurse described morale as very positive.
- We saw throughout our inspection that staff respected and supported each other.
- There was a culture of growing staff from within and encouraging them to develop. We were told of one new HCA who had shown interest in pursuing this role when they had previously been a cleaner on the unit and was encouraged to apply for it.

Public engagement

- There was a support group called 'Little Miracles' for mothers who had previously had their children treated in the neonatal unit, who kept in regular contact with the service. There was a board in the unit with updates, photos and details of events and fundraising carried out by the group.
- The NNU had planned an Easter charity ball as a fundraising event for the service, which was booked for March 2018.
- The local Brownies and Cubs groups visited the ward once a week for group play and activity sessions with the patients.
- The diabetes nurse told us about initiatives to engage their most severe diabetes patients in the community, including picnics and trampolining, to encourage social interaction.
- The service produced a quarterly newsletter to update families on the service and any events or developments.

Staff engagement

- Two band six nurses had recently been nominated by the service for a commendation because of their work fundraising with support from a local retailer for new duvet covers with a variety of colours, patterns and children's characters.
- One student nurse said they wanted to continue working in the service when they had qualified, because they had a positive experience and received much support on their placement.

Innovation, improvement and sustainability

- The service's dedicated transition team was the only one in the region and other trusts sought advice from them.
- The NNU was piloting a 'discharge passport' to empower parent involvement in ensuring a timely discharge for babies.
- The diabetes team were, at the time of our inspection, taking part in a study called 'ADDRESS 2' looking at the causes of diabetes and factors such as family history to see if there was any action they could take to improve the service and best meet patients' needs.

End of life care

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

Information about the service

Colchester General Hospital provides palliative and end of life care to patients across all its clinical areas and treats a variety of conditions. The hospital does not have a dedicated palliative and end of life care ward. There were 1824 in-hospital deaths in the year from April 2016 to March 2017.

The specialist palliative care team (SPCT) consists of a palliative care consultant, specialist palliative care nurses, end of life care facilitator, and administrative staff. The SPCT provide advice, assessment and treatment to patients across all clinical areas within the hospital. They also support ward staff to deliver care to patients at the end of their life. The team are available seven days a week between the hours of 9am and 5pm. Out of hours advice was provided via switchboard to contact the on call palliative medicine consultant or for members of the public via a telephone advice service from a local hospice.

The specialist palliative care team is comprised of 6.4 whole time equivalent (WTE) clinical nurse specialists, including the team leader, one WTE palliative and end of life (EOL) clinical skills nurse. Two consultants, who together make up 1.4 WTE, and 1.4 WTE administrative staff. End of life care in the trust is also supported by 0.8 WTE end of life care facilitator.

Palliative and end of life care champions were identified within each clinical area and team, including allied health professionals. Champions were given additional ongoing training to support them within their roles. This is undertaken by the EOL clinical skills nurse.

During this inspection we visited 10 wards at Colchester General Hospital, including the stroke unit, Accident & Emergency, Emergency Assessment unit (EAU), hospital mortuary, and the hospital chapel. We spoke to 47 members of staff, which included medical and nursing staff, allied health professionals, the SPCT, the director of nursing, integrated discharge team, mortuary and chaplaincy staff. We spoke to one patient who was at the end of their life and nine patients' relatives. Care records for eight patients receiving end of life care, 35 do not attempt cardiopulmonary resuscitation (DNACPR) records and eight prescription charts were reviewed during the inspection.

During the last inspection in September 2015, there were significant concerns with the end of life care service. This included; a lack of recognition when assessing patients at the end of their life, equipment not being serviced or maintained, lack of staff training on end of life care and the absence of a fully developed end of life care strategy that included prioritised, time bound actions with appropriately allocated leads. Work had been taken to address the concerns raised and considerable progress has been made.

End of life care

Summary of findings

End of life care at Colchester General Hospital was rated good overall.

- There were systems and processes in place to report and investigate incidents involving palliative care patients and those at the end of life.
- Staff were aware of their role and responsibilities in relation to safeguarding. The trust's mandatory induction programme provided training from the palliative and end of life care team.
- The trust had an end of life care facilitator, a palliative clinical skills nurse who worked across the trust to support ward based training and each ward had a palliative/end of life care champion.
- Care and treatment followed national guidelines within individualised care plans for patients.
- The trust monitored its own effectiveness with clinical audits and compared its performance with other trusts nationally.
- The trust specialist palliative care team provided support Monday to Sunday between 9am and 5pm.
- Staff were seen to provide kind and compassionate care across clinical areas. Patients' dignity was maintained at the end of life. Patients and relatives felt well informed about the care being provided.
- The specialist palliative care team and chaplaincy service provided emotional support to patients and relatives.
- The specialist palliative care team (SPCT) and the ward staff were passionate about ensuring patients and people close to them received safe, effective and quality care.
- The SPCT was led by a consultant in palliative medicine. The SPCT and the trust's end of life care facilitator were focussed on raising staff awareness around end of life care (EOLC). The SPCT delivered education for medical, nursing and allied health care professionals at trust induction, preceptorship programme, study days, and also on the medical training programme.
- The chaplaincy was able to contact religious leaders of other faiths and had over 40 chaplaincy volunteers on the list.
- There was evidence of learning from complaints and concerns raised by patients and their relatives.

- Staff across all areas of the hospital acknowledged the importance of end of life care. The executive team and senior nursing team were aware of the concerns with end of life care and were receptive to the need to improve the service for patients.
- The trust had a clear strategy and vision in place for end of life care.
- The trust was robustly monitoring the effectiveness and the responsiveness of the service to patients and their families. Minutes of meetings both operational and business meetings did demonstrate a review of key performance indicators.

However:

- The Individual Care Record for The Last Days of Life (ICRLDL) recorded prescription, treatment and care plan. The ICRLDL had guidance on anticipatory prescribing but did not contain maximum doses or advise on the frequency of the administration of medication. This could potentially lead to inappropriate doses being administered. However we found no evidence that this had happened and there were systems in place so prescriptions were reviewed.
- There was a lack of consistency in how patient's mental capacity was assessed and not all decision-making was informed or in line with guidance and legislation when a do not attempt cardiopulmonary resuscitation order (DNACPR) was completed. In three cases we found that the patient was not made aware of the decision taken by medical staff not to resuscitate, despite the patient having capacity.
- The trust had a process in place for fast track discharge, however it was acknowledged by the trust to not always be rapid or fast, with some cases taking up to 189 hours (7.8 days) in May and 119 hours (five days) in June to get a patient discharged. There were focused action plans in place to monitor and address this through a range of initiatives in the Every Patient Every Day programme.

End of life care

Are end of life care services safe?

Good ●

We rated safe as good because:

- There were systems and processes in place to report and investigate incidents involving palliative care patients and those at the end of life.
- We found good nursing care documentation, nutrition and hydration reviews and documentation standards. End of life care plan documentation was comprehensive and complete in records we reviewed.
- Data submitted demonstrated complaince rates for mandatory training was 100% for all memebrs of the specialist palliative care team, with the exception on manual handling that was 78%.
- Compliance rate for both medical and nursing staff in the end of life care team showed 100% in both adult and children safeguarding level 1 and 2.
- Staff were aware of their role and responsibilities in relation to safeguarding. The trust's mandatory induction programme provided training from the palliative and end of life care team.
- The trust had an end of life care facilitator, a palliative clinical skills nurse who worked across the trust to support ward based training and each ward had a palliative/end of life care champion.

However:

- The trust used the Individual Care Record for The Last Days of Life (ICRLDL) to record prescription, treatment and care plan. The ICRLDL had guidance on anticipatory prescribing but did not contain maximum doses or advise on the frequency of the administration of medication. This could potentially lead to inappropriate doses being administered.However we found no evidence that this had happened and there were sysytems in place to prescriptions were reviewed.
- We saw a whiteboard outside each bay indicating patient beds and next observation. This included 'no obs' written against bed numbers of patients who were identified as end of life. This meant that confidential patient information could be seen by anyone visiting the ward areas and was in breach of patient confidentiality

Incidents

- The trust reported no serious incidents relating to end of life care, for the period of May 2016 to April 2017.Staff at the trust highlighted when a reported incident related to end of life care so that they could identify incidnets relating to this service.
- In the reporting period from May 2016 to April 2017, the trust reported 66 incidents relating to the end of life care services across the hospital. One was recorded as moderate harm, 13 were recorded as low harm and 51 were recorded as happening but caused no harm.
- There were systems and processes in place to report incidents and staff told us they were encouraged to do so. Incidents were reported through the trust's electronic reporting system.
- Processes were in place to investigate incidents, whereby a root cause analysis is completed and learning points identified.
- Any incident relating to end of life care was referred to the End of Life Steering Group for discussion and dissemination. The group met monthly and incidents were a standing agenda item.
- Ward staff we spoke with knew how to report incidents using the hospital electronic reporting system. They were able to give examples of the type of incidents which required escalation and reporting but could not recall any that related specifically to palliative care or end of life care.
- Staff in all roles supporting palliative and end of life care services had a basic understanding of the duty of candour requirement. The duty of candour is a regulatory duty that related to openness and transparency and requires providers of health and social care services to notify patients (or relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to the person.

Environment and equipment

- Staff were able to access syringe drivers to provide anticipatory medicines to patients at the end of their life.
- Staff reported there were sufficient syringe drivers available from the hospital equipment library and these were calibrated and serviced through a regular contract. We reviewed a selection of syringe drivers and the planned preventive maintenance (PPM) schedule which were all tested and in date. This addressed the concerns

End of life care

raised at the last inspection where there were no systems and process in place to ensure equipment required for the use of providing safe care to patients at the end of their life were being serviced or maintained.

- Fridge temperatures in the mortuary were consistently recorded on a computer system. An alarm sounded should the fridge temperatures drop below the required temperature. Faults on the fridges were alerted through the hospital switchboard to the mortuary and maintenance teams, who were available 24 hours a day to respond to any problems.
- In the mortuary and wards we visited, equipment such as trolleys, cleaning equipment and personal protective equipment were visibly clean and stored in a tidy manner.
- We saw that mortuary equipment, such as trolleys, fridges, taps and air handling unit were on a planned preventive maintenance (PPM) schedule and were all tested and in date.
- We reviewed the daily cleaning schedule between 1 May to 26 July 2017 for the mortuary area, viewing area and the post mortem room. The schedules were complete and signed by staff with no omissions.
- A viewing room provided families or friends a private quiet space should they wish to spend time with the deceased.

Medicines

- Patients who required end of life care medicines were written up for anticipatory medicines (medications that are prescribed for use on an "as required" basis) to manage common symptoms that can occur at the end of life.
- The trust used the Individual Care Record for The Last Days of Life (ICRLDL) to record prescription, treatment and care plan. The ICRLDL had guidance on anticipatory prescribing, and during our inspection it was noted that the guidance did not contain maximum doses or advise on the frequency of the administration of medication.
- We reviewed medication administration records of eight patients who were prescribed anticipatory medicines, and only one had frequency and maximum dose recorded correctly. This could potentially lead to inappropriate doses being administered.
- We raised the concern with the hospital specialist palliative care team (SPCT), who were aware that the guidance on the ICRLDL did not give the maximum dose or frequency of administration for anticipatory

medication. The clinical team lead told us that there was an extended guidance on anticipatory prescribing for symptoms at the end of life available on the hospital intranet page for staff to use. However, the team was also in the process of reviewing the ICRLDL document and would amend the guidance accordingly. The clinical lead also told us that to date they had not received any incidents relating to inappropriate administration of anticipatory medication used in end of life care.

- During our inspection, we observed that a patient in Nayland ward was prescribed a syringe driver for pain relief, which was too high a dose. The staff nurse had picked up the error and sought advice from the SPCT, who recommended 5mg Oxycodone per 24 hours This error was highlighted to the ward sister, who raised it with the doctor and nurse that was caring for the patient. The sister also said that she would report it as an incident. The patient was unharmed by the error.
- Following our inspection we requested the investigation report for this particular incident and we were able to see the full root cause analysis and lessons learnt action plan. We saw from the analyses appropriate action was taken including that the incident was explained and an apology given to the patient. The SPCT also attended the ward to follow up on the actions taken by the ward staff. As a result of the incident the staff involved would be receiving extra training on syringe driver and EOLC. As part of the trust policy of investigating incidents, a reflective account and e-learning package of EOLC and controlled drugs would be completed by the staff. The incident would also be discussed at clinical and ward governance meetings.

Records

- Patients approaching end of life had a designated end of life care plan which was recorded on the Individual Care Record for The Last Days of Life (ICRLDL). This included a structured approach whereby nurses conducted checks on patients every two hours to assess and manage their fundamental care needs. These contained progress and evaluation of the patient's health, and clearly documented care given.
- Information provided showed that the trust audited the use of the Individual Care records in The Last Days of Life (ICRLDL) between September 2016 and February 2017.
- Use of the ICRLDL had improved over time, from 34% in October 2016 to 45% in March 2017. The audit results for

End of life care

January and February 2017 showed a significant decrease. We were informed by the trust that the data from January and February 2017 was reviewed and that there were elements of the data that were not interpreted accurately. The trust anticipated that the implementation of end of life care champions on each ward would assist with the increased use of this tool. There was a trust wide training programme which also assisted with the implementation of this tool.

- Senior members of SPCT told us that the usage of the ICRLDL and data the team had collected and reported to the trust EOLC steering group in July 2017 showed ICRLDL usage continued to improve, whereby 60% of patients dying in June were on the ICRLDL.
- The SPCT told us that improvement was required in the quality of ICRLDL documentation. As a result each ward review two ICR LDL records per month. The outcome was fed back through the "2 at the top", ward governance meeting with senior nurses and doctors.
- We reviewed eight ICRLDL records, which were generally completed well. However, in two out of the eight records, the emotional needs assessment was incomplete and one record referred to the medical notes instead.
- The SPCT told us that the use of ICRLDL records have now been embedded across the hospital, the team is working to improve the quality of the ICRDL documentation and monitoring through audits.
- In three of the wards we visited, patients' records were stored in trolleys at the end of each bay or near the nurses' station; we observed that the trolleys were left open. This meant that confidential patient information could be accessed by anyone visiting the ward areas. We had identified this at our last inspection in September 2015.During our inspection we noticed that information written on whiteboards was not always appropriate and presented patient confidentiality issues. On Birch Ward we saw a whiteboard outside each bay indicating patient beds and next observation. This included 'no obs' written against bed numbers of patients who were identified as end of life. This meant that confidential patient information could be seen by anyone visiting the ward areas and was in breach of patient confidentiality.

Safeguarding

- All staff we spoke with understood their role with regards to keeping patients safe and reporting any potential safeguarding issues.

- Staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse.
- Staff told us if they had any concerns they would speak to the trust safeguarding lead or their manager, and knew where to access the trust policy on the intranet.
- Safeguarding training was part of the mandatory training programme and the trust set a target of 95% for completion. Records as of April 2017 showed that the compliance rate for both medical and nursing staff in the end of life care team showed 100% in both adult and children safeguarding level 1 and 2.

Mandatory training

- All members of the SPCT took part in mandatory and statutory training to ensure they were trained in safety systems, process and practices such as basic life support, conflict resolution, fire safety, infection control and health and safety. The team were 100% complaint with these mandatory training modules. However, for manual handling training, seven out of the required nine members of the team had attended the training, giving a compliance rate of 78% against the trust target of 95%.
- Palliative and end of life care clinical awareness training was part of the mandatory e-learning programme for all medical and nursing staff. Staff we spoke with all confirmed that they had completed the e-learning training. This was an improvement from the last inspection were end of life care training was not provided as a mandatory training subject and there was no formal records available which recorded if staff were trained on end of life care.
- Palliative and end of life care training was delivered by the specialist palliative care team as part of the trust's mandatory induction programme. New staff received training on 'the symptoms and principles of palliative care' during induction, and further training at preceptorship after they had been in post for six months.
- The specialist palliative and end of life care clinical skills nurse also provided ward based training on syringe pumps, basic symptom control, role modelling for communication skills and audit completion of the care record that supports dying patients.
- The chaplaincy team and staff from the mortuary and bereavement centre presented at the trust induction about the services they provide as part of end of life care in the trust.
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End of life care

Assessing and responding to patient risk

- The trust used a version of the National Early Warning Score system (NEWS). We saw evidence of the use of the National Early Warning Score (NEWS) in six sets of the patients' notes we reviewed. The National Early Warning Score system is a way of standardising the identification and assessment of acute illnesses and the deteriorating patient. Eight sets of notes were reviewed and all of the early warning indicators were regularly checked and assessed.
- We saw that patients' documentation was transferred to the Individual Care Record for the Last Days of Life (ICRLDL) when it was recognised that the patient was expected to die within days or hours to ensure care in the last days of life was tailored to the patient's needs and those important to them.
- Ward staff told us that specialist support was available from the palliative care team and confirmed that the team responded promptly to referrals.
- The SPCT told us that the Supportive and Palliative Care Indicator Tool (SPICT), which assists clinical teams in recognising that a patient could be in the last year of life, was used at the trust.

Nursing staffing

- Staffing of the specialist palliative care team (SPCT) was in line with the national guidance (the Association of Palliative Medicine for Great Britain and Ireland, and the National Council for Palliative Care recommends there should be a minimum of one specialist palliative care nurse per 250 beds). The trust's SPCT consisted of 6.4 whole time equivalent (WTE) clinical nurse specialists (CNS) in palliative care, one WTE palliative and end of life clinical skills nurse and 1.4 WTE administrative and clerical support.
- The trust had one WTE end of life care facilitator, who was supported by palliative and end of life care ward champions, whose roles included raising awareness of EOLC processes, and educating and supporting more junior staff.
- One of the CNS worked fundamentally within the Emergency Department and Emergency Assessment Unit to support patients from the beginning of their journey within the hospital and ensure the patient's care and needs were promptly assessed and planned.
- As of April 2017, the trust reported a vacancy rate of 6% in the end of life care nursing establishment.

- The mortuary and bereavement service consisted of a service manager, 3.0 WTE anatomical pathology technicians and 1.94 WTE bereavement officers.

Medical staffing

- As of April 2017, the trust reported a vacancy rate of 51% in end of life care medical staffing.
- The Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care states there should be a minimum of one consultant per 250 beds. There were two part time consultants within the specialist palliative care team, which together equalled 1.4 WTE, covering approximately 596 in-patient beds at Colchester General Hospital. This was an improvement since the last inspection in September 2015; however the staffing provision was still not in line with recommended guidelines. We found that these vacancies did not impact on the care delivered by the SPCT and staff on the wards reported that the consultant was always available should their input be required.
- Palliative medicine has been recognised nationally to be a difficult area to recruit into.
- Consultant support was available out of hours through the hospital switchboard from the palliative medicine consultant on call or via a telephone advice service from the local Hospice.
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Major incident awareness and training

- The mortuary staff were aware of the trust's major incident plan and informed us that they had good links within the trust and received regular communication from the emergency planning office. The environment enabled the isolation of high risk, infectious and contaminated patients. The mortuary staff were clear on the procedures to manage such an event.
- The mortuary had the facilities available to set up temporary storage in the event of a major incident and had received recent training in major incidents. The mortuary manager told us that this temporary storage had recently been used during the 2016/17 demand as per winter period.
- The trust's mortuary had capacity for 74; however contingency plans were put in place to accommodate a further 40. The mortuary staff checked and audited fridge space daily and if capacity was above two-thirds full, this would be escalated.

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Are end of life care services effective?

Good ●

We rated effective as good because:

- Staff were aware of evidence-based guidance and best practice. The specialist palliative care team were using these to develop services. The individual care record for the last days of life' (ICRLDL) incorporated the five priorities set out by the Leadership Alliance 2014 for the Care of Dying People and this was being used across the trust in all adult wards.
- The trust participated in a national audit relating to palliative and EoLC services and carried out its own audits and re-audits to test action plans for improvement including the Last Days of Life Audit which measures compliance with the care provision for the last days of life at the trust.
- Pain relief, including anticipatory medication, was being managed appropriately, and nutrition and hydration needs for patients were being monitored and documented.
- There was good multidisciplinary working across professions.
- End of life champions were in every ward area inspected and received additional training to ensure competence.
- The specialist palliative care team (SPCT) supported nursing and medical staff and delivered training across the trust.

However:

- There was a lack of consistency in how patients' mental capacity was assessed. We noted that a number of DNACPR forms stated that the patient lacked capacity but there was no evidence of a mental capacity assessment being completed.

Evidence-based care and treatment

- The trust had an End of Life Policy and Procedure (date approved 30 March 2016) which referred to various national standards and guidance, including the Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020; Department of Health (2008) End of Life Care Strategy: Promoting high quality care for all adults at the end of life and National Institute for Health and Care Excellence (NICE) (2011 modified 2013).Quality standard for end of life care for adults (QS13).

- The 'individual care record for the last days of life' (ICRLDL) recognised the five priorities for care according to the Leadership Alliance for the Care of Dying People (2014). The Leadership Alliance for the Care of Dying People promotes a consistent approach to end of life care through five key principles.
- The Last Days of Life Care Plan document guided clinicians through a series of prompts to discuss the patient's personal and clinical needs, preferences, and the amount of intervention required. It guided clinicians to consider the emotional, psychological and spiritual support needed.
- We reviewed eight records, which showed details of conversation with the patient and/or family, recognition of dying, symptom control, and assessment of nutrition and hydration needs.
- The SPCT told us the ICRLDL was under review to incorporate the NICE quality standard [QS144] Care of dying adults in the last days of life (March 2017). We were told that a draft version of amended ICRLDL would be circulated for feedback at the next trust EOL steering group.To mitigate this the trust were monitoring the service through the Every Pattient Every Day programme using a number of avenues to monitor the effectiveness of the service.

Pain relief

- The trust used the North East Essex guidelines for management of pain in the care of a patient in the last days of life. These guidelines were available as flow charts within the Individual Care Record for the Last Days of Life (ICRLDL) and also on the intranet so staff had easy access to them.
- Anticipatory prescribing (medications that are prescribed for use on an "as required" basis to manage common symptoms that can occur at the end of life) followed the draft NICE guidelines for symptom control.
- We saw eight prescription records of patients who were considered to be in the last days/weeks of life were appropriately prescribed anticipatory medicines for their symptoms.
- We spoke to nine relatives, and eight of these told us that their loved ones received good pain relief and their pain was under control. One relative told us about a

End of life care

delayed pain relief and which they drew to the attention of staff on the ward who took immediate action to ensure that their loved one received appropriate pain relief.

- The Specialist Palliative Care Team (SPCT) consultants and nurses had specialist knowledge were experts in their field and were able to provide guidance on the most effective and appropriate treatments and care at end of life, which included pain relief and management of nausea and vomiting.
- Where appropriate, patients had syringe drivers, which delivered measured doses of drugs over 24 hours. In the wards we visited, all qualified nursing staff were trained in using syringe drivers and symptom management.
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Nutrition and hydration

- Results from the latest National Care of the Dying Audit (2014/15) published in March 2016 showed that the trust scored 66% for nutrition against a national average of 61% and for hydration received a score of 70% against a national average of 67%. This meant that the trust performed better for nutrition and hydration assessment of patients in the last 24 hours of life.
- We saw evidence in patients' records that nutrition and hydration needs for patients were being met. The ICRLDL plan, which had been rolled out across the trust, included a comprehensive list of nutrition and hydration considerations. This included prompts for nutrition and hydration assessment at every review, mouth care, swallowing difficulties and respecting the dying person's choice to eat and drink. Staff we spoke to showed a good understanding of the above.
- We saw the use of mouth trays to provide regular mouth care to end of life patients. in a number of wards we visited. Mouth trays were used to assist end of life patients with mild hydration and is good practice.

Patient outcomes

- In the latest End of Life Care Audit: Dying in Hospital published March 2016 by the Royal College of Physicians, the trust met one of the five clinical outcomes, assessing a patient's individual needs in the last 24 hours of life. The trust achieved this in 73% of cases, with the national average being 66%. An action plan was put in place to address the four outcomes the trust was not meeting. The action plan for the audit was

included within the "Every Patient, Every Day" programme of work which had a designated work stream for EOLC, which meant there was regular sight of the actions and performance of the service at the trust.

- We reviewed eight sets of multidisciplinary notes from patients who were at the end of their lives. All had clearly documented that the patient was palliative or near the end of life. We found this was often documented on the Individual Care Records for The Last Days of Life (ICRLDL), with only one stating to refer to medical notes.
- The trust participated in local audits to measure patient outcomes. This includes the Last Days of life Audit which measured compliance with the care provision for the last days of life at the trust. Information provided by the trust was from February 2017. The result showed 40% were fully compliant with trust policy on completion of the ICRLDL, which was a slight increase from January 2017 (38%).
- The SPCT told us that the compliance rate for using the ICRDL had increased to 60%. We saw evidence of this in the meeting notes of the trust end of life steering group meeting July 2017.
- Between April 2016 and March 2017, 1327 referrals were made to the Specialist Palliative Care Team (SPCT), of these referrals 44% were cancer related and 56% were non-cancer related. This is a reduction in the percentage of cancer related referrals from 2015/16, when 71% of the 1278 referrals to the SPCT were cancer related.

Competent staff

- Palliative and end of life care (clinical awareness) e-learning was mandatory training for all staff. During trust induction all registered nurses and health care assistants are shown how to access and use My Care Choices Register (locality wide palliative and end of life register) and the trust's last days of life database.
- Since November 2016, a palliative and EOL clinical skills nurse has been in post, who provided ward based education including training on syringe pumps, basic symptom control, role modelling for communication skills and advocates and audits completion of the ICRLDL record that supports dying patients.
- Staff we spoke with told us all newly qualified nurses that start at the trust have a day on EOLC training, covering sensitive communication, recognising the dying patient, planning care and physical care.

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- The SPCT told us that they delivered communication skills workshops through role play for junior doctors. In addition, senior nurses, registrars and above received a three hour workshop on communication skills delivered by the local hospice.
- Ward staff told us that the SPCT also delivered training on divisional team days covering what 'good end of life care' looks like, the use of assessment tools and sharing real scenarios and complaints to improve care given to dying patients and those important to them.
- Palliative and end of life care ward champions were in place on every ward and we saw this for each area visited during the inspection. End of life champions must attend a two hour update session and complete competencies.
- We were also told that the EOLC awareness training was extended for porters, housekeepers, catering staff and non-clinical staff who may have contact with dying patients.
- Junior doctors confirmed they had received information and training on palliative and EoLC from the trust. This included treatment escalation plan, syringe driver and communicating with patients and relatives.
- Staff told us and supporting evidence was provided that showed all SPCT, mortuary and bereavement centre and chaplaincy staff had completed 100% of their appraisals.
- We noted the trust had a nursing revalidation action plan that was updated on 12 May 2017. Revalidation is the process that all nurses and midwives in the UK need to follow every three years to maintain their registration.

Multidisciplinary working

- Multidisciplinary team (MDT) meetings were held weekly and attended by the hospital SPCT nurses and consultant and the community team at St. Helena Hospice. During the inspection we observed a regular SPCT MDT meeting. Staff from each designation contributed to the needs of each patient.
- My Care Choices Register (MCCR), a register of patients that are deemed to be potentially in the last year of life, was hosted by the local hospice. The wishes and preferences of the patient plus other useful information for the professionals who are delivering or coordinating care is recorded. The information was shared with the GPs, hospital teams, community teams and local hospice.

- The stroke ward had been trialling adding patients to this register themselves whilst the palliative care team had access to update a patient's details as their condition/needs or wishes changed – thus allowing the wider community teams to be informed of the patient's current situation.
- Each morning an email was sent to ward clinical staff to alert them to any new patient who had been admitted to the hospital that was registered on MCCR - they could directly access the care record for that patient.
- The trust had put in place a database which was populated by ward staff to highlight patients in the last days of life. This aided the palliative care and clinical teams to assess, support and advise on care and for clear individualised supportive communication and care plans to be achieved.
- Referrals to the SPCT came from multiple professionals, including nursing, medical and allied health professionals. Nursing staff felt confident to refer to the SPCT for advice and support.
- The specialist palliative care team worked well with the wards, including West Bergholt, Birch, D'Arcy, Mersea, Brightlingsea, Layer Marney, Peldon and the stroke unit. The managers for these wards spoke with great respect about the dedication of the palliative care team.
- Ward staff and managers told us the specialist palliative care team attended the ward when referrals were made formally and less formally for advice and support when requested to do so. The specialist palliative care team routinely visited the wards.
- Members of the SPCT also told us that they attended the weekly site specific oncology MDT meetings, where the palliative care team was a core member.

Seven-day services

- The specialist palliative care team provided support Monday to Sunday between 9am and 5pm. We were told that out of hours advice was available via a telephone advice service run by the local hospice.
- The mortuary and bereavement team told us they provided a service between 8am to 4pm Monday to Friday and had an on-call rota for staff at weekends.
- Chaplains of all denominations could be contacted to provide holistic support to patients and families 24-hours a day.

Access to information

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- The Accident and Emergency department electronic system "flagged" patients who were on the My Care Choices Register. This meant that staff were made aware accordingly and ensured that care was co-ordinated between the palliative care team and others that were already involved in the patient's care.
- Staff across the trust could access information from the intranet, such as policies and national guidance. In the wards that we visited, staff were able to demonstrate that they could easily access information on palliative/ end of life care from the intranet, and also from an end of life care folder kept in the ward. Staff spoke positively about the SPCT and the ease of accessing information and guidance whenever they needed it.
- 'Last Offices' boxes had been introduced onto ward areas, containing all the items required to perform care after the death of a patient.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training was part of staff's mandatory training. Staff we spoke with were able to describe the process they would follow should someone be found to not have capacity to agree to treatment or be able to make decisions in relation to their care.
- MCA and Deprivation of Liberty Safeguards guidance was available on the trust's intranet and associated documents such as the consent policy, dementia policy and safeguarding adults at risk policy.
- Mandatory training information provided by the trust showed that 100% of the specialist palliative care team were up to date with Mental Capacity Act and Deprivation of Liberty Safeguards training.
- We reviewed 35 do not attempt cardio pulmonary resuscitation (DNACPR). Of the 35 DNACPR records reviewed, 26 (74%) were completed in line with Resuscitation Council UK guidelines.
- Of those not accurately completed, three did not have clearly documented discussions of the decisions with the patients. Two had incomplete documentation for mental capacity assessments in three DNACPR records it was stated that the patient did not have capacity but no assessment or best interest decision recorded. The reasons stated on the forms for not having those required conversations included reasons such as, 'age', the patient was 'unwell', the patient was 'elderly'.

- We were not assured that the Mental Capacity Act and Deprivation of Liberty Safeguards were always implemented for people who had do not attempt cardio pulmonary resuscitation (DNACPR) documentation.
- The trust-wide DNACPR audit report dated March 2017 looked at 999 DNACPR orders across 16 wards. Overall compliance with the completion of the DNACPR form was 82%. A further analysis was carried out on 50 randomly selected patients' notes, who had passed away within March 2017. The rationale for the DNACPR decision was found to be well documented (96%) and forms were consistently signed and dated (100%). Compared with the audit completed in February 2017 there was a 6% decrease of patients/relatives/carers being involved in the decision (from 100% to 94%). Evidencing that other members of the healthcare team have been informed of the decision was only 52%. The audit result also showed were MCA completion was applicable; this was indicated in 100% of the forms reviewed.

Are end of life care services caring?

Good 🟢

We rated caring as good because:

- Patients were treated with compassion, dignity and respect.
- Patients and their relatives spoke positively about the care they received.
- Interactions between staff and patients were kind, caring and compassionate.
- All ward staff provided emotional support in addition to the specialist palliative care team and chaplaincy team.
- Within the mortuary, the team were very receptive to providing a caring service to the families and to the deceased. Staff within the mortuary and bereavement service demonstrated their passion for making a difficult situation better for those involved, and worked to deliver this with the limited resource available.

Compassionate care

- Throughout our inspection, we observed patients treated with compassion, dignity and respect. Medical and nursing staff we spoke to were aware of the

End of life care

importance of treating patients and their visitors in a sensitive manner. All staff spoken with had a genuine desire to want to provide the best possible care to patients at the end of life.

- We saw that end of life patients, wherever possible were cared for by ward staff in side rooms to protect the privacy and dignity of the dying patient and their families.
- Chaplaincy, bereavement and mortuary staff were passionate and committed to ensuring that the deceased were cared for with compassion and respect, both before and after death.
- The chaplaincy provided examples of marriage blessings that had taken place at the hospital for patients who had a limited life expectancy. The chaplaincy, SPCT and ward staff organised three weddings in the last six months to fulfil the wishes of dying patients. One of these weddings was organised within five hours, by contacting the Chelmsford registry office, who granted a special licence for the marriage to take place.
- We spoke with one patient and nine relatives during the inspection. The patient and relatives were consistently complementary about staff attitude and engagement.
- The comments received from patients and relatives demonstrated that staff cared about meeting patients' individual needs and they had been extremely caring and attentive to the needs of relatives.
- We saw a letter from a relative who was cared for on D'Arcy ward. The family member stated that "…the whole team were kind, caring and did their very best".
- The families we spoke with said that staff were very busy and sometimes very stretched but they would always respond to the needs of their loved ones.
- We heard of two occasions where ward staff had facilitated so that end of life patients could be visited by their dogs.
- The chief executive wrote letters to all families of patients who had died in the hospital expressing their condolences.
- Porters and mortuary staff said that the bodies of deceased patients were handled in a compassionate way. There had been one incident relating to concern around the condition of a deceased patient. This had been investigated and action had been. We reviewed the investigation of the incident and the lessons learnt that were documented on the electronic incident reporting system.

- The trust conducted a care of the dying evaluation survey (bereavement survey), to determine the care provided in the last few days of life and experience of that time. The most recent survey was conducted in May 2017 and of the 26 respondents, 19 (76%) either strongly agreed or agreed that there was enough help available to meet personal care needs of their loved ones. This was previously 82%. The survey results were being discussed in the August EOL steering group meeting.
- The trust chaplain told us that invites were sent out to the next of kin of patients who had died within the trust, offering them the opportunity to attend one of the memorial services that were conducted as a supportive measure to the relatives of recently deceased.

Understanding and involvement of patients and those close to them

- We reviewed eight care records, which showed some discussions between clinicians and patients and those close to them. In some cases the views of the family were detailed, while others only stated that the family member understood the plan.
- Family members we spoke with told us they felt involved in the care delivered.
- One family member we spoke with on Birch Ward said that they had conflicting or inaccurate information from the nursing and medical team regarding their loved ones nutrition uptake.
- Relatives confirmed there was open visiting. Local leaders told us they would offer relatives to stay over if they wished to do so and would organise foldaway beds if the patient was in a side room.
- Relatives confirmed staff supported them to stay overnight as comfortably as possible and we saw arrangements were in place to facilitate this.
- The Individual Care Record for the Last days of life document included prompts for discussing issues of care with patients and relatives.

Emotional support

- The SPCT, ward staff and chaplain gave emotional support to patients and their relatives. Staff told us they would give them as much time as they needed to talk about their thoughts and feelings.

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- The clinical nurse specialists (CNS) from the specialist palliative care team (SPCT) spent time with patients and their families to provide reassurance and support and answer any difficult questions that they may have in relation to the treatment being received.
- The chaplaincy provided a seven day service, which was available 24 hours per day to provide emotional support to patients and their families. Wards had signs displayed with methods to contact the teams at any time of the day. Information provided by the trust showed that there were 42 chaplaincy volunteers of varying denominations who could provide emotional support across the trust. The trust employed 2.84 WTE trust Chaplains.
- Ward staff told us that as of June 2017 the trust has started to utilise palliative and end of life care volunteers, which had been mostly recruited by the Chaplaincy team to offer emotional support to patients and relatives.
- The bereavement team understood the importance of emotional support. The mortuary bereavement service was by appointment in half hour slots and staff would try to accommodate requests for particular times. We heard of examples of how the mortuary and bereavement team ensured that people could take the time they needed and didn't rush people so that they could say goodbye to their relatives and ask any questions they may have of the bereavement team.
- There was a guidance document available through the bereavement team for what to expect at the next stages once a person has died, this provided information and support to people to inform them of what to expect and how the bereavement team signpost them to relevant information and support.
- The SPCT told us that relatives and families felt to be at risk of a more difficult bereavement were formally assessed by the team and referred for follow up by bereavement services in the local hospices.

Are end of life care services responsive?

Good 🟢

We rated responsive as good because:

- Patient's preferred place of care/death (PPC/D) was captured through the My Care Choices Register (MCCR), a locality wide register. The trust also monitored if patients achieved their PPC/D.
- Care was planned on an individualised basis for patients at the end of life, using the Individual Care record for Last Days of Life (ICRLDL).
- Patients at the end of life were identified through the trust electronic database.
- The trust had undertaken audits into the use of the Last Days of Life (ICRLDL) and preferred place of care compliance.
- Wherever possible, patients approaching end of life could have a side room and visitors could have unlimited time with the patient.
- Of the 1327 referrals received, the SPCT were able to visit and assess 1272 (95%) of patients within 24 hours of referral.
- Complaints were fully investigated, reviewed and discussed by the end of life care team, and lessons learnt.

However:

- The trust had a process in place for fast track discharge, however it was acknowledged by the trust to not always be rapid or fast, with some cases taking up to 189 hours (7.8 days) in May and 119 hours (five days) in June to get a patient discharged. There were focused action plans in place to monitor and address this through a range of initiatives in the Every Patient Every Day programme.

Service planning and delivery to meet the needs of local people

- At the last inspection in September 2015, the hospital was not recording patient's preferred place of care/death (PPC/D). However, at this inspection patient's PPC/D was captured through the My Care Choices Register (MCCR), a locality wide register. On average 40% of those who died in North East Essex were on MCCR. A review of the locality data from MCCR showed that between January and June 2017, on average 68% of patients achieved their first or second choice of PPC/D.
- Within the trust, for the months of May and June 2017, 79% and 83% respectively of palliative care patients or those at the end of life were discharged to their preferred place of death. The trust had set a target of 90% to drive improvement. Staff told us that this target

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was often not met due to a number of issues, including not recognising rapidly deteriorating patients and patients changing their minds about their preferred place of care/death.

- The mortuary manager showed us a business case and an architect plan to increase fridge capacity in the mortuary for the deceased to take account of population expansion in the Colchester area. We were told that the service had submitted plans to increase capacity by 40 more fridges. However, no plans had been approved by the trust at the time of inspection. The trust had mitigation plans in place for high demand period, such as the winter months.
- The SPCT worked collaboratively across the locality whereby the clinical lead and head of cancer nursing attended the locality group for EoLC, This group met on a monthly basis and had representation from the clinical commissioning groups (CCGs), local hospice, county council and ambulance service. The clinical lead also attended the Suffolk and North East Essex Sustainability and Transformation Plan (STP) EOLC Group.
- The trust was involved with the NHS Improvement end of life care improvement collaborative, which supports providers to improve how they deliver end of life care. The trust told us that as part of this collaborative, they would be looking at the discharge of rapidly deteriorating patients as an improvement project as they were aware it was an area that required some focused work.
- All staff we spoke with told us patients approaching the last days or hours of their life, wherever possible, were given the option of being nursed in a side room to protect their privacy and dignity.
- There were no visiting restrictions for family or friends for those receiving end of life care.
- The wards we visited provided portable beds for those relatives wishing to stay with their loved ones in a side room.
- The bereavement office had two dedicated rooms where relatives could relax, ask questions and be supported throughout the process

Meeting people's individual needs

- The chaplaincy gave examples of when wedding ceremonies, baptisms and special services had been organised for patients within the hospital. There had

recently been three civil service and marriage blessings in the hospital. This was facilitated so patients, in the last days of life, could have their wedding before they died.
- The Chapel had a segregation screen and prayer mats for people with a Muslim faith. We saw copies of the Holy Bible and Koran and multi-faith books.
- The Chapel had a prayer book where relatives could request a prayer for patients on the wards. They also had a memorial tree where relatives could write prayers and memories on leaves.
- A variety of leaflets were available on the wards including information about coping with dying, chaplaincy and spiritual care and what to do following bereavement.
- In the wards we visited, a symbol of a purple butterfly was placed on the door or curtain, to make all staff aware that the patient was receiving end of life care. This was also communicated during ward handovers.
- A ward sister told us that 'comfort packs' had been given out over the past few months for families and relatives who may have to stay at short notice as their loved one was dying. The SPCT told us that funding for further supply of these was secured and the palliative and end of life care volunteers would work alongside SPCT in providing these.
- The trust had a system in place to access telephone and face to face translation and interpreter services.
- We didn't see any specific facilities within the mortuary to accommodate religious needs in terms of end of life rituals, for example allowing a family to wash the deceased. The mortuary staff stated that it could be possible to facilitate specific needs if they were told prior to the family arriving. Alternative arrangements could be made and or facilities brought into the viewing room to accommodate specific requirements.
- The Individual Care Record for the Last days of life document included prompts for discussing issues of care with patients and relatives. As part of the discussions a guidance leaflet is available for patients and their relatives.

Access and flow

- There were 1278 referrals to the Specialist Palliative Care Team (SPCT) between April 2015 and March 2016. This

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increased to 1327 between April 2016 and March 2017. Of the 1327 referrals received, the SPCT were able to visit and assess 1272 (95%) of patients within 24 hours of referral.

- We noted the patients' preferred place of care/death was identified on the Individual Care Record for the Last Days of Life document. The fast track discharge of patients in the last days and weeks of life (last two to four weeks of life) was coordinated by the integrated discharge team.

- Information was requested from the trust regarding the rapid discharge policy, target times for reviewing patients and achieving rapid discharge, and the monitoring and auditing of rapid discharge compliance and achievement. The trust provided a flow chart with a detailed fast track discharge process. The trust target was 24 hours for the discharge of patients for those with a prognosis of less than four weeks.

- The trust target for the time taken to discharge rapidly deteriorating patients (last weeks of life) to their preferred place of discharge from time of referral to complex discharge team was 24 hours. However, data showed that in May 2017, patients had to wait on average 189 hours. In June 2017 this had gone down to 119 hours.

- Senior staff told as that fast track discharge was an issue. Patients were delayed from being discharged to their preferred place of death due to lack of appropriate community based care providers and also delays in funding decisions from the CCG.

- Ward staff and members of the integrated discharge team told us that the reason for delays to fast track discharge was multifaceted. The trust had identified that there was a capacity issue within the discharge team and at the time of our inspection recruitment for 1.5WTE band 6 nurses to specialise in discharging rapidly deteriorating patients was underway.

- The trust told us that fast track discharge was an area where they needed to improve. We saw that an action plan for rapid discharge had been put in place and was being monitored through the trust's 'Every Patient Every Day' workstream.

- The mortuary had 74 fridge spaces; four deep freeze spaces, dedicated fridge space for children and six of the fridges spaces could accommodate larger bodies. Based on the rate of population growth these facilities were not sufficient to meet the needs of the hospital and local population.

- The hospital had a service level agreement with local funeral directors who provided 40 additional storage spaces when required. The option of temporary storage was available on site, though there was recognition that the facilities required expansion.

Learning from complaints and concerns

- Staff reported receiving very few complaints in relation to EOLC. In the 11 month period from July 2016 to June 2017, the trust received 20 complaints. Senior members of the SPCT told us that since the last CQC inspection a huge amount of work was done around the complaints procedure. The trust told us that a thematic review of all end of life care complaints received (monthly review, ongoing) was carried out and ward based packs had been produced that addressed the key areas of improvement required, which included clinical skills, bedside training and communication.

- The SPCT told us that the clinical skills nurse attended team days to promote education around EOLC. As the vast majority of complaints related to poor communication, the SPCT had also provided communication skills training to senior nurses and registrar doctors and above.

- Each complaint was reviewed by the end of life team with a specific complaint looked at in detail at each End of Life Steering group. Complaints were discussed as a standing agenda item in the trust's End of Life Steering group meeting as well as the "2 at the top" meeting, ward governance meetings. We were able to see from the meeting minutes recent complaints concerning EOLC discussed and key learning points shared with staff at ward meetings.

- The SPCT told us that complaints relating to end of life care were sometimes not specifically highlighted on the trust's complaints database. Complaints were logged under the speciality that the patient was being treated within, for example surgery. The SPCT told us that this is an area that the team had worked very hard on with the complaints department and felt that they had made good progress.

- Ward staff gave an example where lessons learnt were shared following a complaint, regarding communicating with the families of a patient. The complaint was discussed at the EOL steering group and the findings were disseminated to all staff concerned

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Are end of life care services well-led?

Good 🟢

We rated well-led as good because:

- There was a clear vision and strategy in place for end of life care.
- The service had the medical director and director of nursing as executive leads on end of life care for the trust.
- Governance arrangements included 'well embedded' regular monthly meetings that were active and inclusive.
- A risk register was in place and had actions identified. However, there were no target date for completion of the actions, although the risks were reviewed regularly.
- The culture of the service was one of positivity and resilience.

However:

- A non-executive lead had not been appointed for end of life care.

Leadership of service

- The trust's medical director and director of nursing were the executive directors responsible for end of life care. The medical director chaired the end of life care steering group. Staff we spoke with felt that this was positive as it provided executive oversight on end of life care. However, despite escalating to the executive team, since early 2016 there has been a lack of Non-Executive Director (NED) presence at the steering group meetings.
- The More Care, Less Pathway report, published July 2013 by the Department of Health (DH), recommended that all healthcare organisations appoint a non-executive member of the board to oversee end of life care, whose focus will be on the dying patient, their relatives and carers. At the time of the inspection, there was no non-executive director with responsibility for end of life care. However local leaders told us that two public governors were members of the steering group meeting.

- There was an established multidisciplinary SPCT in place. The palliative care consultant and palliative care nurses demonstrated good leadership in the clinical areas, and staff we spoke with on the wards recognised who they were.
- Staff we spoke to throughout the trust were aware of the SPCT. Staff also reported about the good working relationship with them and the support and training they provided.
- In January 2017 the trust introduced the role of a palliative care clinical nurse specialist to work fundamentally in the Emergency Department (ED) and Emergency Assessment Unit (EAU). The purpose of this role was to support patients form the beginning of their journey within the hospital to ensure that patients' care and needs were promptly assessed. All staff we spoke to in ED and EAU could tell us about the work of the palliative care clinical nurse specialist, in particular the rolling out of the 'last days of life care plan' across the trust and the Watch point database. Staff spoke positively of this new role and how it has helped in coordinating end of life care within the trust
- Locally, the mortuary was well-led, with all staff feeling supported.
- Within the wards we visited, we observed that the care for patients with end of life needs was well-led.

Vision and strategy for this service

- The trust had an end of life care strategy (2016-2017) in place and provided relevant copies as supporting evidence prior to the inspection. The strategy built on the Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2012, outlined the goals and aims for 2016/17 and recognised that end of life care was everyone's business.
- The strategy for end of life care had been set around the trust's values of caring, communication and consistency. To help with the implementation of the strategy, the trust had in place an end of life policy and procedure which aimed to bring together the documents available within the trust to guide staff in the care of patients at the end of their life.
- The trust was also part of the North East Essex Clinical Commissioning (NEECC) Group End of Life Strategy 2013 - 2017, a system wide locality strategy for end of life care.
- The NEECC programme group for end of life was a strategic group that had representations from across health and social care organisations, in North East

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Essex, that were involved in providing care and support for people in the last years of their life. The SPCT clinical lead and head of cancer nursing attended the monthly meetings.

- At local level, the SPCT were clear about the strategy and vision for palliative and end of life care service. The end of life care facilitator had regular meetings with end of life ward champions to share information at ward level.

- The trust's End of Life Steering Group met monthly and was accountable to the trust board to deliver palliative and end of life strategies.

- Leaders and nursing staff were able to tell us about the end of life care strategy. For example, they spoke of the projects to improve education to nursing and clinical staff about palliative and EoLC in addition to supporting patients at the earliest opportunity with their decision making.

Governance, risk management and quality measurement

- Palliative and EoLC services operated throughout the trust. Governance of the services sat within the division of medicine and emergency care. This was headed by a divisional director and head of nursing.

- The trust monitored the end of life service through the end of life steering group, which met monthly. This group was supported through weekly meetings of the multidisciplinary team, who discussed patients at the end of their life, delays in discharges and current plans of care. A monthly palliative care business meeting also reviewed the service provided. Any risks would be escalated to the divisional governance group and entered on the divisional risk register.

- Minutes of the palliative care business meeting in February, March and April 2017 demonstrate that the continued education programme and planned and recently received audits were discussed. Discussion on the performance of the service was noted. We reviewed the May 2017 report to the programme board and we were assured that effectiveness and responsiveness of the service was being monitored.

- The trust risk register for end of life care was reviewed and a summary of the register submitted. The risk register contained concerns identified at the inspection. Each risk had control measures in place and a review

date but there was no target date for completion of the action on the information received from the trust. However the register was reviewed regularly. No further concerns were raised with regards to the risk register.

- The trust achieved only three of the eight organisational indicators in the End of Life Care Audit: Dying in Hospital 2016. Senior members of the SPCT told us that the action plan for the audit was included within the "Every Patient, Every Day" programme of work, which aimed to improve the quality of patient care and experience by addressing issues that are faced and holding the services to account.

- For palliative and end of life care there were five key performance indicators (KPIs) that were measured and RAG rated. These were incidents, complaints, use of ICRLDL, discharge to patient's preferred place of care/death and length of time to discharge rapidly deteriorating patients.

- We reviewed the May 2017 report to the programme oversight group of "Every Patient, Every Day programme" which showed that two out of the five KPIs were flagged red. These were complaints related to end of life care (as these were greater than 12 over 12 months) and time taken to discharge rapidly deteriorating patients (as this was taking over 48 hours, data from April 2017 showed it took 193hours). From the report we could see that mitigation/action to resolve the issue had been put in place and were being reviewed by the programme board. In addition, key activities and actions to improve the performance were highlighted for action.

Culture within the service

- The focus on end of life care was beginning to shift hospital-wide, with staff commencing the new procedures, and recognising the changes and importance of end of life care.

- Staff we spoke with showed a commitment to delivering good quality end of life care. Although they all mentioned the issue with lack of staffing within the wards, staff felt proud of the care they were able to give and there was positive feedback from nursing and care staff about the level of support they received from the SPCT.

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- Mortuary and bereavement staff showed a strong team ethic and a structured working relationship. The mortuary and bereavement teams demonstrated a willingness to improve the care of the deceased and experience of the relatives.

Public engagement

- The trust conducted a quarterly bereavement survey. Questionnaires were handed out by the bereavement suite with a freepost envelope to the loved ones of those who had died to obtain information on the care provided in the last few days of life and their experience of that time.
- The most recent survey was conducted in May 2017 and 26 surveys were completed and returned. The survey highlighted some good practices including; legal and administrative procedures explained after death (95% previously 91%), healthcare team explaining their loved ones condition and/or treatment in a way that was easy to understand (88% previously 76%) and being clearly told that my loved one was dying (88% previously 62%).
- The survey also highlighted areas for improvement. These areas included; doctors and nurses did enough to help relieve symptoms of their loved one (83% previously 96%), there was enough help available to meet personal care needs (76% previously 79%) and that they were supported adequately during their loved one's last few days of life (70% previously 75%).
- At the time of our inspection we were told that the survey data was recently released and would be discussed in at the next EOL Steering group and then disseminated across the trust.
- Patient representatives were invited to the end of life care steering group. Minutes from the end of life steering group from February to July 2017 showed patient representation at the group.
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Staff engagement

- Overall, compared to the national findings, there were 17 negative findings and one positive finding; all other measures were within expectations.
- The questions for which the trust performed better than other trusts were: recognition and value of staff by managers and the organisation (3.29) compared to the England average of 3.45.

- We were told that staff engagement with end of life care had improved; this was predominantly due to the focus on end of life care both at local and board level.
- Local leaders told us the trust was engaging with staff through education and training to work with some of the issues such has lack of or poor communication around delivering a positive end of life care.
- All the wards we visited had palliative/end of life champions that assisted with training and information sharing.

Innovation, improvement and sustainability

- As part of the trust's end of life care improvement plan a working group had been set up to develop a Time Garden in the hospital grounds. This would provide a quiet outdoor place for patients who are dying and those important to them to spend time away from the wards. The project is a fundraising initiative whereby fundraising events and donations from various organisations, local community and staff involvement had raised a significant amount. Staff were very proud of this project and the support it had received so far.
- The trust had a hospital database that was populated by ward staff to highlight that a patient was dying. The SPCT told us that the database aided the team to assess, support and advise on the care for dying patients and those important to them. The Palliative and EOL clinical skills nurse particularly focused on these patients to aid learning on the wards.
- As part of the locality wide end of life care strategy, My Care Choices Register (MCCR) was developed to register people that were deemed to be potentially in the last year of life. The register held information regarding patient wishes/choices pertaining to their care and needs, including DNACPR status and PPC/PPD.
- Each morning an email was sent to ward clinical staff to alert them of any new patient who had been admitted to the hospital that was registered on MCCR. The register was held by the local hospice and only the patient's GP could add them to it. However, the SPCT told us that one of the wards were trialling adding patients to the register, whilst the SPCT currently have access to update a patient's details as their condition, needs or wishes change. This allows the wider community teams to be informed of the patient's situation.

Outpatients and diagnostic imaging

Safe	**Requires improvement**	🟠
Effective		
Caring	**Good**	🟢
Responsive	**Requires improvement**	🟠
Well-led	**Requires improvement**	🟠
Overall	**Requires improvement**	🟠

Information about the service

The outpatient services at Colchester Hospital University NHS Foundation Trust (CHUFT) cover a number of sites, which include Colchester General, Essex County, Clacton and Harwich Hospitals. The majority of outpatient clinics are located in the main outpatient area and the Gainsborough Unit at Colchester General Hospital (CGH) and Essex County Hospital (ECH).

Between February 2016 and January 2017 the trust had 660,188 first and follow up outpatient appointments with 405,768 held at CGH, 156,405 at ECH, 70,590 at Clacton Hospital and the remaining 27,425 at other local sites. Specialities include but are not limited to; ophthalmology, trauma and orthopaedics, clinical oncology, cardiology, urology, gynaecology, neurology, haematology, gastroenterology, respiratory general surgery and rheumatology.

There were a number of specialities that were excluded from the inspection, dermatology, plastic surgery and diabetes as they are not provided by the trust. Orthotics, dietetics, community physiotherapy, physiotherapy, pain management, occupational therapy, and speech and language therapy for patients with the clinical comissioning group of North East Essex, these services are no longer run by the trust due to a care closer to home initiative.

Outpatient and diagnostic imaging services are managed within the Women's, Children and Clinical Support Services Division. Outpatient appointments are available Monday to Friday between 8am to 6.30pm with occasional evening and weekend clinics dependent on speciality, capacity and need at CGH.

Outpatient clinics were held daily at ECH and on specific days of the week at Clacton and Harwich Hospital. ECH also scheduled clinics every Saturday and occasional Sundays.

CHUFT provides a full range of diagnostic imaging, including general radiography, computed tomography (CT), ultrasound, nuclear medicine, cardiac imaging and interventional radiology at Colchester General hospital. They perform approximately 23,650 examinations each month and also provide radiotherapy services. An external company provides magnetic resonance imaging (MRI) and positron emission tomography PET-CT services under contract with the trust.

The last inspection in September 2015 reported significant concerns regarding; incorrectly recorded outcomes, risk of patients being lost in the booking system, equipment not being safety checked or serviced, poor mandatory training, duplicated notes and a backlog of patients awaiting appointments. It was also reported that the trust executive team were not clear on what their risks within outpatients were, and there was 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.

Following that inspection we were informed about the issues with validating outpatient data and the backlog of pathways. In June 2017 there were 12,194 patients awaiting their initial appointment in the outpatient department and 817 patients awaiting follow up appointments. The trust had a process for reviewing the patients waiting on the waiting list however each speciality had individualised

Outpatients and diagnostic imaging

escalation procedures. Senior staff acknowledged that there were issues in the booking service that needed rectifying and there were new managers in post to address this.

Considerable progress had been made to address some of the concerns such as equipment checking and mandatory training, and work was ongoing to address the backlog concerns.

We inspected four outpatient areas, and eight diagnostic imaging areas at Colchester General Hospital (CGH). These included; the main outpatient department, Gainsborough clinic, cardiology/respiratory investigations, and the Alpha and Beta radiology departments, interventional radiology, cardiac catheter laboratory, ultrasound, nuclear medicine and radiotherapy. On the unannounced inspection we visited the ophthalmology, ear nose and throat, and breast clinics, and the breast imaging department at Essex County Hospital (ECH).

We spoke to 59 members of staff including managers, administrative staff, technicians, radiographers, nurses, and doctors. We also spoke to 17 patients, and reviewed 17 patient records. We reviewed trust policies, procedures, and performance data and we observed two radiology procedures and eight patient consultations.

Summary of findings

Summary of findings

We rated this service as requires improvement because:

- Referral to treatment times (RTT) were worse than the England average in all but one measurement (urgent two week referrals where they were better) and below the operational standards.
- There were 2,863 patients out of 12,194 patients who had waited 13 weeks and over for a first appointment. The number waiting had been below 1,500 for most of the year April 2017 – May 2017 but had increased in the month prior to our inspection.
- There was still a significant backlog of patients shown as awaiting appointments although this had improved since the previous inspection, and review had shown that a large proportion of the backlog was likely due to appointments not being correctly reconciled on the system. There were processes in place to resolve this and every patient had been risk assessed whilst waiting in the backlog.
- Medical staff compliance with mandatory training was variable, with adult basic life support being the lowest at 50%.
- The trust overall cancellation rate was around 25% for the period April 2016 to March 2017. However patient cancellations were high at around 14%. The hospital cancelled around 8% of clinics at short notice (less than 6 weeks' notice).

However:

- There were no significant concerns identified within the diagnostic services we inspected, we found that there was learning from incidents and effective processes in place.
- Leadership in the outpatients department was organised and effective and action plans had been implemented to address known concerns.
- There was a positive culture and staff were proud of the care they gave despite numerous recent leadership changes.
- Patients were treated with dignity and respect.
- Staff in radiology were supported to develop, with radiographers learning reporting skills and a new radiographer consultant post in breast imaging.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement ●

We rated safe as requires improvement because:

- The planned preventative maintenance list for outpatient and cardiac/respiratory equipment across the three outpatient sites showed that there were 88 pieces of equipment due or overdue maintenance out of a total of 324 items (24%) with one of them indicated as a high risk.
- The yearly environment audits indicated concerns that had not been addressed following previous audits. For example the doors in radiology did not close properly therby not mitigating the risk of people being exposed to unnecessary radiation.
- There were nine serious incidents in diagnostic imaging. Whilst there may have been increased reporting there were double the number of serious incidents that required notification to the CQC during this time.
- There was no patient group directive in place for diagnostic imaging staff administering medium in diagnostic radiology.
- Patient notes were seen in poor condition; with pages not properly filed, loose pages and covers falling apart, making clinical review difficult at times.
- Medical staff compliance with mandatory training was variable, with adult basic life support being the lowest at 50%.

However:

- There was a positive culture around incident reporting, and learning was disseminated.
- We observed good practice around the storage of medications and issuing of FP10 prescriptions.
- The radiotherapy department used photos to provide staff with assurance that the correct patient was given the correct treatment.
- World Health Organisation (WHO) Surgical Safety Checklist and five steps to safer surgery audits showed that 99.3% of procedures performed in January-May 2017 had a fully completed checklist.

Incidents

- Between May 2016 and April 2017, the trust reported no never events for outpatients or diagnostic imaging. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- The trust reported one serious incident (SI) in outpatients between May 2016 and July 2017. This was still being investigated at the time of the inspection. Nine serious incidents were reported within radiology between May 2016 and April 2017. Of these, the most common type of incidents reported were; treatment and diagnostic delays meeting SI criteria (including failure to act on test results). Both categories had three incidents (33%). We reviewed the root cause analysis reports of the incidents and found that there was appropriate investigation, learning identified and action plans developed.
- Of the 153 internally reported outpatient incidents across all of the outpatient departments for the period April 2016 to March 2017, 142 were recorded as 'no harm', 10 as 'low harm' and one as moderate harm. The most common themes related to clinics being cancelled or moved and delays in care or long waiting times.
- Senior staff were trained in root cause analysis to investigate incidents.
- Staff told us that they felt confident to raise concerns because they felt that management would listen to them.
- All staff reported incidents on an electronic incident reporting system and confirmed that that they received information back when they reported incidents, and that learning from incidents was shared. Staff gave the example of a change in practice as a result of learning in outcome sheets being printed in blue for cancer patients to ensure that patients received the right type of appointment within the specified time period.
- We saw evidence, confirmed by staff, that the number of diagnostic imaging incidents had increased during the last year. The radiation protection advisor report for 2016 showed that there were 163 incidents involving radiation in 2016 compared with 145 the previous year. Of these, 21 incidents were reportable to the CQC, which is more than double the number for 2015. Common causes were due to referrers completing imaging requests for the wrong patient and a failure of staff to check the previous imaging history and performing

examinations that had already been completed. All of these incidents had been investigated and action taken to reduce the likelihood of something similar happening in future.

- Senior radiology staff told us that the 'Pause and Check' process had been implemented to address the learning from incidents. We saw 'Pause and Check' posters displayed in all imaging areas visited (The Society and College of Radiographers produced 'Pause and Check' resources to reduce the number of radiation incidents occurring within radiology departments). For all examinations we observed, staff identified patients in line with the pause and check process.

- Feedback and learning from diagnostic imaging incident investigations was shared during regular staff meetings. Staff reported that any changes to practice implemented following an incident were communicated to staff by email in addition to being discussed at staff meetings. We saw evidence of this where a flow chart that had been introduced for checking the position of nasogastric tubes (NG tube). This flow chart had been introduced in response to a serious incident involving an incorrectly placed NG tube.

- NHS trusts are required to report any unnecessary exposure of radiation to patients under the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). Diagnostic imaging services followed procedures to report incidents to the correct organisations, including CQC.

- Diagnostic imaging staff told us that any staff who were involved in an incident were required to complete a reflection form as part of their personal development. This form encouraged staff to consider what they would do differently and what learning they could take from the incident.

- We saw evidence in the '2 at the top' monthly ophthalmology report of incidents being discussed and learning shared. The '2 at the top' was a departmental governance report compiled and presented by the senior ophthalmology nurse.

- There were reminder posters in Alpha X-ray reminding staff to check previous imaging history and to report any duplicate imaging requests as a 'near-miss' incident. This process was put in place as a response to incidents involving duplicate requests that were not spotted by radiology staff to try to reduce the likelihood of similar incidents happening in future.

- We reviewed minutes from the monthly radiology clinical governance meetings. These meetings included discussions on incidents and any learning from incident investigations.

- Local rules were seen as required under Ionising Radiations Regulations 1999 (IRR99) and were within review dates. IRR99 are a statutory instrument, which form the main legal requirements for the use and control of ionising radiation in the United Kingdom. The local rules summarise the key working instructions intended to restrict exposure in radiation areas. They will include at least the following information: a description of the area covered by the Rules and its radiological designation, the radiological hazards which may be present in the area, the formal dose investigation level, names and contact details of responsible people, including the Radiation Protection Supervisor (RPS), detailed working arrangements for the area, and contingency plans.

- The Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) procedures were in place and all documentation was available on a shared drive. This ensured only the most recent versions were available for staff to reference.

- Outpatient staff knew about their responsibilities regarding duty of candour although they were not always familiar with the term. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

- Staff were able to give examples of when duty of candour had been discharged in relation to incidents such as wrong appointment letters being sent out and clinics being moved or cancelled without informing patients.

- Most radiographers we spoke to knew what 'duty of candour' was and all said that they would be open and honest with a patient if something had gone wrong.

Cleanliness, infection control and hygiene

- CGH outpatient clinics, corridors, waiting areas and diagnostic imaging departments were visibly clean uncluttered and tidy. There were daily clinic cleaning logs displayed in each outpatient clinic room initialled by the person responsible for that day's clinic.

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- Equipment used in outpatients was visibly clean and equipment was noted to have the 'I am Clean' stickers in place showing last date of cleaning.
- Staff wiped the examining couches with cleaning wipes and fresh paper towels were replaced between each patient.
- Appropriate arrangements were in place for disposing of clinical waste in outpatient clinics and the diagnostic imaging departments, using the yellow clinical waste bags and sharps boxes. The sharps boxes were assembled correctly and the date of assembly clearly marked in line with trust policy.
- Staff had access to infection prevention and control (IPC) advice from the link IPC nurse and there was an up to date IPC policy available for staff to reference on the trust intranet.
- We saw evidence from a cleanliness inspection report from April 2017 that showed an overall compliance rating of 96.9%, 96.3% and 98.6% for Alpha X-ray, Beta X-ray and ultrasound respectively.
- We reviewed cleaning records in interventional radiology and these were complete and up to date.
- We saw ultrasound probe cleaning records that were up to date and signed.
- We checked the disposable curtains in the bed waiting area and found them to be within recommended renewal date.
- Staff adhered to the 'bare below the elbows' policy, used the available personal protection equipment (gloves and aprons) when appropriate and washed their hands between patients. We did observe one doctor who failed to wash their hands after examining a patient, although they did do this at the end of the consultation.
- Alcohol hand foam dispensers were easily accessible and we saw staff and visitors to the departments using them.
- A hand hygiene audit that showed that 96.1% of staff in radiology were compliant in April 2017.
- Outpatient annual IPC audits performed in February and March 2017 showed an improvement on the previous year with a score of 89% versus the previous 81% for CGH, and 81% versus 79% for ECH with one of the main improvements reported as hand hygiene 100%. We did not see further audit evidence to support this. Environmental issues were the greatest worry with

torn coverings on examination couches, fabric backed chairs and rusty pipes. Recommendations were made however we saw no action plans in place to address these.
- There was a process in place for monthly outpatient hand washing audits to take place, however we requested data over a 12 month period but were supplied with only two months for CGH and ECH. Therefore we could not be assured that these were occurring on a monthly basis. Data provided was for April and June and showed 98% in June but no compliance figures for April
- Monthly cleaning audit data showed that the outpatient departments scored between 85% and 100% between August 2016 and April 2017 apart from one occasion in March 2017 when ECH dropped to 80%.
- Two couches in main CGH outpatients had small rips in the wipe clean surface which represented an infection control risk. This had been reported by the outpatient senior nurse and we saw evidence of this dated 2 May 2017 with a request for renewal.
- Chairs in the waiting room of the Gainsborough outpatient waiting area had fabric backs which meant that they could not be easily wiped clean and could represent an infection risk.
- The ear nose and throat outpatient department at ECH did not use best practice (as directed by the Health Technical Memorandum 01-06: Decontamination of flexible endoscopes), for the washing of nasoendoscopes due to their endoscope washer/ disinfector being out of order for approximately 12 months. The trust mitigated this by using a recognised three wipe decontamination system for non-lumened medical devices.
- There was no specific policy for isolating patients who were an infection risk in either outpatient clinics or diagnostic imaging. However, staff confirmed that as soon as information was available regarding a possible risk, patients were booked to the end of a clinic to minimise contact with others. Upon the patient's departure, the equipment and environment were deep cleaned. We saw this process happen during the inspection, with cleaning staff available to clean the interventional room as soon as the patient had been returned to the ward.

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- We saw environmental decontamination records in nuclear medicine, which were appropriately completed and up to date. Nuclear medicine departments routinely monitored the workplace to ensure that no unsealed radioactive sources had contaminated the area.

Environment and equipment

- The main CGH outpatient waiting area was bright and spacious and had plenty of seating and there were electronic patient self-check in kiosks and a staffed reception desk with a separate reception desk for patients arriving by hospital transport.
- The main outpatient department had recently been refurbished and was set up on a colour coded grid system with 20 clinic rooms, all with separate numbered examining rooms containing couches and waiting areas outside.
- There was an electronic screen in the main outpatient waiting area which displayed patient names to inform them which onward waiting area to move to when their appointment time was nearing, and easy to follow colour coded directional lines on the floor leading to colour coded clinic areas.
- A whiteboard in the main outpatient waiting area displayed waiting times during clinics to ensure that patients were kept informed of clinic delays.
- At CGH outpatients, the resuscitation equipment was easily accessible, stored in a security tagged trolleys in the outpatient corridors. The trolley checklists were consistently signed to indicate they had been checked daily and we saw records dating back to June 2016 with no missing entries.
- We spot checked a range of equipment (15 items at CGH and five at ECH) including scales, blood pressure monitors and cardiology/respiratory monitory equipment for maintenance and electrical testing and saw that these were all in date.
- The medication fridges were located in a clinical room and the temperatures of the room and the refrigerators were checked daily to indicate that the temperature was suitable for the safe storage of medications. We saw that this had been consistently recorded daily dating back to January 2017. However the hi/low temperature range was not recorded so staff could not be assured that the temperature had not been out of range during a 24 hour period.
- The ECH main outpatient waiting area contained a manned reception desk, was light and spacious and

provided plenty of seating, however there was no information on clinic waiting/delay times and staff had to call patients to smaller waiting areas for the clinics. The smaller waiting areas were cramped and staff indicated that when it was busy people had to stand as there was not enough room for extra seating.
- The ECH outpatient resuscitation trolley located in ophthalmology, main outpatients and nuclear medicine conformed to trust policy, and attached records indicated that they had been consistently checked daily since April 2017 although there were four days in April when checks were missed in the main outpatients.
- The trust supplied information of planned preventative maintenance (PPM) for outpatient and cardiac/ respiratory equipment across the three outpatient sites. The list showed that as of 8 June 2017 there were 88 pieces of equipment due or overdue PPM out of a total of 324 items (24%) with one of them indicated as a high risk. There was a rolling programme of maintenance checks to bring this up to 100%.
- X-ray equipment was regularly serviced by the manufacturer's engineers and was in date. We saw evidence of the manufacturers completed service reports. We also saw evidence of routine surveys of X-ray equipment.
- The radiology risk register had several entries relating to equipment considered to be beyond 'end of life' however radiology management told us that they did not feel that the aging equipment had not resulted in increased downtime and had not impacted on the service to patients.
- We saw the radiation protection advisor's report for 2016 that stated that both the X-ray units in interventional radiology and the cardiac catheter laboratory were in need of replacement. The report also stated that the manufacturer had indicated that the units were no longer supported and that replacement parts may be difficult to obtain. Poor image quality was also mentioned as a regular complaint from the interventional radiologists. Staff told us that plans were underway to build a new department with interventional radiology and the cardiac catheter laboratory co-located with a completion date of June 2018. Senior radiology staff told us that, if the imaging equipment became unusable before the new department was built, a contingency plan was in place for procedures to be performed in the hybrid theatre or at a nearby trust.

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- Staff in the ultrasound department told us that the ultrasound machines were often not fit for purpose as they did not always provide adequate image quality. However, they also told us that the trust had recently ordered five new machines that will address these concerns.

- The nuclear medicine scanner was also considered to be 'beyond the end of life' and staff commented that they frequently had to call engineers although replacement parts were no longer available, and were just trying to keep the equipment going until the move to the new location with new equipment.

- We saw up to date Quality Assurance (QA) records for all imaging equipment within the trust. The QA records highlighted to staff when measurements were not as they should be. We saw a clear process in place for retesting and/or taking equipment out of use where QA measurements show a problem.

- We saw evidence that the screening of lead aprons (personal protective equipment used during some radiology procedures) was performed on an annual basis; these records were complete and up to date.

- We checked the resuscitation trolleys in Beta X-ray, radiotherapy, and cardiac catheter laboratory and found records were complete and up to date.

- There was no recovery area for interventional radiology patients to go to post procedure. Staff told us that these patients had a bed allocated on one of the wards to recover after their procedure but that there had been occasions where the bed had been given to another patient. This had resulted in delays to the procedure list, as the patient was then recovered in the interventional room meaning that another case could not be started. Staff told us that they no longer started procedures unless a bed was guaranteed. This issue will be addressed when the new department is built, as there will be a dedicated recovery area for patients who have undergone an interventional procedure.

- Staff in Beta X-ray told us that the doors to the X-ray rooms were old and difficult to close properly. This meant that the doors could remain partially open during a procedure, potentially exposing people in the area to ionising radiation, although the risks associated with this are small. We did not see any evidence that this matter had had a risk assessment or was being addressed. This issue was also not included on the risk register.

- Staff in ultrasound told us they were worried about not having a phone in the scan rooms so it would be difficult to call for assistance if a patient deteriorated.

- The nuclear medicine department at ECH ensured safe storage and decay of radioactive waste products in the appropriate lead lined bins whilst awaiting safe removal by an external company.

Medicines

- No controlled medication was stored in any outpatient departments. Small supplies of regularly prescribed medicines were stored in locked cupboards and locked fridges where applicable. We checked a range (15 items) of medicines and injectable drugs, and found them to be in date and appropriately stored.

- We checked the controlled drugs cupboard and other medication in radiotherapy, cardiac catheter laboratory and CT including contrast stored in warming cabinets used in diagnostic imaging. All drugs checked were stored appropriately and found to be in date. We also found that records were accurate and up to date.

- If a medication was needed, the clinic nurse ensured that it was prescribed and brought the prescription to the senior nurse on duty in that area, who held the drug cupboard keys, and the medication was dispensed.

- In outpatients, external (FP10s) and internal prescription sheets were securely stored in clinic specific packs in the clinical room. At the start of a clinic, the clinic nurse signed out the individual packs and the numbered prescriptions within, and signed them back in at the end of the clinic. This ensured that there was good oversight of the number and location of prescriptions in the department.

- The ophthalmology outpatients did have one senior nurse who was able to prescribe and there were patient group directives (PGDs) for regularly used eye drops. PGDs provide a legal framework which allows some registered health professionals to supply and/or administer specified medicines, such as painkillers, to a predefined group of patients without them having to see a doctor.

- We saw some examples of PGDs for radiographers to administer saline and a smooth muscle relaxant. These documents allow radiographers to give patients contrast agents and a very limited number of drugs without an individual prescription from a doctor. We did not see a PGD for giving contrast for computerised tomography (CT) examinations, which is unusual, as

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radiographers in this area routinely administer contrast for many CT examinations. The Faculty of Clinical Radiology Standards for Intravascular Contrast Agents (Third edition 2015) state that "a formal record for the decision to inject contrast should be made before administration and that how this will be achieved depends on local circumstances and pathways of care". PGDs are mentioned as one of the options available to ensure that contrast is administered appropriately.

Records

- Paper patient records were used within the outpatient department as the trust had not yet switched to the planned electronic records system.
- Patient records were transported in sealed blue crates to and from clinics. Records were stored in locked rooms and not accessible to the public which protected patient confidentiality.
- Staff commented that notes were not always available for clinics but that a temporary set was usually supplied by the records department. Between April 2016 and March 2017 the trust reported 0.6% of patients were seen in outpatients without their full medical record being available. The trust reported that they mitigated this by trying to locate the files and if not available, all other correspondence was provided. The consultant made the decision to proceed if no documentation except the referral letter was provided.
- Staff reported that it was rare that a patient was cancelled or not seen due to the unavailability of records.
- We reviewed 11 sets of patient medical notes in outpatients and 4 cardiac pacing notes. The condition of patient notes varied, with patient records not securely attached within the green notes folders, muddled specialities, inpatient records not appropriately filed and generally untidy.
- Written notes were mostly legible, dated and signed and contained pertinent patient identifying information. Alert stickers highlighting allergies were visible on the relevant records and details contained within the inside cover of the notes.
- Clinic nursing staff commented that they did not have time to reorganise notes prior to clinics but did try to place a marker for the current clinic to make it easier for the clinician to find the right place in the notes. The cardiac pacing notes were kept in the cardiac/respiratory department and were of a good standard.

- Staff reported that medical staff often remarked that they found it difficult to find what they were looking for in the notes which added to the consultation time and overrunning of clinics. During the inspection a consultant requested we look at two sets of patient notes which were in a very poor state.
- The records department manager confirmed that there were difficulties in maintaining the paper notes. The trust had been due to move to an electronic notes system prior to the inspection but the medical records manager explained that this had been delayed due to concerns from clinicians regarding the training required to access notes and the availability of information.
- The Trust used a radiology information system (RIS) and picture archiving and communication system (PACS). This meant patients radiological images and records were stored securely and access was password protected.
- The RIS and PACS systems interfaced well with one another and there was rapid access to stored data.
- Radiology senior staff told us that the trust had contracted two external reporting companies to assist with the reporting of examinations out of hours.
- We reviewed five patient records on RIS and saw that the radiographers had completed them accurately, including the documentation of which staff member had checked patient identification.
- The radiotherapy department included a photo of each patient within their individual records. This photo was used during the identification process and this provided staff with assurance that the correct patient was given the correct treatment.

Safeguarding

- There were three levels of adult/children safeguarding training; level one for non-clinical staff, level two for all clinical staff and level three for staff working directly with children and young people. The trust set a target of 95% for completion of safeguarding training. The safeguarding training was comprised of Child Protection Levels 1, land 2, Recognising and Safeguarding Adults at Risk Levels 1 and 2 and Safeguarding of Vulnerable Adults Level 1 and 2. Data provided by the trust for April 2017 showed that outpatient medical staff did not achieve the 95% compliance target for any of the safeguarding training, achieving between 82% and 84%.
- Nursing staff in the outpatient departments achieved the 95% target for all but three of their safeguarding

training. Safeguarding Children Core level 3, and Safeguarding Looked after Children showed 85.7% compliance and Safeguarding Children Update level 3 had the lowest compliance rate at 81%. These were additional to the courses required by the medical staff.

- All diagnostic imaging staff we spoke to had completed level 2 safeguarding training. However, some staff members for whom level 3 training would have been appropriate told us that they had not been able to access that training because spaces were not available despite the staff members trying to access the training on several occasions.
- Staff we spoke with were aware of their safeguarding responsibilities and described their actions in the event of a safeguarding concern.
- All staff we spoke with, knew who the safeguarding lead for the trust and where to seek advice if required and there were safeguarding link staff.
- There was a safeguarding lead for radiology. We were told there was also a file kept in radiology for staff to access which contained information on safeguarding.
- We saw a protocol in the ultrasound department for sonographers who scan patients found to have undergone female genital mutilation (FGM). This information was included as part of the staff training.

Mandatory training

- The trust mandatory training encompassed a wide range of subjects, 24 for nursing and midwifery staff and 19 for medical and dental staff. Not all staff were required to complete all mandatory training modules, this was dependent on their role. The training modules included but were not limited to basic life support, conflict resolution, sepsis, record keeping, dementia awareness, information governance and incident reporting.
- The trust target for completion of mandatory training was 95%. The CGH outpatient nursing staff achieved over 95% for 10 subjects, between 79% and 93% for 11 subjects and between 50% and 59% for three subjects including adult advanced life support.
- The medical staff did not meet the 95% target in any subject, with adult basic life support being the lowest at 50% and dementia level 1 and diversity awareness being the highest at 89%.
- Ophthalmology staff at ECH reported that it was sometimes difficult for them to access face to face

training due to the need to cover clinics and ensure an appropriate skill mix. Staff at both locations we visited said that they could access e-learning at home and were given time back if they did this.

- Senior nursing staff confirmed that they monitored training on a monthly basis and received notification when a staff member required an update. Staff also received an 'update due' e-mail.
- We saw evidence that 83% and 96% of radiologists and radiographers respectively were up-to-date with mandatory training. A small number of staff told us their basic life support (BLS) training was out of date, however these staff members had completed intermediate life support training, which includes BLS.
- Several radiographers told us that they had received emails whenever any mandatory training was due for renewal. Staff told us that they could also access their personal mandatory training records and see when training needed to be done.

Assessing and responding to patient risk

- The trust had a process for reviewing the patients waiting on the waiting list. However each speciality had their own escalation procedures. There were weekly meetings at various levels which included clinicians to prioritise patients who were waiting on the list. This was raised at the previous inspection, action had been taken and systems were in place to mitigate the risk of harm to patients but the backlog of patients waiting for their first and follow up appointments included over 13,000 patients. .
- In June 2017 there were 12,194 patients awaiting their initial appointment in the outpatient department and 817 patients awaiting follow up appointments. The trust monitored these patients on a weekly basis through the clinical reference group.
- The trust had identified an issue with the electronic system which meant that in some instances, once a patient had been discharged, the referral was not recorded as being closed. This depended on whether the referral was closed at the front or rear end of the electronic process. If it was closed at the front end the referral did not appear to be closed. This required manual checking. Senior staff acknowledged that there were issues in the booking service that needed rectifying and there were new managers in post to

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address this. The booking and reception staff were being trained to correctly close referrals and work was ongoing to check each individual open referral to identify those that should have been closed.

- Staff performed observations of patients, such as blood pressure, pulse and respirations as required. Nursing staff were trained to perform blood glucose monitoring if indicated.

- There was no specific protocol regarding deteriorating patients in outpatients or diagnostic imaging, however staff reported that patients who became unwell in the clinic areas were taken to the accident and emergency department for assessment or were admitted under the consulting doctor by contacting the bed site manager.

- We saw evidence that the radiographers checked and documented patient pregnancy status in line with departmental protocol.

- Colchester Hospital University NHS Foundation Trust was supported by an 'in-house' radiation protection service. They provided the radiation protection advisor (RPA), radiation waste advisor (RWA), medical physics expert (MPE), for diagnostic imaging, nuclear medicine, and provided support for laser use within diagnostics throughout the trust.

- There were radiation protection supervisors (RPS) for each controlled radiation area which met the Ionising Radiation Regulations 1999.

- In radiotherapy, we saw a separate waiting area for in-patients directly opposite the nurse's station. Staff told us, and we saw evidence, that the patient call bells in this area were tested on a daily basis.

- We saw evidence of recent dose audits for both adult and paediatric examinations in radiology and nuclear medicine. We also saw the on-going programme for dose audits within the trust. The radiology dose surveys showed that trust doses are lower than the national diagnostic reference levels and demonstrated that staff had undertaken work to optimise exposures. Nuclear medicine dose audits showed that doses were in line with those recommended in national guidance.

- There was CCTV in the Alpha X-ray waiting area; this was used to ensure staff safety when working alone out of hours. It was also used also for patient supervision and allowed radiographers to see when patients were waiting for x-rays.

- We reviewed a draft flowchart for the prioritisation of any in-patients needing an interventional procedure. The flowchart included situations where the patient was

fit for discharge and could have the procedure as an outpatient. These patients were discharged with an appointment to have their procedure within three days of discharge.

- Staff in computerised tomography (CT) told us that there was no system in place to allow radiology staff to prioritise patients based on need, and no system for doctors to 'flag' patients who were clinical priorities.

- World Health Organisation (WHO) Surgical Safety Checklist and five steps to safer surgery checklists were used in the cardiac catheter laboratory and interventional radiology. The WHO surgical safety checklist is a set of checks, identified for improving patient safety during surgery and interventional radiology procedures. We saw an audit for the use of these forms in interventional radiology that showed that 99.3% of procedures performed in January-May 2017 had a fully completed checklist.

Nursing staffing

- There was a dedicated team of outpatient nurses, receptionists and support workers working in the outpatient departments. The outpatient clinics were staffed by registered nurses and health care assistants.

- The trust reported their staffing numbers across the outpatient departments as of April 2017 as whole time equivalent (WTE) establishment of 74.9, with 66.2 WTE in post. This equated to 28.4 WTE trained nurses and 46.3 WTE unqualified staff. The vacancy rate was 12.3%.

- The number of staff required in the outpatient departments changed from day to day dependent on the number of clinics running that day. The outpatient senior nurses told us that nursing staff were flexible to ensure they provided cover for each clinic and department. Senior staff could adjust the number and skill mix of nursing staff covering clinics to help those that were busy or where patients had greater needs.

- A red dot system was used on the off duty to indicate a clinic which was likely to overrun indicating a late finish so that staff were aware in advance.

- Staffing rotas were posted six weeks in advance and we saw that they aligned to service need.

- The outpatient departments did not use any agency staff, but did use bank staff to fill shifts. Between January and July 2017 CGH filled 379 shifts with bank staff, ECH filled 57 shifts and Clacton Hospital filled 10 shifts.

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- Senior staff confirmed that bank staff were usually regular staff who had worked in the outpatient departments and they also participated in a scheme where a bank nurse committed to work in the outpatient department for a period of six months and had the opportunity to join the department on a permanent basis.
- Clinical nurse specialists led their own clinics and supported medical colleagues in a variety of clinics throughout the outpatient departments.
- Staff in interventional radiology told us that until recently there had been difficulties recruiting nursing staff to work in interventional radiology. This had resulted in the nurses being on-call every other night. However, there had been recent successful recruitment with two posts appointed to.

Allied health professional staffing

- Staff in ultrasound told us that there were 3.8 WTE vacancies, although one sonographer had been appointed and was due to start in October.
- There was a specialist consultant radiographer in the breast imaging department.
- The cardiac and respiratory unit was staffed with medical physiologists. There were three existing vacancies out of 11 staff which was due to increase to five vacancies with staff leaving in the near future. Two posts had already been recruited to, but the manager indicated that recruitment was difficult due to the lack of training nationally for physiologists and that they often had to recruit from abroad.

Medical staffing

- Medical staffing was provided by the relevant clinical specialty running the clinics in the outpatient department.
- Medical staff were of mixed grades, ranging from consultants to junior doctors. There was always a consultant to oversee the clinics and provide support to junior doctors.
- The trust reported their medical staffing numbers for outpatients as of April 2017 was a WTE establishment of 22.63 with 17.73 WTE in post. The vacancy rate was 22%, with a turnover rate of 28%. However this may not be truly representative as each speciality staffed its own outpatient clinics and medical staffing figures for each speciality were not included in outpatient medical staffing data provided.

- Between April 2016 and March 2017, the trust reported a bank and locum medical staff usage rate of 10% in outpatients departments to cover staffing gaps. When there were gaps in medical staffing that could not be covered by locums, the clinics were cancelled.
- Radiology management told us that at the time of the inspection there were six radiologist posts vacant. We were also told that interviews were to be held soon after the inspection however, it was unlikely that all vacancies would be filled due to a national shortage of radiologists. We were also told that radiology management had tried to recruit additional interventional radiologists on several occasions but no suitable candidates had applied.

Major incident awareness and training

- The trust major incident plan covered major incidents such as large scale trauma, winter pressures, fire safety, loss of electricity, loss of frontline system for patient information, loss of information technology systems and internet access, loss of staffing, and loss of water supply.
- Staff were aware of the major incident policy found on the trust intranet although there had been no recent major incident practical assessments.
- Staff felt comfortable that they knew what to do in an emergency situation and staff told us that a recent fire alarm at the Colchester General Hospital outpatients department was enacted in a calm manner.
- There were business continuity plans in place to ensure that the delivery of services were maintained in the event of major incident. Staff we spoke to did have a good understanding and could describe the action to cancel all appointments that day and that the outpatients would act as the overflow for the emergency department and to treat minor injuries.
- Radiology management told us that during the recent national cyber-attack the trust had been impacted, including the radiology services. However, within three hours, every area within radiology had at least one room working. Senior staff told us that because of the attack the business continuity plan had been reviewed following lessons learnt.
- There was a major incident folder in Alpha X-ray as well as a box that contained documentation to be used in the event of a major incident.

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- All diagnostic imaging staff had signed a sheet confirming they understood the major incident procedure. We also saw a major incident plan displayed on the wall in Alpha X-ray.

Are outpatient and diagnostic imaging services effective?

We regulate this service but we do not currently have a legal duty to rate the effectiveness of this service for outpatients and diagnostic imaging. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

- Radiology and the cardiac/respiratory physiology departments regularly audited practice to ensure consistency and improvement.
- Staff in radiology were supported to develop with radiographers supported to learn reporting skills and a new radiographer consultant post in breast imaging.
- Staff received appraisals and the overall outpatient nursing figure was above 95% with radiographers at 94%.
- Guidelines, such as the National Institute for Health and Care Excellence (NICE) guidelines were available for reference and followed where appropriate.
- The trust had a range of systems for reminding patients about appointments including telephone calls, text messages and letters.
- There was effective multidisciplinary team working.

However:

- The trust outpatient departments did not participate in any national audits or any Improving Quality in Physiological Services accreditation schemes although the diagnostic radiology department was working towards Imaging Services Accreditation Scheme achievement.

Evidence-based care and treatment

- Staff reported that guidelines, such as the National Institute for Health and Care Excellence (NICE) Guidelines were followed where appropriate and that they worked in line with NICE guidance and local policies and protocols.
- Relevant clinical guidelines, technology appraisals, interventional procedures, quality standards and diagnostic guidelines that are published by NICE, were noted in the directorate performance report. There were treatment protocols and proformas available for staff reference on the trust intranet.
- Staff in cardiology and respiratory performed an audit of echocardiograms monthly, involving eight randomly picked scans to ensure consistency of reporting.
- The breast imaging department introduced a 'high risk' clinic run for women with a higher risk of breast cancer to discuss the diagnostic tests required. Staff were planning an audit to assess the improvement in uptake of more invasive diagnostic tests such as MRI.
- Staff told us that all paediatric protocols had been reviewed in liaison with a paediatric radiologist. The paediatric link radiographer had spent time at a specialist centre and had brought back some practice to improve the service offered at the trust.
- There was a recently updated (February 2017) patient access policy which denoted actions for staff to follow when booking or updating patient outcomes.
- The trust had established a combination of local and national diagnostic reference levels (DRLs) within radiology. We saw evidence that the DRLs for interventional procedures were significantly lower than the national average. We saw DRLs displayed in all areas visited. DRLs are typical doses for examinations commonly performed in Radiology departments. They are set at a level so that roughly 75% of examinations will be lower than the relevant DRL. They are not designed to be directly compared to individual doses however, they can be used as a signpost to indicate to staff when equipment is not operating correctly.
- NICE guidelines set out how quickly imaging should be performed for patients who are suspected of having had a stroke. The urgency of having a scan is dependent on patient symptoms. We saw data from August 2016 to March 2017 which showed that 56% of suspected stroke patients received brain imaging within an hour.
- The trust used to have access to i-refer (a guidance tool written by the Royal College of Radiologists) via the trust intranet, to guide referrers. However, since the update of these referral criteria, the free access given to NHS providers no longer works which is a problem affecting the whole country.

Nutrition and Hydration

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- The trust provided water fountains for patients' use and there was a shop and a hospital café where people could purchase drinks, snacks, and meals.
- Patients who attended clinics on trolleys and were waiting for transport were offered snack boxes and hot drinks.

Pain relief

- The trust pain management service was operated in the community and was not inspected.
- We observed pain relief being administered to a patient in pain following a procedure in the outpatient department.

Patient outcomes

- There were no specific patient reported outcome measures data collected for the outpatients service, however each speciality collected their own clinical data for monitoring and national benchmarking.
- Between September 2016 and June 2017, the new to follow-up ratio for the trust was the same as or better than the England average of 1.8.
- The trust outpatient departments did not participate in any national audits or any Improving Quality in Physiological Services (IQIPS) accreditation schemes.
- Waiting times within the clinic were monitored and there was a plan to have individual waiting times displayed on the patient self-check in kiosks.
- The trust was working towards achieving Imaging Services Accreditation Scheme (ISAS) accreditation. The Royal College of Radiologists and the College of Radiographers developed ISAS to support diagnostic imaging services to manage the quality of their services and make continuous improvements; ensuring that their patients consistently receive high quality services delivered by competent staff working in safe environments. Radiology management told us they had submitted a business case for a project lead to take responsibility for the ISAS accreditation process.
- The radiotherapy services had International Organisation for Standardisation (ISO) accreditation. ISO is an international standard that provides the requirements for a quality management system, which is a framework for an organisation to control its processes in order to meet patient, statutory and regulatory requirements applicable to radiotherapy departments.

Competent staff

- Outpatient nursing staff appraisal rate was 95%, the cardiac and respiratory physiology staff and ophthalmology nursing staff was 100%. There was a cascade system in place in ophthalmology, with senior staff appraising the junior staff that they supervised.
- Staff we spoke with told us they had received appraisals. Managers discussed training needs at annual appraisals and nursing staff told us opportunities to develop and receive trust support was available. For example specialist nurses were supported to re-evaluate their roles and job descriptions and access appropriate training.
- We observed a range of specialist nurses including ophthalmology, oncology, orthopaedics, tissue viability, breast care and breast imaging working within the outpatients and diagnostic imaging departments providing nurse-led clinics alongside medical colleagues and sharing knowledge with other staff.
- Diagnostic imaging staff confirmed they received specialist training and completed competencies for specialist roles.
- Staff completed trust and local induction specific to their roles. We saw completed documentation in staff files showing successful completion of local induction.
- We saw evidence in '2 at the top' meeting minutes regarding the completion of specialist training and the need to continue nurse teaching sessions. It also highlighted the sharing of learning for registered nurse revalidation and staff confirmed that this was monitored by the trust centrally.
- We saw evidence of role development for radiographers. Staff told us that there were a number of reporting radiographers undertaking musculoskeletal work. We were told that two radiographers were undergoing training to report upper gastrointestinal studies and there were plans to train radiographers to report proctograms. There was also an advanced practice radiographer within the radiotherapy department and a consultant radiographer within breast imaging at ECH.
- We heard that radiologists hold monthly discrepancy meetings to discuss radiology cases. Staff told us that the reporting radiographers audited 20% of each other's studies and each had a review with a radiologist every four months.

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- We saw radiology staff induction packs and equipment training records. These appeared comprehensive and were completed for both radiographers and radiologists. Radiology management told us that agency staff had a similar induction process as permanent staff.
- Staff told us and we saw evidence that radiology management were to make attendance at a 'red dot' course mandatory for all radiographers. Red dot systems are an alert system used by some radiology departments that allow radiographers to highlight abnormal findings to assist clinical staff in emergency departments.
- Radiology management told us they had introduced audit half days on a monthly basis. These days had been introduced as staff were struggling to undertake continuing professional development (CPD). We were told that the audit half days were held on days when either the surgery or medicine audit sessions were also held as these were days where there was reduced demand on radiology services, which ensured that more radiology staff were able to attend the training session.
- All staff we spoke to had had an appraisal and staff told us that the appraisals had been useful rather than just a 'tick-box' exercise. We saw evidence that 94% of radiographers had had an appraisal.
- Radiotherapy management told us that all staff who performed contrast computerised tomography (CT) scans had received intermediate life support training.

Multidisciplinary working

- Nursing staff and healthcare assistants we spoke with in outpatients clinics, such as ophthalmology, ear nose and throat (ENT) and orthopaedics, told us the teamwork and multidisciplinary working was effective and professional.
- One-stop clinics involving different disciplines of staff working together were available, for example fracture clinics were organised with input from physiotherapy and occupational therapy teams.
- Staff worked together to assess and plan on-going care and treatment in a timely way. This included when people were due to move between teams or services, including referral, discharge and transition. This was confirmed by a patient who felt that their consultant had managed their care very well, whilst liaising with another healthcare provider.

- Oncology teams worked closely with other specialities and ran joint clinics to enable patients to see both specialists at the same time supported by specialist nurses.
- The cardiac and respiratory physiologists worked closely with the medical specialists to ensure the appropriate investigations were performed at the right time.
- Radiologists supported all multi-disciplinary team meetings (MDTs) that required their input. Staff reported that radiologists operated a buddy system to ensure that there was always radiology representation at the MDTs.
- The breast imaging department employed a specialist nurse to support patients through the process of imaging and liaised with the mammoghraphers, radiologists and radiographers to ensure that patients were supported through the imaging process.

Seven-day services

- CGH outpatient clinics were available Monday to Friday between 8am to 6.30pm. Occasional evening clinics were scheduled according to need.
- The ophthalmology service operated Monday to Friday between 8am to 6.30pm. The service was flexible and also offered all day clinics on Saturdays and occasionally on Sundays dependent on clinical need.
- The diagnostic imaging service provided emergency cover 24/7 across computerised tomography (CT), ultrasound, interventional radiology as well as plain film imaging.
- CT ran extended days for booked appointments 8am to 8pm seven days a week. Radiology senior staff told us that additional lists were offered most weekends for ultrasound appointments;
- Radiotherapy offered appointments Monday to Friday from 8am to 5.45pm. There was also an on-call system in place for emergency palliative treatments.

Access to information

- At the time of inspection the trust was still using paper patient records although it was working towards full digitisation of records to ensure consistent availability of records across departments, and reduction in incidents where records were unavailable, misplaced, or damaged.

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- There was electronic access to last appointment letters, pathology and histology results as well as diagnostic imaging records.

- The trust had recently committed to improving the number of electronic GP referrals rather than using paper referrals. At the time of inspection the electronic referral rate varied between 9% and 19%.

- The Trust used a radiology information system (RIS) and picture archiving and communication system (PACS). This meant patient's radiological images and records were stored securely and access was password protected.

- We were told that all examinations performed within radiology receive a report by a radiologist or an appropriately trained radiographer, with the exception of images for patients from the fracture clinic.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were aware of their duties and responsibilities in relation to patients who lacked mental capacity; they demonstrated a knowledge and understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

- We observed patients giving verbal consent in the outpatient clinics for dressings and examinations.

- We saw that there was a policy and protocols in place for obtaining consent before medical treatment was given.

- We observed a patient consultation in the outpatient department and the clinician gave comprehensive explanations prior to consent. The nurse checked the patients understanding.

- Staff reported they had received training in MCA and DoLS. The trust reported that as of April 2017 MCA level 1 training had been completed by 89% of staff within Outpatients. MCA training levels 2 and 3 were both below the trust completion target of 95% with 89% and 88% completion rates.

- DoLS Level 1 training was completed by 87% of staff in within Outpatients. DoLS levels 2 and 3 training were both below the trust completion target of 95%, with 89% and 81% completion rates.

- We saw evidence of a recent complaint where a perceived lack of formal written consent was highlighted as a potential concern. We discussed this incident with staff and it was clear that the correct local

process for consent was followed however, the complaint investigation had shown that there was no documented process for when formal written consent should be obtained. Staff told us that a process would be put in place.

- Staff in radiotherapy told us that they have a confirmation of consent process for all patients attending for a planning CT scan and prior to first treatment session. This process ensures that patients have consented for radiotherapy treatment. It also provides an opportunity for patients to ask any questions that may have occurred to them after they had consented or discuss any issues about the treatment process.

Are outpatient and diagnostic imaging services caring?

Good ●

We rated caring as good because:

- Staff treated patients with dignity and respect and were polite and friendly.

- Patients we spoke to were very complimentary about the care they received in the outpatient and diagnostic imaging departments.

- Patients told us that they were involved in the decisions made about their care and were given enough information to make their decisions.

- Clinical nurse specialists supported patients in clinic especially if there was bad news to impart, and we heard them being supportive and compassionate.

However;

- In Beta X-ray patients in hospital gowns were waiting in the same area as other patients. We could not see whether dressing gowns were provided for patients and the curtains in cubicle areas did not fully close which was a patient dignity concern

Compassionate care

- We observed eight patient outpatient consultations with doctors, nurses and cardiology/respiratory staff, and also observed nurses and receptionists welcoming patients. Staff introduced themselves and their role, and were polite and friendly.

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- Staff treated patients with dignity and respect knocking on doors prior to entering consulting or changing rooms and ensuring that curtains were drawn to protect patient's privacy.
- Nurse chaperones were available at Colchester General Hospital and there were posters in the consulting rooms reminding patients that they were available. We did not see any chaperone posters at Essex County Hospital.
- Staff were aware that patients had differing cultural, social and religious needs and were able to explain what that meant for their care such as different faiths needing appropriate places to worship and having differing dietary needs.
- One patient was so impressed with their care that they specifically waited after their appointment to talk with us saying that "the service is absolutely amazing, we get answers the same day to e-mail contacts, we always get copies of letters and they liaised with another hospital to make sure that all the doctors are on the same page"
- Staff did their best to make patients and their relatives feel at ease and were observed offering assistance to patients to using the electronic booking in system and directing them to other departments.
- Throughout our inspection we observed care being provided by nursing, medical and other clinical staff. We saw examples of staff being friendly, approachable and professional. For example, when people became lost staff would accompany people to the area in which they should be.
- When patients experienced physical pain, discomfort or emotional distress, staff responded in a compassionate, timely and appropriate way. For example, a patient told us that a member of staff had offered to hold their hand during a procedure.
- Patients we spoke to were very complimentary about the care they received in the outpatient and diagnostic imaging departments.
- Comments such as "can't fault them", "can't do enough", "my experience has been brilliant", "very efficient, always explain everything, don't usually have to wait and booking in system very quick, no problems".
- We saw cards and letters from patients displayed in the cardiac catheter laboratory recovery area praising the staff for the quality of the care the patients had received and the kindness of the staff.
- We were told of a radiology staff member who had delivered paperwork to a patient's home to enable them

to have an urgent blood test. They did this because the patient needed the results of the blood test a few days later as the patient had flights booked to visit a family member but could not travel until the results were known. We saw the letter from the patient where they described the staff member as 'an exceptional person'.

- The radiotherapy department contained a spacious, air-conditioned waiting area for patient's comfort. We saw facilities to ensure that patients that had been changed into gowns waited in separate areas to other patients. We also saw special gowns for patients attending for breast radiotherapy to avoid the need for these patients to be bare above the waist during their treatment and maintain their dignity.
- In Beta X-ray patients in hospital gowns were waiting in the same area as other patients, we could not see whether dressing gowns were provided for patients and the curtains in cubicle areas did not fully close which was a patient dignity concern. Staff told us that some patients were advised to bring their own dressing gown for their appointment.

Understanding and involvement of patients and those close to them

- Over the six month period December 2016 to May 2017, the trust outpatient departments averaged a Friends and Family Test recommendation rate of 97% compared to an England average of 93%, however, response rates for outpatients services were extremely low, with 2,150 responses out of a total eligible of 127,849 (trust rate of 2% over the period compared to an England average of 6%).
- Staff explained what was going to happen to patients and ensured that the patient and their carer or relative understood the information.
- Patients told us that they were involved in the decisions made about their care and were given enough information to make their decisions.
- We observed patients being taught how to manage their own dressings and being encouraged to participate in their own care.
- All of the patients we spoke with told us that their care was discussed with them in detail, and in a manner that they were able to understand. They said, if they had any queries regarding appointments, they would contact individual clinics or medical secretaries.

Emotional support

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- Patients we spoke to were complimentary about emotional support offered.
- Clinical nurse specialists supported patients in clinic especially if there was bad news to impart, and were heard being supportive and compassionate.
- We observed all staff talked kindly to patients and reassuring them during their consultations and procedures.
- Radiology management told us that the paediatric link radiographer had stayed 90 minutes beyond the end of their shift to support a distressed child who needed to have some X-rays taken. They spent this time with the child, building up a rapport, explaining what would happen and adjusted normal techniques to ensure that the examination was successful.

Are outpatient and diagnostic imaging services responsive?

Requires improvement ●

We rated responsive as requires improvement because:

- Referral to treatment times (RTT) were worse than the England average in all but one measurement (urgent two week referrals where they were better) and below the operational standards.
- There were 2,863 patients out of 12,194 patients who had waited 13 weeks and over for a first appointment. The number waiting had been below 1,500 for most of the year, April 2017 – May 2017, but had increased in the month prior to our inspection.
- There were significant medical staff shortages that contributed to long waits in the following specialities; ear, nose and throat, ophthalmology, neurology, trauma and orthopaedics and urology.
- The trust overall cancellation rate was around 25% for the period April 2016 to March 2017. However patient cancellations were high at around 14%. The hospital cancelled around 8% of clinics at short notice (less than 6 weeks notice).

However:

- Demand for the ophthalmology service had grown and in response, the specialist nurses undertook extended roles to include eye injections to free up consultant time to see patients and ensure a more efficient service.

- The trust had introduced a range of measures to improve compliance with their RTT targets including the training for booking staff, employing an RTT manager and regular monitoring via a monthly dashboard.
- As part of the new image reporting system, radiology management had purchased a number of reporting stations to allow radiologists to report from home to allow staff to work flexibly and ensure the trust provided a timely reporting service.
- A new proctogram service had been set up and run by a radiographer, which meant that patients could have their procedure locally, avoiding the need to travel into London.

Service planning and delivery to meet the needs of local people

- Weekly there were, on average, 1,790 outpatient clinics, held on the trust sites, of which 43.0% (approximately 770) were consultant led, 26.6% (approximately 475) were allied health professional (AHP) led and 30.4% (approximately 544) were nurse led.
- Car parking was available and there were public transport stops close by, and in the hospital grounds. The radiotherapy department had its own car park meaning that patients did not have far to walk to access the department.
- Departments were generally well signposted at Colchester General Hospital (CGH) but the nuclear medicine department was located at ECH in a separate building which was not easy to locate.
- The trust was in the process of building works which will house reconfigured radiology services and breast imaging and there were plans to relocate the ophthalmology service to a building near to CGH.
- Information about the needs of the local population was used to inform how services were planned and delivered. Demand for the ophthalmology service had grown and in response, the specialist nurses undertook extended roles to include eye injections to free up consultant time to see patients and ensure a more efficient service. They were also focussing on the patient pathway to ensure that when they move to the new location, the pathway was planned in the most effective way.
- Several services offered a patient and health professional advice telephone service. Some used an answerphone and called patients back and others had a dedicated nurse to answer calls between specific times.

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- Outpatient senior staff planned for the days and weeks ahead, they discussed each specialty and the clinics taking place and staffing requirements for each clinic.
- Radiology had extended working hours, to include weekends for some examinations to meet the demand for imaging services. For instance computerised tomography (CT) ran extended days from 8am to 8pm seven days a week.
- Staff in ultrasound told us that they offered booked appointment lists most weekends to meet demand; however this was dependent on being able to find staff to run the lists.
- Staff told us of a proctogram service that had been started recently. This service had been set up and run by a radiographer, with radiologist support. This service meant that patients could have their procedure locally, avoiding the need to travel into London.
- Radiology management told us that the picture archiving and communication system (PACS) at trust was due to change at the end of the year. They told us that they took into consideration the systems used by surrounding trusts to ensure that the system purchased by the trust would be able to link up with others, ensuring that patient images could be easily shared with other trusts, when appropriate.
- As part of the new PACS, radiology management told us they had purchased a number of reporting stations to allow radiologists to report from home. They told us that they hoped this would allow staff to work flexibly and ensure the trust provided a timely reporting service.
- Radiology management told us they had out-sourced some of the radiology reporting in order to ensure that examinations received a timely report.
- Radiology management told us that they had introduced a system whereby endoscopy patients also had a CT on the same day if appropriate. These patients also left the department with an MRI appointment if that examination was also required.
- Staff reported that the Did Not Attend (DNA) rate for GP patients referred for an ultrasound scan was very high. In order to address this, radiology management told us that they were working with GPs to ensure that GPs did not refer patients to multiple providers and that the examinations were appropriate.
- Senior staff in diagnostic imaging told us that there were very few examinations waiting longer than 14 days to be reported and that systems were in place to monitor on a daily basis the time taken to report each examination,

and to ensure that urgent and high-risk examinations were reported as a priority. We saw evidence that at the end of July 2017, only 52 examinations had waited longer than 14 days to be reported.

Access and flow

- Patients attending the CGH outpatients department booked in via self-service automated electronic kiosks but there were receptionists available if patients did not want to use the automated system, or had difficulties. Patients attended the reception desk to book in at Essex County Hospital (ECH).
- Following an appointment, patients took their outcome sheet to the reception desk. Follow up appointments of less than six weeks were booked directly (dependent on capacity) and appointments of longer than six weeks were added to a partial booking list, and sent out nearer the time.
- The trust had a centralised booking management service responsible for outpatient bookings but appointments were also made by reception staff and medical secretaries.
- We easily located the various imaging departments we visited. They were included on the hospital map and were well signposted.
- The trust provided a number of rapid access clinics including;- Rapid Assessment Chest Pain Clinic; Trans Ischemic Attack Clinics; Direct Access for Ophthalmology Emergency Referrals; Direct Access Glaucoma Clinics; Direct Access for Gastroscopy; Direct Access Haematuria Clinic; and Community Hospital Rapid Access Care of the Elderly Clinic.
- The trust were aware that referral to treatment times (RTT), and access to appointments was an area that required significant improvement. The RTT is the measurement of maximum waits for treatment after being referred to a clinician. As part of the 'delivering great healthcare to every patient, every day' (EPED) there was a dedicated work stream to focus on aspects such as waiting time for first appointments/booking slot utilisation and DNA frequency. The work stream used a 'red to green' dashboard to monitor the key performance indicators.
- Between April 2016 and March 2017 the trust's RTT for non-admitted pathways was worse than the England average overall performance. The performance from December 2016 to March 2017 deteriorated, with March 2017 seeing the worst performance over the 12 month

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period at 82% compared to an England average of 92%. This was the opposite of the England average which saw a slight improvement in performance from December 2016 to March 2017. In 2016, RTT for non-admitted gynaecological patients was 96%. Between January to June 2017 the RTT non-admitted was 94% This was against the England average of 94%.

- Between April 2016 and March 2017 the trust's referral to treatment time (RTT) for incomplete pathways was consistently worse than the England overall performance and below the operational standard of 92%. An incomplete pathway for RTT occurs when a patient has been referred but has not yet started treatment.The rate was lowest in September 2016 at 85%, with an overall average of 86.6% compared to the England average of 92% and was between 5% and 10% lower than other local comparable trusts. Gynaecology services were above the England average of 91% and higher than the target of 92% for incomplete pathways RTT at 95%.

- Between April 2016 and November 2016 the percentage of patients waiting more than six weeks to see a clinician was higher (worse) than the England average; however from October 2016 performance improved. From December 2016 until March 2017 performance was lower than the England average.

- The gynaecology outpatient department showed 777 women waiting for appointments as well as 280 overdue women with partial bookings and one woman with no due date. The percentage of women within the maximum waiting time of 2 weeks from urgent GP referral to first outpatient appointment for all urgent cancer referrals was 94%, exceeding the trust target of 93% between April 2016 and March 2017.

- There were 2,863 patients out of 12,194 patients who had waited 13 weeks and over for a first appointment. The number waiting had been below 1,500 for most of the year April 2017 – May 2017 but had increased in the month prior to our inspection. The specialities with the greatest number of waiters were; ear, nose and throat, ophthalmology, neurology, trauma and orthopaedics and urology. The reason given was that most of these specialities had significant medical staffing vacancies.

- The trust performed below the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The trust has consistently performed worse than the England average in since July 2016.

- The trust performed below the 85% operational standard and the England average for patients receiving their first treatment within 62 days of an urgent GP referral. From October 2016 performance deteriorated.

- The trust had introduced a range of measures to improve compliance with their RTT targets. A new RTT manager had recently been employed to work with the outpatient team to manage RTT times and improve outpatient booking processes. The bookings staff were undergoing training to ensure that bookings were produced a weekly patient tracking list (PTL) which was circulated to speciality managers to inform them of the number of patients awaiting or overdue an appointment and there were weekly meetings with speciality leads to address PTL concerns.

- RTT status was included as a key performance indicator (KPI) on the trust level dashboard and there was oversight via EPED work stream.

- Between April 2016 and March 2017 the trust reported 16% of patients waited over 30 minutes to see a clinician. None of the patients we spoke to had waited more than 10 minutes for their appointment but we did observe staff informing patients of waiting times.

- Information supplied by the trust showed that between December 2016 and March 2017, 28.5% clinics started late. No reasons were given for the late starts and we were not assured that there was effective monitoring or oversight.

- The trust produced a Cancer Performance 100 day Wait Report in December 2016 which focused on concerns raised, regarding the number of patients on a cancer pathway that had waited more than 100 days, in response to a report produced by a local clinical commissioning group (CCG). Recommendations in the CCG report were addressed through the Cancer Improvement workbook and were monitored as part of the twice-weekly Cancer Red to Green meetings. The number of patients waiting over 100 days on a cancer pathway for diagnosis/treatment generally fluctuated between 15-30 patients.

- The trust data submitted regarding their RTT operational standard for people being seen within two weeks of an urgent GP referral showed that they performed above the 93% standard and since July 2016 the trust has also performed better than the England average.

- We saw evidence from April 2017 that 100%, 83.1%, 66.7% and 92.8% of cancer pathway patients requiring

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X-ray, CT, MRI and ultrasound examinations respectively, had their examination within 10 days of a request being made. Radiology management told us that the manager attended twice weekly meetings with the cancer leads to review patient waiting times. At the time of the inspection, radiology management told us that only seven patients had been waiting longer than two weeks from referral to scan and these were all due to patient choice.

- We saw data from July 2017 that showed that only 52 examinations requiring a radiology report were unreported after 14 days.

- Radiology no longer had a dedicated team of porters. Radiographers told us that this caused difficulties when planning CT lists as there was no certainty around when in-patients would be brought to the department and often resulted in multiple patients on beds waiting in the corridor outside CT. During the inspection we did see several ward patients waiting outside CT, not all of whom appeared to have an escort with them. This may be a safety risk if a patient's condition were to deteriorate. However, we also saw a porter bring an infective in-patient to radiology and wait to take them straight back to the ward to avoid a delay in the patient being returned to the ward.

- We saw data from an audit of patient waiting times once they had arrived in the radiology department that had been included in the analysis of the Friends and Family survey from April 2017. This showed that waiting times were on average 10-30 minutes and 5-15 minutes for CT and X-ray respectively. Several outpatients we spoke to told us that they had waited a long time despite having an appointment. One example included a patient who, at the time of speaking with them, had already waited 55 minutes beyond their appointment time with no information provided as to how much longer they would have to wait. Radiology staff told us that some outpatients in Beta X-Ray could wait as long as 90 minutes when the department was busy to be seen and then return to clinic.

Meeting people's individual needs

- The departments were accessible for people with limited mobility and people who used a wheelchair, however this was not as easily accomplished at ECH due to the layout of the building and necessitated going outside to reach some clinics.

- For people living with hearing impairment, there were hearing loops available and identifiable in all the outpatient clinics.

- There were two bariatric couches and one bariatric chair in the main outpatients department at Colchester hospital.

- Translation for non-English speakers was available by a telephone service but there was capacity to provide a face to face translator if necessary. Reception staff at ECH were not all aware of this facility.

- Staff told us when patients with a learning disability or those patients living with dementia attended the outpatients departments their carers', provided clear patient consent was given. They also ensured patients were seen quickly to minimise the possibility of distress to them.

- Staff told us how they made prior arrangements with a learning disability nurse and a patient's carer to ensure that a patient with a learning disability, who was very anxious and easily distressed, was able to wait in a quiet area prior to their appointment. They were then expedited into the clinic via an alternative door at their appointment time, to ensure that they did not become distressed by having to wait with other patients.

- We saw the outpatient departments kept a wide choice of patient information leaflets which meant that patients were supported to make informed choices about their care and treatment.

- The trust provided patient information leaflets in the X-ray departments, cardiology catheter laboratory recovery area and radiotherapy. These leaflets were in a 'reader-friendly' format.

- We saw clear and accessible information leaflets given to patients that had undergone nuclear medicine therapy procedures. Staff told us they also called these patients 24 hours after their procedure as a follow-up and to answer any questions.

- We did not see any leaflets in other languages however all diagnostic imaging staff we spoke to knew how to access translation services.

- We saw the departmental procedure for imaging pregnant patients. This process included providing patients with information regarding the potential risks of having the procedure during pregnancy. Staff told us that, wherever possible, they gave patients this information in advance of the examination so that the patient had time to read the leaflet and consider the information it contained before being imaged.

Outpatients and diagnostic imaging

- Radiology management told us that clerical staff called all two-week wait patients with an appointment. Patients for non-urgent examinations within radiology were not given a choice as to when their appointment would be. We were told that patients could phone to change their appointment times to accommodate patient needs.
- There was a separate waiting area for in-patients in beds in Alpha X-ray. The area was divided into five curtained bays. The waiting area in Beta X-ray also had a curtained area for patients to have cannulas inserted and staff told us that this area could also be used for in-patients. However, when this occurred, in-patients in beds waited in the corridor opposite the seating area for outpatients waiting for X-ray and CT scans as there was no other area to locate them.
- Staff in nuclear medicine told us that any paediatric patients had their cannulas inserted on the children's unit before coming to the department. Staff told us that these patients attended with a play assistant. We saw a distraction box, TV, and DVDs to make the experience more pleasant for paediatric patients.
- At CGH main outpatients we saw patients on trolleys, in a corridor in the main outpatient department waiting for transport home following their outpatient appointment. We observed staff checking on them and offering drinks, but the patients had no way of contacting a member of staff unless someone walked by.
- Staff in CT told us that they had one scanner that could be used for bariatric patients however that scanner only had a standard diameter bore, meaning that not all bariatric patients would fit in the scanner. The other CT scanner was a wide bore scanner but the table weight limit was not suitable for bariatric patients.
- The nuclear medicine scanner at ECH scanner was not suitable for patients over 120kg which meant that they were referred to another location several miles away. This will not be an issue when the department moves to the new location at CGH in 2018.

Learning from complaints and concerns

- Between April 2016 and March 2017 there were 51 complaints about outpatients and diagnostic imaging. The trust took an average of 37 days to investigate and close complaints. The most common primary theme was poor staff attitude, followed by appointments either not being received or changed/delayed.

- Staff we spoke with were aware of the local complaints procedure, and were confident in dealing with complaints if they arose. Information about the Patient Advice and Liaison Service (PALS) and how to make a complaint were available and displayed at the hospital.
- Patients we spoke to were aware how to make a complaint but only one had done so and felt that it was resolved to their satisfaction although it took several months.
- Radiology management told us that PALS sent complaints to the division. They also told us there was a system in place to contact patients within 24 hours of a complaint.
- Complaints were discussed at outpatient clinical governance meetings.
- Staff in radiology told us that complaints, and learning from complaint investigations were discussed in staff meetings to ensure that staff were aware of any change to practice.
- Radiology management told us that they attended weekly divisional meetings where all complaints were discussed.
- We saw evidence and staff told us about a recent patient complaint that had been investigated promptly and action taken to address highlighted issues.
- There was a safeguarding lead for radiology. This role was introduced following a safeguarding concern that arose in the emergency department that was discovered by a radiographer.

Are outpatient and diagnostic imaging services well-led?

Requires improvement ●

We rated well-led as requires improvement because:

- The management were mostly relatively new in post and processes were not yet embedded. In radiology the senior team in post worked as a cohesive unit and had made significant progress in addressing concerns raised during the previous inspection.
- There was a lack of understanding of the risk to patients overdue appointments despite this being noted as a concern at the last inspection.

Outpatients and diagnostic imaging

- The outpatient team had no real oversight of the number of patients awaiting follow up appointments due to previous practice of recording patient outcomes.
- There was a lack of systematic clinical and internal audit to monitor quality and systems and we were not assured that all clinical areas submitted regular audit data.
- There was a lack of co-ordination with other departments to address risks.

However:

- Leadership was organised and effective and action plans had been implemented to address known concerns.
- The leadership and culture of the senior management reflected the vision and values of the trust, delivering safe and compassionate care.
- Staff were engaged in decision making processes and felt valued and managers were open to comments and suggestions for improvements from staff.
- There was an open culture, with staff encouraged to report concerns, incidents and take part in team meetings.

Leadership of service

- There was a clear management structure with individuals identified for specific roles and responsibilities. However the leadership team for the outpatient departments had recently changed and most of the senior leaders were fairly new in post (less than four months). They had performed a deep review of the outpatient booking service and were just starting to implement actions to resolve the issues. This meant that there had also been significant changes that had not had time to become embedded at the time of inspection.
- The local managers had the skills, knowledge and experience to lead the departments and demonstrated a thorough understanding of the challenges to good quality care. They were able to identify the actions needed address the challenges but there was a lack of co-ordination with other departments to address risks.
- Staff we spoke to were broadly complimentary about the new local and the trust executive leadership and were keen to have leaders in post for a prolonged period having had an unsettled previous 12 months with interims or no leaders in place.

- Most outpatient staff had met or come into contact with the chief executive and director of nursing and knew their names.
- Staff understood the outpatient departmental structure and knew who their line manager was.
- Most of the outpatient staff we spoke with were confident about approaching the matron, senior nurses, service and operational managers to discuss issues or to gain support and commented that they were visible and supportive.
- There were several management vacancies within radiology, with several staff members 'acting up' in a temporary capacity to fill the roles. However, we observed that these staff members worked as a cohesive unit and had made significant progress in addressing concerns raised during the previous inspection and ensuring a robust governance structure within the department.
- All diagnostic imaging staff we spoke to knew who their immediate management team were, however, many staff told us that it was difficult to know whom the senior managers were at executive level due to the number of changes that had taken place.

Vision and strategy for this service

- The staff we spoke with were aware of the trust's values, vision and strategies that included the 'delivering great healthcare to every patient, every day' (EPED). They were committed to work towards achieving the trust's broad vision and strategy.
- There was a long term vision for the outpatients department which was linked to the trust's goals. This included; self-check-in kiosks in all outpatient areas, a centralised patient contact centre, ensuring effective clinic utilisation, electronic referrals being fully embedded and triaged to reduce delays in processing and clear standard operating procedures and reporting.
- Senior managers in the outpatient and diagnostic imaging services talked about visions and plans for their departments, and these were communicated to staff at all levels in the service.
- The senior management team were able to identify strengths in service delivery such as the improved utilisation of clinical rooms to ensure availability of clinics and areas that were noted for improvement including the clinical environments at Essex County Hospital (ECH).

Outpatients and diagnostic imaging

- The outpatient and ophthalmology departments displayed department specific 'three things' posters. This was a trust initiative to describe three things the departments were proud of and three things they were working to improve. The three things for improvement were known by staff and were achievable with ophthalmology working towards consistency in completing mandatory training, improving the environment and incorporating Royal College of Ophthalmologist framework for updating nurse competencies. The Colchester General Hospital (CGH) outpatient department improvement aims were; improving the environment, ensuring "gold standard" decontamination following department move minimising the amount of missing and letters notes prior to clinics.

- Radiology management told us they were working towards achieving ISAS accreditation and had submitted a business case for a project lead to take responsibility for the accreditation process. ISAS is a patient-focussed assessment and accreditation programme designed to help diagnostic imaging services ensure patients consistently receive high quality services, delivered by competent staff working in safe environments.

- Staff in nuclear medicine and breast imaging told us that they had been closely involved in the design of the new nuclear medicine department that was being built at the time of the inspection.

Governance, risk management and quality measurement

- The governance structure in outpatients was not yet embedded although senior staff had undertaken reviews of the service to identify governance weaknesses.

- There was a lack of systematic clinical and internal audit to monitor quality and systems. We were not assured that all clinical areas submitted regular audit data such as handwashing compliance as data was not provided.

- There was a new divisional governance manager in place and there was a plan to meet with senior outpatient staff on a monthly basis although this had not happened yet.

- Local governance and risks meetings covering the outpatient department were held although staff indicated that historically these were not always well attended which meant that decisions could not always be made in a timely manner. We reviewed the minutes from the outpatient governance meetings held in February and March 2017 and saw that they were well attended and issues such as the risk register, patient experience, incidents and complaints were discussed, and actions allocated to individuals.

- The governance manager confirmed that the three local risks for outpatients on the risk register were; open referrals, appointment booking and clinic reconciliation. At the most recent governance meeting, it had been identified that clinic cancellation was not showing up as a risk on the electronic incident system and there was on-going work looking into why this was not being reported. Concerns regarding the risk to patients with delayed appointments, who were not on a cancer pathway, had not been raised or addressed.

- Senior staff had oversight of the outpatients improvement projects; technology and strategy, outpatient productivity, and capacity and demand workstreams. However there was no oversight of risk to patients on a partial booking list or the waiting list for follow up outpatient appointments and due to the historical dual system of updating outcomes the trust had no way of know how many patients were in fact awaiting appointments. The senior outpatient team were aware of this and were working towards reducing the numbers on the partial booking list over the next few months which would allow them to have an up to date figure.

- There was good oversight of the ophthalmology department with the senior nurse producing a '2 at the top' report monthly. This was circulated around the department and staff we spoke to were aware of the contents of the report.

- Senior staff were clear about their responsibilities and what they were accountable for.

- Daily outpatient safety huddles (meetings) were held at CGH main outpatient department with the senior nurse in charge and staff said they were all welcome to attend and participate in the discussions.

- Radiology management told us that they met with the governance lead on a monthly basis. We were also told that the radiology manager meets with the leads in each area within radiology each month.

- Regular radiology clinical governance meetings included discussions on complaints, incidents and any learning from incident investigations.

Outpatients and diagnostic imaging

- Regular weekly meetings were held attended by senior staff to monitor the outpatient recovery programme and the patient tracking lists for each department.
- There was a trust Programme Overview Group which reviewed the capacity and demand EPED work streams and key performance indicators and we saw that there was monitoring of improving and failing areas and actions to resolve.

Culture within the service

- There was a positive culture amongst staff. Staff explained that they had been through a prolonged period of upheaval with lots of change in management and systems and that they were now starting to feel the benefit.
- Staff were committed and proud of their work. Quality and patient experience was seen as a priority and everyone's responsibility.
- Staff commented that managers were supportive and always had time to address concerns.
- We saw positive and friendly interactions between staff and managers with mutual respect for each other's roles.
- All diagnostic imaging staff we spoke with told us that they felt that their immediate manager would listen to staff suggestions to improve the service.
- Staff in radiotherapy gave us examples where management had acted quickly to address issues raised by staff.
- All staff we spoke to, told us they liked working at the trust and some had worked there for a long period of time (in at least one case, for more than 20 years). All staff told us that they felt there was good teamwork within the diagnostic imaging departments and that they felt supported by their colleagues. However, whilst staff spoke of being proud of the service they provide, a common theme from our discussions with staff was "we do the best we can with what we have".
- One manager did comment that support from the human resources department was poor when they had to instigate poor performance reviews for a member of staff which made it difficult. Another staff member felt that the human resources department were not effective and took several months to process applications and answer queries.

Public engagement

- Patients' views were obtained through variety of surveys including friends and family tests, and national cancer patient experience survey.
- The outpatients and diagnostic service engaged with patients, relatives and patient representatives to involve them in decision making about the planning and delivery of the service.
- Staff in the cardiac catheter laboratory told us that they had difficulty getting patients to complete patient satisfaction surveys as a lot of their patients weren't able to use their right hand immediately after the procedure (the right wrist is a common access site for cardiac catheter procedures and should not be used for a period of time post-procedure to allow wound closure). Staff told us that they used to use tablet computers for the patients to complete surveys but these had been removed from use by management. Staff told us they were considering other options to increase the number of completed surveys.

Staff engagement

- Doctors and nurses told us communication between different professionals was very effective. Nursing staff told us they felt able to raise concerns and discuss issues with the managers of the department.
- Staff were encouraged to have input into the design of new or upgraded services and told us about the recommendations they had made towards new building works.
- Staff told us the departments had an open culture, where staff were encouraged to report concerns, record incidents and take part in team meetings. We were told that managers were open to comments and suggestions for improvements from staff.
- Staff within radiology were awarded a commendation certificate by the trust for the way they had reacted to the cyber-attack.
- Staff in nuclear medicine told us that they would be moving to a newly built department early in 2018. They told us they had been closely involved in the design of the new department and the architect had commented on how impressed they were with the input of the staff.
- Radiology management described their staff as hard working and flexible and were proud of the quality of the service they provided and the level of expertise.

Outpatients and diagnostic imaging

- The trust indicated that an external company had been employed to engage with staff regarding changes to the trust but none of the junior staff were aware of this or had been involved in any initial groups looking at alternative working.

Innovation, improvement and sustainability

- Staff were proud of the proctogram service set up and run by a radiographer, with radiologist support service. This meant that patients could have their procedure locally, avoiding the need to travel into London. Staff told us that there was a plan in place for the lead radiographer to be trained to report the proctogram studies they performed.

- The breast imaging department introduced a 'high risk' clinic run by a for women with a higher risk of breast cancer to discuss the diagnostic tests required. Staff were planning an audit to assess the improvement in uptake of more invasive diagnostic tests such as MRI.

Outstanding practice and areas for improvement

Outstanding practice

- The service's dedicated childrens transition team was the only one in the region and other trusts sought advice from them. The transition team worked with other teams to meet the more complex individual needs of patients at the age of transitioning to other services. For example, they ran a joint clinic with the epilepsy specialist nurse three to four times a year.

- The neonatal unit (NNU) was piloting a 'discharge passport' to empower parent involvement in ensuring a timely discharge for babies.

Areas for improvement

Action the hospital MUST take to improve

- The trust must ensure that nursing and medical staff complete all safeguarding and mandatory training including basic life support.
- The trust must ensure that all equipment is maintained and fit for purpose.
- The trust must ensure that initial assessments within the emergency department are undertaken and documented to maintain an accurate clinical record based on clinical judgement, and that initial assessments in the emergency department are documented.
- The trust must ensure access to a designated mental health assessment room.
- The trust must take action to ensure that patients are clinically risk assessed as safe to wait for out patient appointments.
- The trust must ensure that medical records contain completed risk assessments relevant to patient care.
- Ensure that patient's records are appropriately stored in accordance with legislation at all times
- The trust must ensure that staff administering contrast for diagnostic imaging investigations use a patient group direction or have it prescribed.
- Ensure that do not attempt cardiopulmonary resuscitation (DNACPR) decisions are undertaken in accordance with national guidance and best practice.
- The trust must ensure that the design and layout of the paediatric emergency department enables effective oversight of paediatric waiting areas to ensure patient safety.

- The trust must ensure that there is an effective governance and risk management framework in place to identify and assess all risks relevant to the emergency department.
- The trust must ensure that patient's dignity is protected in changing cubicles in In Beta X-ray.
- The Trust must ensure that the doors for Beta X-ray are fully fitted and a risk assessment is in place to ensure patients are not a risk of unnecessary exposure of ionising radiation.
- The trust must ensure there is an effective process in place for timely review of policies and procedures and that these comply with national guidance and best practice.

Action the hospital SHOULD take to improve

- The trust should improve its overall performance in the management of referral to treatment times.
- The trust should ensure that clinics are not cancelled without exploring every option in order to contribute to reduced waiting times.
- The trust should ensure the clinics start on time.
- The trust should ensure that all staff are aware of translation services for non-English speakers.
- The trust should ensure that clinical audit is undertaken and where data is not submitted, that it is followed up.
- The trust should ensure that all staff have received an appraisal and frequent supervision.
- The trust should review admission times and fasting periods for patients awaiting surgery to meet the nutritional and hydration needs of the patient.

Outstanding practice and areas for improvement

- The trust should ensure managers and senior staff have the relevant level of skill and experience to perform their roles.
- The trust should ensure that staffing levels reflect the needs of patients at all times.
- The trust should ensure that it reviews its existing staff practice in relation to MCA and DoLS specifically in relation to the cohorting of patients in supervised bays.
- The trust should ensure that domestic staff follow infection control procedures, wear correct uniform, identification and personal protective equipment at all times.
- The trust should improve its overall performance in the management of patient falls.
- Continue to work to improve delayed discharges and discharges that occur between the hours of 10pm and 7am.

- Continue to work to improve attendance and documentation of meeting minutes at mortality and morbidity meetings.
- To ensure that patients diaries are being completed in line with guidance, and that these diaries are used throughout the patient journey.
- To improve the recording of actions following governance meetings and ensure that these are followed up and that evidence of learning or changes in practice are recorded.
- Ensure there are appropriate formal systems to share actions and learning from incidents consistently among all staff in the service.
- Update the policy for safeguarding children in line with best practice and national guidance, for example to ensure all child protection cases are overseen by a paediatrician.

Requirement notices

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Mandatory training amongst staff was not at the trusts target with some notable improvements required in some areas such as medical staff training and safeguarding training. Not all equipment was maintained and serviced in a timely manner. Specifically within the Outpatient department 24% of equipment was out of date for planned preventive maintenance. The emergency department did not have a dedicated mental health assessment room. Plans were in place for this to be in place by October 2017. However mental health patients were accommodated in an isolation room adjacent to the majors' area in the emergency department. This room had one point of access and exit, no panic buttons and lacked direct oversight from staff. There were ligature points on the door handle. There were no formal risk assessments in place to show that patients would be assessed on an individual basis if they were appropriate to be admitted into this area. The trust did not have a standardised formal process or policy to risk assess patients who were awaiting follow-up appointments that were delayed. This was raised at the previous inspection but had not been fully addressed.

Requirement notices

Medical records did not always contain completed risk assessments relevant to patient care.

A clinical assessment tool was built in to computer systems however, this was not being used within the emergency department. Decisions were being based on clinical judgement, without formal documentation.

Medical records were not always stored securely to prevent a potential breach of confidential personal information.

There were no patient group directives in place for diagnostic imaging staff administering medium in diagnostic radiology.

26% of do not attempt cardio pulmonary resuscitation (DNACPR) records reviewed during the inspection were not accurately completed, with a lack of documented discussions of the decisions with patients noted. Of those not completed in line with guidelines, in three cases the patient had a DNACPR order in place when the patient did not have capacity and there was no evidence of a mental capacity assessment undertaken.

The design and layout of the paediatric waiting area within the emergency department did not allow for the safe and effective oversight of patients within this area.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance
Surgical procedures	
Treatment of disease, disorder or injury	

Requirement notices

This section is primarily information for the provider

The trust must ensure that there is an effective governance and risk management framework in place to identify and assess all risks relevant to emergency the department.

Not all risks were identified on the emergency department's risk register. For example the use of three different early warning scoring systems (EWS) for paediatrics and lack of appropriate documented triage tool.

Divisional governance meetings and senior staff meetings appeared to lack a standard agenda and attendance by representative from the emergency department was not consistent.

Not all policies and procedures had been updated. We found some guidance out of date and significantly overdue for review. Some audits reflected that further work was required to meet national standards.

The doors in Beta X-ray rooms were old and difficult to close properly. This meant that the doors could remain partially open during a procedure, potentially exposing people in the area to ionising radiation. We did not see any evidence that this matter had had a risk assessment or was being addressed. This issue was also not included on the risk register.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect In Beta X-ray patients in hospital gowns were waiting in the same area as other patients, we could not see whether dressing gowns were provided for patients and the curtains in cubicle areas did not fully close which was a patient dignity concern. Staff told us that some patients were advised to bring their own dressing gown for their appointment.