Care Quality Commission

Colchester Hospital University NHS Foundation Trust

Colchester General Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

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

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

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

During this inspection we found that the trust had capacity issues and were having to reassess bed capacity at least three times a day. We found that staff shortages meant that there was a high use of agency staff which did impact on the quality of care provided to patients. We found that required improvements, identified at previous inspections since May 2014, had not been undertaken, this included the service, maintenance and repair of equipment which was found to be poorly undertaken throughout the trust. Outpatient service provision had deteriorated and the trust had lost grip on the number of patients who required treatment through outpatients. End of life care provision had also deteriorated since it was last inspected in May 2014 with patients not receiving safe or effective care at the end of their life.

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

Our key findings were:

- There was a significant and substantial shortfalls in registered nursing staff in a number of areas. Overall the trust had a shortfall of 244 (20%) registered nurse vacancies from Band 5 to Band 7 in May 2015.
- There were wards throughout the trust which had very high agency usage noted with staffing on five wards ranging between 80-100% agency use at weekends and at night time. A further 6 wards had agency use above 30% continuously.
- There were significant medical staffing vacancies with a shortfall of 81 WTE (15.8%), which meant that there was a high use of locum medical staff. The shortages of junior, trainee and middle grades was especially notable across medical and surgical specialties during the inspection.

Summary of findings

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

Summary of findings

- The approach from the trust the monitoring of mortality including the undertaking of mortality and morbidity meetings to review trends and improve patient care was inconsistent. There were areas where these meetings and reviews were not taking place.
- The trust has seen a steady increase in mortality over the last six months. At the time of the inspection the last Hospital Standardised Mortality Ratio (HSMR) for the trust was 103 and their Summary Hospital-level Mortality Indicator (SHMI) was 106.7 however their weekend mortality ratio was 113.6.
- The way in which responses to complaints and concerns were handled by the trust was not consistent, with some poorly investigated and non-supportive responses being issued, which resulted in further complaints being raised about the complaints process. This was evident with the trust being highlighted as one of the top reported trusts in England where complaints management and responses are referred to the Parliamentary Health Service Ombudsman.
- The four hour standard was only being achieved for around 80% of patients, with significant numbers of patients waiting more than 4-12 hours for admission.
- Overall there had been some improvement in the care delivered on the medical wards.However, Safety was rated as inadequate.
- Care on some medical and surgical wards as well as the postnatal ward was poor with patients not being treated with sufficient dignity and respect and call bells not always being answered promptly.
- There was improvement in the culture of being open in some areas of the hospital, however staff in many areas still felt unable to speak up about concerns they had regarding services and care.

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

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

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

Importantly, the trust must ensure that:

- Ensure that there is a suitable training provision in place to support staff to recognise and identify patients at the end of their life so that appropriate treatment can be provided.
- Ensure that staff receive training to use the dedicated end of life pathway so that patients can receive appropriate care at the end of their life care and treatment.
- Ensure that do not attempt cardiopulmonary resuscitation (DNACPR) decisions are undertaken in accordance with national guidance and best practice.

Summary of findings

- Ensure that mental capacity assessment are undertaken in the patients best interest, prior to agreeing medical decisions regarding care or treatment.
- Ensure that staff are trained and assessed as competent to use equipment which is required for the provision of patient care.
- Ensure that there a policy, procedure and strategy for end of life care is developed.
- Ensure there is a robust incident and accident reporting system, including reporting of lessons learnt to all groups of staff.
- Take action to ensure patients receive appropriate and timely clinical review and that the system for escalation of a patients deteriorating condition is robust.
- Ensure that there are sufficient numbers of qualified, skilled and experienced nursing staff in all patient areas at all times.
- Complete a review of senior medical staffing and consultant support, especially within Orthopaedics, to ensure that there are sufficient numbers of qualified, skilled and experienced medical staff at all times, across all specialities.
- Ensure that there are sufficient numbers of suitably qualified medical staff, below consultant grade, on duty at all times.
- Ensure that medicines are stored in accordance with manufacturers and legislative guidance and that staff take appropriate actions when temperatures breaches occur.
- Ensure that patient's records are appropriately stored in accordance with legislation at all times.
- Ensure that policies and procedures are formalised and in place and that all staff have awareness and can access trust policies and procedures.
- Ensure that temporary and locum medical staff have access to the appropriate hospital systems to ensure continuity of patient care.
- Review admission times and fasting periods for patients awaiting surgery to ensure the nutritional and hydration needs of the patient are met.
- Ensure local audit and review of patient outcomes is consistent across all areas.
- Ensure that all staff have receive an appraisal and frequent supervision.
- Review handover arrangements and ward rounds to ensure that they are effective and include the multidisciplinary team to ensure holistic review of a patients care and treatment.
- Review the process for obtaining patient consent to surgery to ensure that patients have adequate time to consider informed consent.
- Review staff communication with patients and relatives to ensure that patients are treated with dignity and respect, to include maintenance of patient privacy during nursing handover.
- Review the arrangements for internal transfers of patient, including moves at night, to ensure this is kept to a minimum.
- Ensure a robust system for risk assessment is in place and that the governance structure introduced is consistent across all areas to ensure safe care and treatment.
- Improve patient care to those on cancer pathways by reducing waiting times for treatment.

Summary of findings

- Improve mandatory and statutory training rates.
- Ensure that patients are risk assessed and prioritised in outpatient pathways.
- Ensure that duty of candour is undertaken in all outpatient cases where significant delays have been identified and the patient was placed at risk of harm.
- Ensure that there is a robust safety oversight of dermatology service provision.
- Ensure that staff are enabled to freely speak up about concerns and provide feedback about services and care without fear of reprisal.
- Review the processes formotality and morbidity within the divisions to ensure that risks, trends and lessons are learned from patient deaths.

The trust should also:

- Provide support to medical staff throughout the trust on breaking bad news to patients and their families.
- Review the handover procedures on wards so that patient privacy is respected.
- Review the fridge capacity within the mortuary and develop a future plan for the sustainability of service provision.
- Review working relationships and arrangements in place to support rapid and fast track discharges for patients at the end of their life.
- Undertake audits and monitor activity on preferred place of death to meet patients preferences.
- Reviewing the nursing, and medical and leadership establishments within end of life care.
- Improve governance arrangements by improving learning and the identification of trends from complaints and incidents.
- Review the arrangements and focus on end of life care to ensure that its given sufficient priority on the directorate, board and patient council agenda.
- Review the complaints process to ensure that lessons to be learnt are communicated to staff.
- Ensure there are sufficient therapy staff out of hours and at weekends to provide services and minimise delays to patient discharge.
- Review staff communication and engagement within the therapy services and theatre.
- Review the length of time patients are on trolleys within the emergency department, EAU, SAU and on Copford ward and ensure risks of harm to patients is minimised.
- Improve staff understanding to raise concerns and report incidents and near misses.
- Ensure the care and treatment of those patients identified as having a long term conditions reflects current evidence-based guidance, standards and best practice.
- Consider reviewing the policy for patient movement out of hours.
- Ensure there is a timely review of the provision of services within the endoscopy unit.
- Ensure the security of patient records to minimise the risk of access by an unauthorised person.
- The trust should ensure there is a consistent approach to patient handover within the division to ensure patient's privacy and dignity is maintained.

Summary of findings

- Review the process for the creation of temporary records in outpatients.
- Review caring, culture and morale on the wards highlighted in the inspection report as requiring support to improve the attitude and care provided to patients.
- Review the staff morale and concerns highlighted by staff in outpatient booking centre, therapies, endoscopy and radiology to find a resolution which improves services.

Following our inspection at Colchester Hospitals University NHS Foundation Trust a new chief executive was appointed and a new action plan drawn up against the feedback provided at the inspection. We note that since our inspection there has been some limited progress against our areas of concern. I am therefore recommending that the trust remain in special measures for a period of three months during which time they will submit a weekly dashboard of key improvement indicators to relevant stakeholders in order that we continue to monitor improvements. Based on the findings of this inspection I have recommended that further regulatory action be taken and required the trust to make significant improvements on the care and service they provide to patients.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	We rated urgent and emergency services at Colchester General Hospital as requires improvement overall. With effective being rated as good and safety, caring, responsive, and well led requiring improvement. Safety was rated as requires improvement because we found multiple items of equipment that were currently in use and had not had portable appliance testing, maintenance, or servicing for several years. When the department was at its busiest we observed examples of patients, including a patient receiving oxygen, not being monitored as necessary. The paediatric department does not have a designated paediatric doctor, which is not in line with the 2012 Intercollegiate Emergency Standards. The service does not have a clear process or procedure for the assessment of risk to skin integrity for patients who have been on trolleys for a period of longer than four hours and not all notes we observed in the department were secure. The compliance with life support training for medical staff was low with less than 50% of medical staff being trained in basic adults and basic child life support training and only 20% were up to date with advanced life support training. However we also found that there was a positive incident reporting culture in the department, and all paediatric nurses were trained in safeguarding children at Level 3. The service was rated as good for effective because people were treated and cared for in line with evidence based guidelines. Local policies were available on the trust intranet, and staff told us it was easy to locate them. The majority of staff in the service had received appraisals within the last 12 months and Induction of agency and locum staff was established and we observed that this was implemented effectively in the service. However there were some areas that could be improved because there had been a deterioration in performance on key indicators of the sepsis and septic shock audit and neutropenic sepsis audit. In

Summary of findings

the data provided to us by the trust, equipment competencies were not recorded as assessed on equipment including moving and handling equipment.

The service was rated as requiring improvement for caring because when the department was at its busiest we saw that several patients were not always afforded the level of care and compassion we saw for the majority of our inspection. We observed three examples of poor care, two involved patients who were not supported, offered comfort and were not acknowledge by staff and the third was an inappropriate comment made by a doctor about a patient who could hear what the doctor was saying. However we also found that when the department was quiet we saw several examples of patient interactions demonstrating that patients' were cared for compassionately and that their privacy and dignity was considered when delivering care and treatment.

The service was rated as requires improvement for being responsive because the department was not meeting the 95% target for patients who attend should be treated and discharged or admitted within four hours of arrival, and the total time spent in A&E at the trust is generally above the England average. Bed meetings were ineffective in responding to the issues the department had to address. However we also found that the clinical decision unit avoided 130 admissions per week and there was a low re-admittance rate for patients seen by the unit.

Urgent and emergency services required improvement for leadership because risks identified during the inspection around the major incident store, staff safety in children's department, equipment, and risk assessments were not identified on the risk register. We were therefore not assured that the risks were not all being addressed. We also observed that there was a real disconnect between the supportive of element of team working following an event between the children's and adults emergency department. However we also found that staff felt there had been a positive change in the culture of the service which was a result of the changes in leadership, and staff were very enthusiastic about their service and had taken

Summary of findings

ownership of the issues identified during previous inspections and demonstrated to us that they wanted to make a difference to provide the right service to patients.

Medical care

Requires improvement

Medical Care Services at the hospital were rated as requires improvement overall. Safety was rated as inadequate because staff did not always raise concerns and report incidents. There was insufficient equipment in the endoscopy unit to safely maintain the decontamination of endoscopes. Equipment which was used for patient care was not in service date, had not always been maintained or been electrical safety tested. We were concerned about the levels of staffing, skill mix of staff and the high use of agency and locums in medical and nursing specialties. We saw elements of good practice including the safeguarding of vulnerable adults.

Effectiveness required improvement because care and treatment of those patients with long term conditions did not always reflect current evidence-based guidance, standards, and best practice. Current local and national guidance in endoscopy and the cardiac catheter laboratory had not been implemented. The endoscopy service was no longer joint advisory group (JAG) accredited due to the accreditation being revoked in June 2015 due to concerns identified.

Caring required improvement because there were times when patients did not feel well supported or cared for and some patients and their relatives had concerns about the way staff treated them and felt they were not always treated with kindness or respect or in a timely way when receiving care and treatment. We also observed that during handovers on wards that the staff did not see patient's privacy and dignity as a priority. We saw elements of good practice. We observed staff responding compassionately when patients needed help and support to meet their basic personal needs.

Responsiveness was rated as requirements because the needs of medical outliers were not always met. The numbers of patients being moved between wards out of hours was high between the hours of 10pm and 8am. The Referral to Treatment Times

Summary of findings

(RTT) for the cancer standards was not being achieved by the trust. And we identified incidences where patients had gone for more than 100 days without treatment for their cancers.
Leadership of medical care services required improvement because the governance arrangements were not fully effective. Whilst improvements with local ward leadership were noted however there was a lack of awareness from the divisional and trust leads regarding the concerns that staff had in endoscopy. The culture within the service was improving and was becoming more open.

Surgery **Inadequate**

Surgery services were rated as inadequate overall with safety, effectiveness and responsiveness being rated inadequate and service requiring improvement in care, and leadership. The service had recently undergone some senior divisional changes and whilst the new structure had the foundations to improve patient care, this was in its infancy.
Oversight of standards of care and governance was fragile. There was a structured governance process in place but this was not yet embedded; good practice in one area was not cascaded and the service remained very reactive. There had been a reconfiguration of the nursing team and focused effort on Brightlingsea ward and patient safety and care had improved. Similar issues and concerns regarding staffing numbers, escalation of deteriorating patients and medical review were now apparent on Mersea and Aldham wards, which indicated a lack of oversight of the service.
There was disparity with consultant and middle grade medical cover and support for junior doctors across surgery. The vascular, general surgery and urology specialties provided good support and clinical supervision. This was not the case within orthopaedics, where consultant led ward rounds occurred infrequently. Medical cover, out of hours and at weekends, was variable with consultant and middle grade staff providing support from off site.
At ward level multidisciplinary team working was not united, nursing safety huddles had been introduced but the wider team were not included.
Some operational policies and procedures were in

Summary of findings

draft form or required updating to reflect current service status. Risk assessments at local level were not robust and the divisional risk register was incomplete. There was equipment in use that was out of date for service and maintenance.

Critical care **Requires improvement**

We rated the critical care as requires improvement overall. We rated the safety of the service as requires improvement. There was adequate equipment in place to ensure safe care. However, on the visual inspection of 164 pieces of medical equipment, a number were found to be soiled (18) and there was a lack of evidence of medical servicing. Some medical and nursing staff were observed not washing their hands between patients. 'Bare below the elbow' practices were adhered to by all nursing staff. One doctor was noted wearing a wristwatch during a patient consultation. Doctors and facilities staff were observed to enter and leave the unit without using hand sanitising gels. There were sufficient nursing and medical staff on the unit at all times. Incidents were reported and learnt from appropriately.
Critical care services were effective. Treatment and care was delivered in accordance with best practice and recognised national guidelines (ICNARC) NICE and care bundles. There was a multidisciplinary approach to assessing and planning care and treatment for patients. The unit performed within the expected range for all indicators in the Annual Quality Report 2013/14 for adult critical care.
Critical care services were caring. Feedback from people using the service including patients and their families was very positive. Staff ensured patients experienced compassionate care and their privacy and dignity needs were protected at all times.
Critical care services were responsive to patient's needs. The majority of patients were discharged from unit in a timely way (within four hours) and complaints were handled appropriately. Where suggestions had been made by patients and relative's actions had been taken by staff to improve care services. Follow up services were in place to support patients discharged from the unit.
Critical care services required improvement in leadership because there was no formal clinical

strategy for the development of critical care services in the trust. Governance systems were not robust to ensure that risk was being proactively managed within the department. The lead sister did not have access to the trust risk register. Staff were aware of the risks but no action to mitigate these had been taken. The risk register for Anaesthesia did not highlight the specific concerns identified regarding the service, maintenance, and cleanliness of equipment; however it referred to an overarching risk on the trust risk register regarding equipment. Equipment was discussed as a risk and minuted at governance meetings. The service was not auditing outreach services to ensure the effectiveness of this service.

Maternity and gynaecology

Requires improvement

We rated maternity and gynaecology services as requires improvement overall. With the service being rated as good for effectiveness, responsiveness and leadership but requiring improvement in safety and caring.

Safety required improvement because the environment within the unit was not secure and meant that there was a risk of child abduction or absconsion of vulnerable women, which the service had not identified. The mandatory training rates for both medical and nursing/ midwifery staff in maternity and gynaecology were poor in subjects including Safeguarding Children and adult and paediatric life support. The midwife-to-birth ratio was in line with the recommended average and at times was better than the England average as was the number of consultant hours provided to the service.

The service was rated as good for being effective because outcomes for women who used services were in line with or better than expected when compared with other similar sized services. The termination of pregnancy process followed all elements of national guidelines and legislation. The service took part in national audits and completed a range of local audits as well as reviewing their service in line with nationally published recommendations through the Kirkup report.

The service was rated as requiring improvement for the care provided to women who use the service. Feedback from people who use the service, those

who are close to them and stakeholders was mixed about the way staff treat women. Women were positive about some of the care provided however we received several comments through our dedicated women's focus group about poor attitude of staff providing care to mothers on the postnatal ward.
The service was rated as good for being responsive to the needs of women because it had responded to the changing demand for the service. Access to the service was through a simple route, which enabled women to be seen by the medical teams soon after arrival. The waiting times for emergency and elective gynaecology were good and meant that patient's pathways were generally delivered within 18 weeks. However the service needed to improve the processes in place for investigating, responding to, and managing complaints.
The service leadership locally was good. Staff spoke positively of the clinical leads for the service and how involved and approachable they were which created an open culture. Governance and risk management systems within maternity and gynaecology were well established but required some refinement to link into the trust board.

Services for children and young people

Good

Children's and young people's services at this trust were rated as good overall with safety of services being the only domain requiring improvement. High numbers of medication errors, inconsistency in hand hygiene compliance, the understaffing of qualified nurses and allocation of children to adult wards without appropriate risk assessment and outside trust policy meant that safety required improvement. Information links between the trust and other providers that shared care for some patients was not robust and readmission rates for some patients with long term conditions were high. Three staff members indicated that the reputation of the trust was not reflective of the good care that takes place in children's and young people's services. This meant that there was a disconnect between children's and young people's services and the rest of the trust which could make sharing of learning and communications less effective.
Children's and young people's services had a good incident reporting system that was understood by

staff and there was evidence of scrutiny and learning from incidents and risks. Medicines and controlled drugs were stored safely. Data showed that staff completed their mandatory training and clinical competencies were regularly checked and updated, medical staffing levels were adequate to provide safe care and there was a robust integrated care pathway for children in place. Clinical audit was conducted, reported and learnt from and was co-ordinated by a lead physician. Caring was good with overwhelming positive feedback from patients and carers and positive interactions seen. Children's individual needs were met with good play provision and bespoke facilities such as a sensory room. Referral to treatment times was consistently within the 18-week target and there was an embedded respect for the matron. Leadership of children's and young people's services was good. Staff were engaged and informed, for example, staff received debriefing after unexpected events.

End of life care

Inadequate

We have rate end of life care services as inadequate overall with all domains being rated as inadequate. There was a lack of recognition, when assessing patients that patients were at the end of their life. We observed several examples of patients who should have been receiving dedicated end of life care who were not because staff had not identified that they were at the end of their life. Equipment required for the use of providing care to patients at the end of their life was not serviced or maintained and therefore were not assured they were safe to use. End of life care training was not provided as a mandatory training subject and there were no formal records available which recorded if patients were trained on end of life care and the individualised care record for the last days of life. We have rated end of life care services as inadequate for effectiveness because people are at risk of not receiving effective care or treatment. The trust does not have a policy in place for end of life care, their action plans, and strategies made no reference to end of life care. The trust had removed the Liverpool Care Pathway and replaced it with an 'individual care record for the last days of life', however not all staff were aware of this record, not all staff had been trained to use it and in one

Summary of findings

instance a member of medical staff told us that they refused to use the new record. There was a lack of consistency in how people's mental capacity is assessed and not all decision-making is informed or in line with guidance and legislation when a do not attempt cardiopulmonary resuscitation order (DNACPR) is completed.

We rated end of life care services as inadequate for caring because there were times where patients and relatives did not feel well supported or cared for. We spoke with nine relatives and eight patients at the end of their life and whilst some praised the care received several concerns were raised about the way patients were treated including examples of delays in receiving pain relief, and a lack of information provided at the end of the patient's life about what to expect.

We rated end of life care services as inadequate for responsiveness because services do not always meet people's needs. The hospital was not recording a patient's preferred place of death, or recording the breakdown of referrals to determine what referrals were received relating to cancer and which were related to other conditions. Fast track was acknowledged by the trust to not always be rapid or fast with some cases taking up to 21 days to get a person discharged. The fridge capacity in the mortuary for the deceased had not been upgraded to increase capacity in the last five years to take account of population expansion.

The Leadership for end of life care was rated inadequate because the trust does not have a fully developed end of life care strategy that included prioritised, time bound actions with appropriately allocated leads. Issues around end of life care have been brought to the attention of the trust through previous inspections in May, November and December 2014 and in July 2015. However little progress has been made to improve the provision for end of life care.

Outpatients and diagnostic imaging — **Inadequate**

This service was inadequate overall. We rated safety, responsiveness, and leadership of the service as inadequate, we do not rate effectiveness of outpatients currently, and we rated care provided by staff as good.

Summary of findings

Safety was inadequate because people using the service were at high risk of avoidable harm. During our inspection we identified a significant number of patients for whom the outcome of their outpatient appointment was not recorded correctly on the patient portal or they were overdue for a new or review appointment. There are currently 370,791 open referrals on the Portal system and there was a risk of patient being 'lost' in the system. Where the outcome of appointments was not recorded, patients were at risk of appropriate and timely action not being taken regarding the care and treatment they needed. As of January 2016 the trust confirmed that they had commenced the validation of the open referrals on their system to assess if there had been any adverse impact of this issue on patients, and ensure patients receive appropriate treatment.

We were not assured staff had fully completed or recorded concerns related to the age, servicing, and maintenance requirements for some equipment. We found gaps in the recording of staff checks and found staff had not always followed the trust required schedules of resuscitation equipment and trolley checks. Not all staff in outpatients and diagnostic imaging had completed mandatory training. There was a potential risk because any staff member could create a set of temporary notes for outpatients, which meant patients may have multiple and duplicated medical records.

Clinical staff in outpatients and diagnostic imaging were not always aware of consent considerations, to ensure patients gave appropriate consent for their care.

No administrative and clerical staff in outpatients had had an appraisal between April 2013 and May 2015.

The trust had implemented a new clinical portal to replace its patient administration system (PAS) in November 2014. The trust acknowledged there was a large scale backlog of historical data inaccuracies and open referrals on the portal, which remained nearly a year after the new portal had been implemented.

Summary of findings

Staff in the Gainsborough Unit, therapies, and diagnostic radiology teams worked with a multidisciplinary approach which was well managed.

Patients who used the service at Colchester General Hospital told us they had been treated with compassion and respect. Diagnostic imaging and radiology staff at Colchester General Hospitals had a caring approach and attitude towards patients for whom they provided treatment. Patients in Gainsborough Unit told us they appreciated and valued the help and support of volunteers who were based in the unit.

The trust worked with local commissioners to provide outpatient and diagnostic imaging services for local people at Colchester General Hospital. However, we noted that local commissioners did not have full confidence in the management of outpatients' appointments and were not using electronic referrals to the trust. All outpatient referrals were made by using a paper based referral system.

The trust did not referral to treatment time data from November 2014 due to the implementation of a new patient records system called the portal. The service did not always meet patients' needs. The time waited by patients from referral to treatment was worse than the England average and below the expected standard. When attending clinics, some patients experienced delays for their appointments.

We found a disconnect between the trust and divisional senior management teams and operational staff in outpatients and diagnostic imaging services. We did not find a clear and embedded clinical governance structure, processes, and management in place across all outpatients' services at Colchester General Hospital. We found outpatients' services across all of Colchester General Hospital were disconnected and there was a lack of overall governance and management.

Colchester General Hospital

Detailed findings

Services we looked at
Urgent and 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 and diagnostic imaging

Detailed findings

Contents

Background to Colchester General Hospital

Colchester General Hospital is a medium sized teaching hospital in Colchester with approximately 560 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.

In 2013, the trust was identified nationally as having high mortality rates and it was one of 14 hospital trusts to be investigated by Sir Bruce Keogh (the Medical Director for NHS England) as part of the Keogh mortality Review in May that year. Following concerns regarding the authenticity of cancer waiting times the trust was placed in Special Measures by Monitor in November 2013 At that time there was a significant turnover of the executive team. In addition the Chief Executive in post at the time of our inspection was replaced shortly afterwards.

Since the trust was placed into special measures we have inspected Colchester General Hospital three times and we have taken enforcement action to protect patients from the risk of harm on all three occasions.

Our inspection team

Our inspection team was led by:

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

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

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

Detailed findings

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

The inspection took place between 15 and 18 September 2015.

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

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

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

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

We spoke with a range of staff in the hospital, including nurses, junior doctors, consultants, administrative and clerical staff, radiologists, radiographers, pharmacy assistants, pharmacy technicians, and pharmacists. We also spoke with staff individually as requested and held 'drop in' sessions.

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

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

Facts and data about Colchester General Hospital

Size and throughput

Beds: 640 (plus 86 day beds)

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

Staff posts: 4,229

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

- 515 Medical
- 1,198 Nursing
- 2,516 Other

Vacancies as of May 2015:

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

The overall staff deficit equated to 556.95 WTE staff.

Revenue: £267,576.000

Full Cost: £289,894,000

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

Safety (trust wide)

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

Effective (trust wide)

HSMR Weekday 102.8

Weekend 113.6

Overall 103.0

Detailed findings

SHMI Overall 106.7

Caring (trust wide)

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

Cancer patient experience survey:

No. of items in top 20%: 4

No. of items 'average': 26

No. of items bottom 20%: 4

Responsive (trust wide)

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

RTT non admitted (12 months): 62.9%

RTT admitted (12 months): 87.2%

Diagnostic 6 weeks wait: 4.0%

Cancer 2 week wait: 83.9%

Cancer 31 day wait: 90.5%

Cancer 62 day wait: 70.2%

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

Well led (trust wide)

Staff sickness: 4.00%

Staff turnover: 18.0%

Staff survey:

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

CQC Intelligent Monitoring

Elevated risks:

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

Risks:

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

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

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Urgent and emergency services

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

Information about the service

The emergency department (ED) at Colchester General Hospital provides a 24 hour, seven day a week service to the local area.

From 1 April 2014 to 31 March 2015, 77,834 people attended the emergency department. Compared to all trusts in England the department is relatively small. 24,026 (29.9%) people were admitted compared to the England average of 22.2%. 44,781 people were discharged from the department.

Patients present to the department either by walking in via the reception or arriving by ambulance. The department had facilities for assessment, treatment of minor and major injuries, a resuscitation area, a clinical decision unit (CDU) and a paediatric emergency department service. 80% of people attending the emergency department were aged 17 or over, 20% were aged 0-16.

Patients attending the accident and emergency department should expect to be assessed and admitted, transferred or discharged within a four-hour period. If an immediate decision cannot be reached, a patient may be transferred to the emergency assessment unit (EAU), for

up to 48 hours. Once patients were admitted to the EAU, they were cared for by the medical team.

Summary of findings

We rated urgent and emergency services at Colchester General Hospital as requires improvement overall. With effective being rated as good and safety, caring, responsive, and well led requiring improvement.

Safety was rated as requires improvement because we found multiple items of equipment that were currently in use and had not had portable appliance testing, maintenance, or servicing for several years. When the department was at its busiest we observed examples of patients, including a patient receiving oxygen, not being monitored as necessary. The paediatric department does not have a designated paediatric doctor, which is not in line with the 2012 Intercollegiate Emergency Standards. The service does not have a clear process or procedure for the assessment of risk to skin integrity for patients who have been on trolleys for a period of longer than four hours and not all notes we observed in the department were secure. The compliance with life support training for medical staff was low with less than 50% of medical staff being trained in basic adults and basic child life support training and only 20% were up to date with advanced life support training. However we also found that there was a positive incident reporting culture in the department, and all paediatric nurses were trained in safeguarding children at Level 3.

The service was rated as good for effective because people were treated and cared for in line with evidence based guidelines. Local policies were available on the trust intranet, and staff told us it was easy to locate

them. The majority of staff in the service had received appraisals within the last 12 months and Induction of agency and locum staff was established and we observed that this was implemented effectively in the service. However there were some areas that could be improved because there had been a deterioration in performance on key indicators of the sepsis and septic shock audit and neutropenic sepsis audit. In the data provided to us by the trust, equipment competencies were not recorded as assessed on equipment including moving and handling equipment.

The service was rated as requiring improvement for caring because when the department was at its busiest we saw that several patients were not always afforded the level of care and compassion we saw for the majority of our inspection. We observed three examples of poor care, two involved patients who were not supported, offered comfort and were not acknowledge by staff and the third was an inappropriate comment made by a doctor about a patient who could hear what the doctor was saying. However we also found that when the department was quiet we saw several examples of patient interactions demonstrating that patients' were cared for compassionately and that their privacy and dignity was considered when delivering care and treatment.

The service was rated as requires improvement for being responsive because the department was not meeting the 95% target for patients who attend should be treated and discharged or admitted within four hours of arrival, and the total time spent in A&E at the trust is generally above the England average. Bed meetings were ineffective in responding to the issues the department had to address. However we also found that the clinical decision unit avoided 130 admissions per week and there was a low re-admittance rate for patients seen by the unit.

Urgent and emergency services required improvement for leadership because risks identified during the inspection around the major incident store, staff safety in children's department, equipment, and risk assessments were not identified on the risk register. We were therefore not assured that the risks were not all being addressed. We also observed that there was a real disconnect between the supportive of element of team working following an event between the children's and adults emergency department. However we also found that staff felt there had been a positive change in the culture of the service which was a result of the changes in leadership, and staff were very enthusiastic about their service and had taken ownership of the issues identified during previous inspections and demonstrated to us that they wanted to make a difference to provide the right service to patients.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

Urgent and emergency services at Colchester General Hospital required improvement because:

- We found multiple items of equipment that were currently in use and had not had portable appliance testing, maintenance or servicing for several years with the oldest item identified being last checked in 2009.
- When the department was at its busiest we observed examples of patients, including a patient receiving oxygen, not being monitored as necessary.
- The paediatric department sees 17,500 children a year and does not have a designated substantive paediatric doctor, which is not in line with the 2012 Intercollegiate Emergency Standards. Whilst the department utilised a locum doctor this was not on a permanent basis.
- We identified that signatures were not always recorded on medicines administration charts.
- Doctors were not provided with any in-house duty of candour training.
- We observed incidents of poor hand hygiene and infection control.
- The service does not have a clear process or procedure for the assessment of risk to skin integrity for patients who have been on trolleys for a period of longer than four hours.
- Not all notes we observed in the department were secure.
- There were no band 7 nurses working in the department at night and limited coverage at weekends with many shifts being led by band 6 staff.
- Compliance with life support training for medical staff was low. Less than 50% of medical staff were up to date with basic adults and basic child life support training and only 20% of medical staff were up to date with advanced life support training.

However we also found:

- There was a positive incident reporting culture in the department.
- All paediatric nurses were trained in safeguarding children at Level 3.
- Nursing handovers were comprehensive and provided nursing staff with necessary patient information.

Incidents

- There was a positive incident reporting culture in the department which was especially demonstrable among nursing staff. Incidents were routinely reported which meant that they could be investigated, and that learning could be implemented and shared to prevent future incidents of a similar nature.
- Staff told us that learning from incidents was fed back to them, and we saw evidence of this learning being shared in minutes from team meetings.
- We saw examples of incidents that had been reported where there was 'potential for harm' rather than actual harm, and evidence of changes made to practise as a result of these incidents being reported.
- No Never Events or Serious Incidents had been reported from May 2014 to April 2015.
- From May to June 2015 three serious incidents were reported regarding sub-optimal care, they related to a patient whose condition was deteriorating, a medication incident, and a diagnostic delay.
- Mortality and Morbidity was a standard agenda item at the monthly departmental clinical governance meetings. We observed this by attending a meeting the week of our inspection. The meeting was well attended by service managers, clinical leads, other clinical and support function managers and was chaired by the divisional director. We reviewed three sets of minutes from these meetings from February to May 2015 inclusive and saw that mortality and morbidity had not previously been overseen as part of this meeting's agenda, but was discussed separately.
- The minutes from May 2015 showed that the chair requested a more divisional overview and it was added to the agenda which meant that mortality and morbidity was not seen as a priority for the department prior to May 2015.
- The minutes from the separately held meetings to discuss mortality and morbidity for the division, which took place every six weeks, identified lessons learned, recorded actions, and identified other governance committees and meetings to share the learning at.
- All nursing staff had attended duty of candour training, and we saw posters in the department explaining what duty of candour was. We asked five nurses to tell us their understanding of duty of candour, and all were able to demonstrate a correct understanding and also explain how it related to practice.

- Doctors were not provided with any in-house duty of candour training.

Cleanliness, infection control and hygiene

- In the 2014 A&E survey the department scored similar to other trusts when people were asked if the department was clean. The trust scored 8.7 from a range of 0-10.
- An action plan was produced by the trust in January 2015 after a comprehensive infection control audit in the department. Two of the actions in this action plan were to provide e-learning to 100% of staff and to carry-out monthly audits to improve the safe use of sharps bins. We found several sharps bins left unsecured during our inspection.
- Regular hand-hygiene audits were undertaken. Previous audits had produced an action plan in January 2015 which outlined that most actions would be completed by July 2015; however during the inspection when we reviewed the progress of the action plan not all items had been completed.
- During the unannounced inspection in the resuscitation area of the department, we observed a staff member clean a bay ready for the next patient. The staff member cleaned the bed only and did not clean the side table or the monitors above the bed.
- We also observed a staff nurse walk from resuscitation into the utility room near majors still wearing their examination gloves. The nurse removed the gloves once inside the utility room; however, they should have been removed prior to leaving the resuscitation area.
- We observed a nurse wearing an apron leave the bedside of a patient and then leave the resuscitation area; they then entered the resuscitation area again and went back to the patient's bedside behind the curtain still wearing the same apron.
- The department had one cleaner dedicated to the department for 15 hours per week to support nursing staff in the cleaning of medical and patient equipment. Outside of these hours the nursing staff were required to maintain the cleaning of the equipment.
- Recent environment audits had improved to 92% compliance in August, however, cleanliness of equipment carried-out by nurses had significantly regressed. Compliance in June in the department was 85%, but this dropped significantly in July to 58% with a slight increase in August up to 69%.
- There were handwashing facilities available at the point of care and we observed that staff were using PPE when required. Clinical staff adhered to the trusts bare below the elbows policy.
- There were no cases of Methicillin-resistant Staphylococcus aureus (MRSA) or Clostridium difficile (C.difficile, or C.diff) contracted within the department for the 12 months prior to inspection.

Environment and equipment

- The department was free from clutter and there was signage on the floor to direct people between departments.
- The paediatric department was separate to the adult area, and was in an appropriate environment in which to deliver safe care to children. However, while the department was a secure area with a coded entry system, there were release buttons to exit the area which were within reach of children in the department. We observed one child activating the release to leave the department.
- During the inspection we found multiple items of equipment, including a fluid warmer, syringe driver, intravenous infusers and dynamaps that were currently in use and had not had portable appliance testing (PAT), maintenance or servicing for several years with the oldest item identified being last checked in 2009.
- This was bought to the attention of the department and all of the equipment identified was taken out of use immediately. Testing was then arranged by the department and the equipment was tested within 12 hours of us raising this issue.
- During the inspection the team removed equipment from the front treatment rooms of minors to ensure that this was not accessible to the public. During the unannounced inspection we found that the items, including ring cutting equipment, was left out on the side in the treatment room. The doors were left open and no one was present in the room. We removed the items and took them to the nurse in charge, who informed us that they would take action on the issue immediately.

Medicines

- There was a lead pharmacist for emergency admissions who was available on the ward most of the day and at weekdays. They were supported by two pharmacy technicians in the mornings and a pharmacy assistant technical officer who maintained the stock levels.
- The pharmacy team on the ward were involved in all aspects of patients' individual medicine requirements. This included taking a detailed medicine history as well as checking that any prescribed medicines were correct. Any concerns or additional advice about medicines were written directly onto the patient's medicine charts by the pharmacist.
- We saw that pharmacy staff checked that the medicines patients were taking when they were admitted were correct and that records were up to date. Medicines interventions by a pharmacist were recorded on the prescription chart to help guide staff in the safe administration of medicines.
- Of the records we examined we identified that five out of the 12 prescription charts had missed signatures. This meant that there was a risk that these patients had not had their medicines or they had their medicines but this was not recorded, in this instance there is a risk of overdose to the patient should another dose be administered.
- A member of the pharmacy department told us the ED was a poor performing department for missed doses because people arrived without their medicines with them. They said their focus was on making sure that critical medicines were given and there were processes in place to support this. The team based in the department could get things quickly if needed; there was an emergency cupboard for out of hours and an on call pharmacist.
- Controlled drugs were stored as per trust policy. The trust commissioned a medicines review carried-out by an external trust in August 2015 which had identified many issues with controlled drug management and storage.
- The department had developed an action plan in September 2015 to address this issue. The department had implemented the majority of the recommended actions in its plan at the time of our inspection.
- Fridge temperatures were regularly checked and were found to be within appropriate parameters.
- During the announced inspection all IV bags were securely stored behind a locked door in the treatment rooms. During the unannounced inspection we found IV bags stored on portable trolleys within majors, these were not secured and could have been tampered with.
- In the paediatric department, medicines were secured in a locked cupboard within a locked treatment room.

Records

- Not all notes we observed in the department were secure. We found large shelving units containing patient notes, in a communal corridor, which all staff, including those from other areas of the trust, had access to.
- We examined the initial assessment records of both adults and children and found they had been completed correctly.
- We reviewed 25 sets of records including and found that early warning score documentation and risk assessments, including assessment for susceptibility to pressure ulcers using the Braden tool, were completed, had been completed and reviewed in a timely way and were signed by the correct signatory.
- We examined the records of three patients during the course of our unannounced inspection. All were completed with the care provided to the patients and included details of the pathways they were on.
- We noted that the nurse in charge was continually checking the patient records of those who were being cared for by newly qualified staff or agency staff to ensure that the records were completed in a timely way. Where records were not appropriately completed the nurse in charge ensured that the person updated the notes and spoke with them regarding record keeping. We observed this during the unannounced inspection.

Safeguarding

- All paediatric nurses were trained in safeguarding children at Level 3. Those spoken with were all able to explain the trust's safeguarding policy.
- 90% of medical staff had attended children's safeguarding level 2 training but only 69% had attended core safeguarding children level 3 training.
- All children's safeguarding status is assessed on their arrival to the department. An alert system was in place to identify children already on the child protection register.

- A liaison health visitor checked the records of all children under the age of five and all school age attendances were reported to their school nurses.
- 100% per cent of nurses had received level 1 adult safeguarding training and 98% had received level 1 children safeguarding training. For level 2 the percentage of staff was exactly the same as level 1 and for core level 3 training, 60% of nursing staff had received this role dependent training.
- 95% per cent of medical staff had received level 1 adult safeguarding training and 91% had received level 1 children safeguarding training. For level 2 the percentage of staff was 95% and 90% respectively and for core level 3 training, 69% of medical staff had received this role dependent training.
- We spoke with three nurses and two doctors about adult safeguarding procedures within the department. All could clearly articulate the requirements of safeguarding vulnerable adults including those at risk of financial abuse and those at risk of domestic violence.
- When asked about safeguarding vulnerable people from neglect two of the nurses were able to tell us of examples of patients being brought in from care homes in a poor condition, and in these instances they raised safeguarding concerns.

Mandatory training

- All paediatric nurses were paediatric intensive life support (PILS) trained. Two of the emergency nurse practitioners within the department and an advanced nurse practitioner were PILS trained. Within the paediatric department nursing staff had four protected days per year for training which included mandatory training.
- Compliance with life support training for medical staff was low. Less than 50% of medical staff were up to date with basic adults and basic child life support training and only 20% of medical staff were up to date with advanced life support training.
- The department had a clinical support nurse who supported nursing staff to maintain their mandatory training. Attendance was displayed on the wall in a staff area within the department so all staff could see at a glance, what training they had completed and what training they needed to attend or refresh, and when by. This practice lead also reminded staff and facilitated their attendance on courses.
- 91% of nursing staff had received infection control training, 92% had received information governance training and 71% had received manual handling training in relation to supporting patients to mobilise, 88% had received record keeping training and 84% had received risk management training.91% of medical staff had received infection control training, 73% had received information governance training, 76% had received record keeping training and 77% had received risk management training.

Assessing and responding to patient risk

- The time from a patient arriving in an ambulance to receiving initial assessment was worse than the England average from December 2014 to April 2015. The average treatment time to initial assessment peaked in March at 12 minutes.
- From December 2014 to July 2015 patients waited on average more than 60 minutes for time to treatment.
- From April 2014 to June 2015 the total number of 'black breaches', where handovers from ambulance arrival to the patient being taken to the emergency department took longer than 60 minutes was 1584. The highest being 314 in December and 302 in March 2015. In May and June the numbers had fallen to 39 and 22, which demonstrated a marked improvement in this area.
- In the 2014 A&E survey for the question “once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the A&E staff?” The trust scored 8.2 (out of a range from 0-10) which was similar to other trusts.
- In the 2014 A&E survey for the question “how long did you wait before you first spoke to a nurse or doctor?” The trust scored 6.3 (out of a range from 0-10) which was similar to other trusts.
- All attendances by foot to the department for both adults and children were assessed by either an Advanced Nurse Practitioner or an Emergency Nurse Practitioner assigned to streaming. They made a clinical decision upon presentation as to where the patient should be treated and whether treatment was required urgently.
- Ambulances (unless they had pre-alerted the department as to the patient’s arrival) arrived within the majors area of the department.
- The department had introduced the rapid assessment and triage (RAT) of these patients which we saw and this worked well when it was used.

- The department uses the National Early Warning Score (NEWS) to monitor patients while they are in the department. We saw that this system was being appropriately used, with documentation completed and triggering an escalation occurring when required.
- We saw one example where a patient who was receiving oxygen therapy was not on correct monitoring. We spoke to the nurse caring for the patient and the nurse told us they were unaware of the patient's diagnosis or why they were receiving oxygen.
- The service does not have a clear process or procedure for the assessment of risk to skin integrity for patients who have been on trolleys for a period of longer than four hours. There was no defined process for when a patient should be risk assessed or transferred onto a bed.
- Two nurses told us that if there was a flow issue in the hospital all patients who were admitted but awaiting a bed would be placed onto a bed after 12 hours, which placed people at risk of compromised skin integrity.
- During the unannounced inspection we examined the risk assessments and records of two patients in the resuscitation department who were unwell. Both patients had dedicated risk assessments, observations recorded and their National Early Warning Scores (NEWS) was calculated correctly.
- We followed one of those patients through the EAU and observed that their clinical risks and level of observation was appropriately handed over to ensure that the patient received appropriate high observation care.
- A large proportion of the oncology patients were recorded as presenting their patient ALERT cards on admission. This appeared not to be the case for haematology patients. In addition to this medical staff told us, doctors in the emergency department were not always using the antibiotic guidance indicated on the ALERT card. When a patient presented with neutropenic sepsis, antibiotics were sometimes re-prescribed on a medication chart, which would result in a delay in the administration of antibiotics.

Nursing staffing

- The department's whole time equivalent was budgeted for 7.6 band 7 nurses with 5.6 actually employed, 11 band 6 nurses with 10.8 actually employed, and 59 band 5 nurses with 45.5 actually employed. They also employed 9 emergency and advanced nurse practitioners against an establishment of 12.6. This meant that the service was not yet at their establishment for nursing staff within the department. The department met the requirements of the college of emergency medicine guidelines for nurse staffing.
- The paediatric department held bi-weekly recruitment meetings, targeted at children's nursing staff deficits, to make sure recruitment aims and needs were decided and that actions were progressed as planned. There was always a registered children's nurse on duty in the department. No agency staff were used within the paediatric department.
- Agency use within main department has been as high as 50% at night and higher weekends. During our unannounced inspection the nursing ratio was 60% agency on duty in the department.
- A nursing needs assessment was carried-out in August 2015 and a report had been sent to the trust board recommending an increase in the nursing establishment within the emergency department, however the service was not at full establishment and had 21% vacancy rate prior to the agreement to increase the establishment further.
- We were told that there were plans to use a tool known as the BEST, which is the baseline emergency staffing tool, however this had not yet commenced. This tool can help emergency departments to calculate the whole time equivalent workforce, and skill mix, which would be required to provide the nursing care needed in the department.
- There were no band 7 nurses working in the department at night and limited coverage at weekends with many shifts being led by band 6 staff. Nurses told us that they felt that this was noticeable.
- During the unannounced inspection on a Saturday, the shift was led by a senior and experienced band 7 nurse. At night time the service is led by a senior band 6 nurse, the plan for the service is to have a band 7 on each shift; however, this was challenged due to the ongoing recruitment position.
- Three nurses we spoke with explained that the week prior to our unannounced visit had been exceptionally busy and the standard of care provided to the patients was not what they had wanted it to be. They told us that they tried to keep patients as safe as possible but that there were errors. For example, they said that high NEWS or low oxygen saturation had not been reported to nurses by agency staff, and the lack of escalation was not ideal for the patients.

- During the unannounced inspection there were four agency nurses and three newly qualified nurses supported by four experienced nurses. This skill mix created a pressure on the experienced team to deliver their role due to the level of support they were required to provide.
- When asked if the skill mix including the newly qualified and agency staff was impacting on the quality of care staff told us that it was, but they were doing their best to mitigate this. Two nurses told us that they felt the care would not be good enough for them, their friends or their family.
- The nurse in charge explained how during one shift they got all staff together for a "huddle" to remind them of the standards expected in the care they were providing, not only for the patients, but for the trust and for them as registered nurses, they told us "they needed to do better than what they were".
- Where agency nurses did not perform to the expected standard of the trust these nurses were reported to the site managers and to the agency. We were informed that three agency nurses who worked in the service the week of our inspection would not be invited back to work at the trust due to concerns regarding their performance.
- Concerns were raised by two experienced nurses that due to staff shortages some of the nurses still get to come back on shift which causes them concern. We discussed this with the Director of Nursing following our inspection to ensure that this matter was appropriately addressed.
- During the unannounced inspection there was a lack of clarity regarding the staffing of the minors cubicles area near majors. This area contained four cubicles, three were used for minors and one was used for majors. We asked the nurse in the department who was looking after the minors patients and they did not know as they were looking after majors patients. We observed for ten minutes and no nurses came to the area. We asked the nurse in charge who informed us that the majors' nurse would look after all four patients in that area if they required support. We escalated our concerns that no one may be looking at those patients, who required close monitoring, and they immediately went to resolve this staffing issue.
- We attended the senior staff morning meeting. This was led by the consultant in charge and was attended by the senior nurse. The meeting followed a standard structure and included discussions about staffing and the number of admissions to the hospital. This meant the senior team were able to plan their day and organise their teams in a coordinated way.
- Nursing handovers were comprehensive and provided nursing staff with necessary patient information, presented the department's top risks to maintain awareness of the issues and shared any particular issues relevant to the environment or department on that day. Routine departmental checks such as checking medicine fridge temperatures were completed by the nurse in charge as part of the handover.

Medical staffing

- The department medical leadership team acknowledged that it lacks sufficient permanent consultant and middle grade staffing.
- There was a consultant presence for 16 hours a day, five days a week from 8am until Midnight. During our unannounced inspection at a weekend, there was one consultant, two registrars and three junior doctors working in the ED. This was sufficient based on the number of patients who required treatment at the time.
- The department had 10 consultants, 8 on rota. 2 of these on rota were substantive with one of the off-rota consultants substantive also. There were five locum consultants. Two of whom have worked in ED for four years, and three others on short-term contracts. Two of the locum consultants on short-term contracts were applying for substantive posts at the trust. There were 13 locum doctors working as middle grades covering shifts.
- The department had six registrars of which four were regular locums and four substantive middle grade posts.
- An average of approximately 6% of medical shifts (consultants, SHOs and clinical fellows) were unfilled between July and September 2015.
- The department currently sees over 17, 500 children per year. However, there is no designated substantive doctor for the paediatric department which is not in line with the 2012 Intercollegiate Emergency Standards. The department utilised a locum consultant with a special interest in paediatrics whilst they were recruiting a substantive doctor.

Major incident awareness and training

Urgent and emergency services

- During our inspection we inspected the department's Major Incident Store. This store was cluttered and contained out of date equipment.
- We raised this with the trust lead for Emergency Planning who told us that there was very little equipment in the room that was to be used in the event of a major incident. Following this conversation the room was relabelled as a 'Store' rather than the 'Major Incident Store'.
- The actual equipment for a major incident was kept in two separate places outside of the main department. The key for accessing the major incident equipment was held by the band 7 nurse in charge and staff did not appear aware of the process if a band 6 nurse was in charge.
- The trust had last called a major incident in January 2015 due to capacity and flow issues. A practise incident was performed in June 2015, and Band 7 nurses had undertaken a table top major incident exercise the week before our inspection. There were no formal debrief notes or learning which could be shared to the team from the major incident in January 2015.
- During the unannounced inspection we found the staff had removed all out of date equipment and medicines from the major incident store room. The team were in the process of re-organising the room and ordering new items required for a major incident.
- The light in the major incident room was not working, it was dark and it was not easy to find items. The nurse in charge informed us that they were in the process of reorganising this area and would report the light issue to get it repaired.
- The team tried to ensure that a staff member trained in Chemical Biological, Radiological and Nuclear (CBRN) emergencies was on each shift, however due to the current vacancy rates this was not always possible.
- Training rates for mandatory CBRN and major incident response training, including exercises undertaken, were not available in the department.
- We asked two doctors and two nurses what the process would be should a major incident be declared and all could articulate the need to speak to site team and refer to their major incident plan for guidance.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

Urgent and emergency services were rated as good for effective because:

- People were treated and cared for in line with evidence based guidelines. Local policies were available on the trust intranet, and staff told us it was easy to locate them.
- The majority of staff in the service had received appraisals within the last 12 months.
- Induction of agency and locum staff was established and we observed that this was implemented effectively in the service.
- The majority of staff had received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

However there were some areas that could be improved because:

- There had been a deterioration in performance on key indicators of the sepsis and septic shock audit.
- The outcome of the East of England neutropenic sepsis audit for 2014 / 2015 showed deterioration in performance against the 'door to needle' time (DTN) and compliance of antibiotics within one hour.
- In the data provided to us by the trust, equipment competencies were not recorded as assessed on equipment including moving and handling equipment.

Evidence-based care and treatment

- Local policies were available on the trust intranet in both departments. A quick link was available via an ambulance logo and doctors commented to us how easy it was to find them. Policies we looked at, included Sepsis were in keeping with NICE guidance and were all in date.
- The service offered hyper acute stroke services with acute stroke nurses who were requested to attend the department to see stoke patients and assess for thrombolysis, this service was available seven days per week.

- Outside of hours the nurses worked, thrombolysis calls go to a Medical specialist registrar – the pathway was visible on the wall of the department. Non thrombolysis patients are taken straight to the stroke unit after being clerked for admittance.
- We examined the records of two patients who were admitted to the department with a stroke/ transient ischaemic attack (TIA). In both cases the team had pre-alerted the acute stroke nurse who attended the resuscitation to prepare with the team. We reviewed the medical records of both patients which evidenced that the care provided followed the requirements of the NICE guideline CG68 Diagnosis and initial management of acute stroke and transient ischaemic attack.
- One patient who had a TIA was placed onto a pathway specifically for TIA treatment including the need for high observation monitoring and escalation if their condition progressed. The second patient was placed onto the stroke pathway and admitted to the stroke unit within two hours of admission.
- A fractured neck of femur pathway was followed which included outreach and medical registrar review when early warning scores triggered a review.
- Band 7 nurses led on local audit activity and they fed the results back to nursing colleagues at team days. The results were displayed in the staff room.

Pain relief

- Pain was assessed on arrival, and was age appropriate within the paediatric department.
- Patients at adult triage who had already been streamed by an emergency nurse practitioner received appropriate pain relief.
- Guidance was available for staff on pain management. We observed staff involving the family of a patient in a discussion about the provision of pain relief for the patient.

Nutrition and hydration

- Due to capacity issues in the trust some patients would remain in the department for long periods of time. We saw that cold meals and hot drinks were being provided regularly in both departments. Breakfasts in picnic bags were provided for patients in the morning.
- One patient we spoke with was offered food that was compatible with their food intolerance, specifically a gluten intolerance where staff had actively sought out food choices to provide to this patient which met their individual needs.

Patient outcomes

- The CEM 2013/14 audit of severe sepsis and septic shock, found overall there had been deterioration in performance compared to the previous audit in 2011 based on 50 patients. However, the department measured and recorded all patient vital signs in 98% of cases, with the national median being 94%.
- In the CEM asthma in children clinical audit 2013/14 based on 14 patients the department was performing better when compared to the national results in most areas including initial observations, treatment, and discharge medication.
- In the CEM paracetamol overdose clinical audit 2013/14 based on 50 patients the department performed similar or better than other departments in the five standards.
- Unplanned re-attendance rates (within 7 days) were better than the England average for a reporting period between January 2013 and March 2015.
- The department performed better than the UK average in all reported measures in the 2013 Consultant Sign-off audit.
- The trust took part in the East of England neutropenic sepsis audit for 2014 / 2015. Overall the 'door to needle' time (DTN) compliance of antibiotics within one hour occurred in 53% of cases, this was worse than the previous year's audit results of 57%, with the worst performance in haematology. The trust response to these results was to encourage patients to present their ALERT card to ensure they get assessed and treated on an urgent basis.
- The trust submitted 95% of patients to TARN compared to the number of patients expected based on the Hospital Episode Statistics (HES) dataset.
- TARN showed that the majority of indicators were established for trauma at the hospital however the TARN report as well as associated trauma network peer review reports from January and April 2015 showed some areas of concern with recommendations for improvement.
- The first identified concern was that there were lengthy delays in accessing computerised tomography (CT) scans, and there were no audits which looked at those

delays specifically. They also had not undertaken any assessment of incidents of complaints relating to traumas where there had been delays in access to CT scans.
- The report cites that there is a trauma committee in place, however it does not meet regularly, and attendance has been poor.
- The reports also highlight the lack of a trauma coordinator as a concern. The need for the role was discussed with the executive team formally in June 2015 and approval was given for recruitment.
- The other concern highlighted was a lack of clarity around pathways and patient guidelines relating to TBI and spinal patients as well as rib fractures.

Competent staff

- Newly qualified paediatric nurses had a one year preceptorship to develop core competencies in emergency nursing.
- Nursing staff spoken with told us that they hadn't historically received an annual appraisal, but said appraisals had been happening for the last year approximately.
- The department had a dedicated clinical support nurse to support nurses with achieving and maintaining key competencies.
- Out of 12 ED middle grade staff, 11 were up to date with their appraisal. One doctor had received an appraisal in years 1 and 2, but due to long term sickness, didn't complete his appraisal last year. All four ED consultants were up to date with their Appraisals. Middle grades spoken with were positive about the appraisal process and felt that their development was valued by the department.
- Medical staff within the department were up to date with their revalidation.
- 81% of nursing staff had received non-patent related manual handling training. In the data provided to us by the trust equipment competencies were not recorded as assessed.

Multidisciplinary working

- There was evidence of excellent multidisciplinary team working within the paediatric department. The paediatric nurses rotated between the department and the children's' assessment unit routinely.
- We saw evidence of prompt review of patients by specialities. Staff reported however, that this input could be inconsistent, and that professional standards were being written to ensure that review occurred within thirty minutes of referral. Nurses told our inspection team that they felt comfortable escalating delays to more senior team members, and to the responsible consultant if necessary.
- Physiotherapists led two clinics per week to see patients with soft tissue conditions which meant that patients with these conditions did not have to wait long to see a physiotherapist.

Seven-day services

- The emergency department was open 24 hours a day, seven days a week.
- There was a discharge team to support discharge of patients that was supported by a pharmacist. There were therapists to support patients on discharge with respiratory problems and after having a stroke. Diagnostic tests were available 24 hours a day.
- There was seven day per week cover from the acute stroke specialist nurses available to provide care and support to patients admitted with a stroke or transient ischaemic attack.
- There was a lead pharmacist for emergency admissions who was available on the ward seven days a week.

Access to information

- There were computers situated in each area which were linked to the main systems of radiology, pathology and the patient administration.
- Agency staff who had worked in the department on several occasions, and in one case for over a year, did not have access to the hospital systems or to the intranet. They were required to ask for a permanent staff to allow them access to systems.
- Due to the limited access available to agency staff we observed that hospital ID smartcards were kept in the computer keyboard to grant staff open access to the systems which could breach information governance for that individual, with potentially entries being made on systems in their name, without their prior knowledge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- 80% of medical staff had received level 3 training on the Mental Capacity Act (MCA). 85% had received training up to level 2.

Urgent and emergency services

- 95% of nursing staff had received level 3 training on the Mental Capacity Act (MCA). 93% had received training up to level 2.
- An MCA checklist formed part of the initial assessment of patients and was completed at that time.
- The department leadership recognised that historically there was limited documentation with reference to consent to treatment, but we saw that new documentation had been implemented which included space for patients to consent to their plan for care.
- Nursing and medical staff received training on the deprivation of liberty safeguards with 85% of medical staff and 71% of nursing staff having received level 3 training.
- Junior doctors' induction to the department included MCA and deprivation of liberty safeguards training. Individual doctors told us that when they arrived in department their consultant also checked to ensure they were aware of their responsibilities in relation to capacity assessment.
- We observed a doctor assess a 15 year old for their full understanding when requesting consent.

Are urgent and emergency services caring?

Requires improvement

Urgent and Emergency services required improvement for caring because:

- When the department was at its busiest we saw that several patients were not always afforded the level of care and compassion we saw for the majority of our inspection.
- We observed three examples of poor care, two involved patients who were not supported, offered comfort and were not acknowledge by staff and the third was an inappropriate comment made by a doctor about a patient who could hear what the doctor was saying.

However we also found:

- When the department was quiet we saw several examples of patient interactions demonstrating that patients' were cared for compassionately and that their privacy and dignity was considered when delivering care and treatment.
- Patients and their families were involved in the delivery of care and treatment.
- Clinical nurse specialists for many services were available from Monday to Friday but were accessible to patients through referrals for their attendance on Mondays if they were admitted over the weekend.

Compassionate care

- We spoke with many of the patients and relatives of patients in the department about their experience of the care provided. Patients told us that staff were caring and that their needs were met.
- Patients and relatives commented on how busy staff were, but that this did not stop them checking in with them regularly and making sure that their needs were being met.
- In both the paediatric and adult emergency department we saw several examples of patient interactions demonstrating that patients' privacy and dignity was considered when delivering care and treatment.
- However, the department was busier on the last day of our inspection and was noticeably different in the care provided to patients from the previous days. We observed a patient who had tried to climb out of bed and got their leg caught in their bedrails. One of our team supported the patient and covered them with a blanket while they waited for a nurse to attend.
- In another case a patient was distressed and had knocked their cannula and their arm was bleeding, we observed a nurse and a care assistant walk past this patient and not offer comfort or support, our inspectors had to step in to stop the bleeding and comfort the patient.
- Also during our inspection, we heard a doctor in one case inappropriately refer to a patients' condition as "pretty dire" which was said within earshot of the patient.
- For the NHS Friends and Family Test, the percentage of people recommending the trust was below the England average from March 2014 to February 2015 with an average score of 76%. However for September the score was 80%, which demonstrated an improvement and the response rate was in line with the England average of 14%.

Understanding and involvement of patients and those close to them

Urgent and emergency services

- We observed a handover of an acutely unwell patient from an ambulance crew to the departments' staff. The receiving consultant introduced themselves and explained the care that was going to be delivered.
- Patients told us that staff involved them in the delivery of their care and treatment and one person we spoke with said they felt prepared for the next stage of care, felt involved and that staff had listened to them.
- A family told us that they had been asked in what way they would like to help their mother, who was a patient in the department.

Emotional support

- Clinical nurse specialists for many services were available from Monday to Friday but were accessible to patients through referrals for their attendance on Mondays if they were admitted over the weekend.
- Access to specialist palliative care service nurses were available with out of hours support if required.
- There were on call services available from the chaplaincy services and counsellors in the event of a traumatic incident for relatives and families and we were provided with examples of when the teams had been called to provide support to patients and families.
- We observed this during the inspection where a patient died in the department and the Child Death Review Rapid Response Service, which is provided county wide by Essex County Council, were called in to provide support to the family.
- The counselling team provided one to one dedicated support and counselling for the family following the death of their relative. This team stayed with the family, identifying what they needed and providing support for the tasks they needed to complete during a difficult time. The staff stayed with the family throughout the day and for the duration of our inspection and were truly caring towards the family and the staff involved.
- Play specialists were available to use distraction techniques to care for children who were distressed or upset about being at a hospital.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Urgent and emergency services required improvement for being responsive because:

- The 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.
- The total time spent in A&E at the trust is generally above the England average. It rose sharply in December 2014 and remains high between 180 and 195 minutes.
- Bed meetings were ineffective in responding to the issues the department had to address.

However we also found:

- The clinical decision unit avoided 130 admissions per week and there was a low re-admittance rate for patients seen by the unit.
- Upon presenting, if a patient did not need emergency treatment, the department could telephone their GP on a telephone number given by each provider, to be able to book them an appointment with their GP.
- Complaint response times had improved in each of the three months prior to inspection.

Service planning and delivery to meet the needs of local people

- The emergency department had undergone considerable redevelopment which had included expanding a number of areas such as the paediatric ED and the opening of a Clinical Decision Unit (CDU)
- The CDU remained under the management of the emergency department team, but was staffed by a nursing team independent of the emergency department rota. The aim of the CDU was to support patients for a short period of time rather than admit them for an extended period to hospital
- As part of the restructuring of the emergency department an advanced nurse practitioner was leading on a project looking at the streaming of patients and the provision of information for patients to make sure that

people were seen by the appropriate service. Patients were referred to local GP practices upon presenting when appropriate and the department was able to ring ahead and book appointments directly for the patients.
- The advanced nurse practitioner had also provided training on treating minor injuries and wound care to nursing staff at a local walk-in centre, so that they would be able to confidently and competently treat these patients.

Meeting people's individual needs

- Translation arrangements were available via telephone translation service.
- The department had a learning disability liaison nurse and we observed staff engaging them to support a patient.
- The areas of the department where children were seen were child friendly with appropriate décor and distraction facilities. A play specialist visited the emergency department regularly to provide distraction for children.

Access and flow

- The ED 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 from the trust showed that between September 2014 and June 2015 performance ranged between 70-80% which meant that this target had not been met.
- The performance for July was 81% and 82% for August 2015 as an overall number. However daily performance varied greatly between 50-90% and was not consistently managed to achieve improvements.
- The department had pathways for streaming patients to local walk in centres and GP services. These patients were not included in the figures of those treated. This meant that the patients they did see tended to be more complex, requiring more clinical intervention, which took longer.
- This was also shown in data, which showed a higher proportion of patients than the England average were admitted to hospital. This may have had a negative impact on the departments overall four hour target
- The percentage of patients leaving before being seen was regularly below the England average between January 2013 and May 2014. It has since risen monthly between May and August 2015 to above the England average of around 2.5 patients.
- During the course of our inspection we saw that the vast majority of those who waited longer in the department were those who were waiting for admission to the hospitals' wards. The staff in the department kept data on the reasons for the delay. We reviewed this data and saw that the vast majority of patients who were delayed were waiting for a medical bed.
- Percentage of patients waiting between 4-12 hours before being admitted was regularly lower than the England average between April 2014 and February 2015. This percentage rose during the winter months and was above the England average in March 2015 and through to August 2015.
- The department of health requires trusts to admit patients to hospital wards within 12 hours of a decision being made to admit them. The decision to admit was made by speciality doctors who reviewed the patient in the department. The total time spent in A&E at the trust is generally above the England average. It rose sharply in December 2014 and remains high between 180 and 195 minutes. The England average for this period is between 135- 140 minutes.
- Staff attended a bed meeting three times a day to discuss their requirements for beds within the trust. Staff told us that the tone of these meetings had changed significantly in recent months with much more emphasis on the response of the hospital rather than a focus on the department's performance.
- We attended and observed the bed meetings and found that the meetings did not deliver clear objectives to clear pathways and beds through the hospital, staff attended and raised their capacity issues but no clearly defined actions were taken at those meetings. This meant that at the next meeting the same issues were being raised again and did not support the department in responding to the issues that were being raised.
- During time so of the trust defined 'black alert' on pressures the number of meetings increased from three to four or five per day which two staff in the emergency department told us was excessive when their time could be better spent in the department.
- Data showed that use of the CDU avoided 130 admissions per week and that there was a low

re-admittance rate for patients seen by the unit. We saw data that showed that in August 2015 the unit had cared for 419 patients, 90% of which had been able to go home without requiring admission.

Learning from complaints and concerns

- The department received 32 complaints from 1 June 2015 to 31 August 2015.
- Average response times for responding to complaints had significantly improved in the three months prior to inspection. In July 2015 the average response time was 42 days decreasing through 35 days in August to an average of 31 days taken to respond in September 2015.
- Between June and August 2015 the two areas that most complaints were received about, were staff attitude and treatment plans.
- Complaints and compliments were printed out and placed in the staff room and feedback on complaints was shared at nursing team days.
- Recent complaints numbers were discussed in departmental clinical governance meetings but no further detail, but there was a weekly departmental meeting for a more detailed oversight of complaints issues.

Are urgent and emergency services well-led?

Requires improvement

Urgent and emergency services required improvement for leadership because:

- A band 6 nurse was on their own in the paediatric department from 11pm to 7am. Which was a risk to the nurse on duty as they were isolated in the department.
- Risks identified during the inspection around the major incident store, staff safety in children's department, equipment, and risk assessments were not identified on the risk register. We were therefore not assured that the risks were not all being addressed.
- We observed that there was a real disconnect between the supportive of element of team working following an event between the children's and adults emergency department.
- Following a traumatic event we observed during the unannounced inspection the service did not undertake any debrief or dedicated staff support sessions.

However we also found:

- Staff felt there had been a positive change in the culture of the service which was a result of the changes in leadership.
- Staff were very enthusiastic about their service and had taken ownership of the issues identified during previous inspections and demonstrated to us that they wanted to make a difference to provide the right service to patients.

Vision and strategy for this service

- The department's lead consultant had a clear vision for staff development and service development which is ongoing.
- The matron also had clear vision for the service and a clear strategy for driving service improvement.
- As well as the matron, nursing staff were able to verbalise their vision for the department which was aligned to the overall trust vision. The department leadership communicated the trust vision in monthly newsletters provided to all staff.

Governance, risk management and quality measurement

- Monthly governance meetings were held and were well attended by appropriate personnel. Agenda items included the departmental risk register, urgent patient safety issues, shared learning from incidents and clinical effectiveness. We saw the minutes from March 2015 until May 2015 and attended the September meeting. The meeting was well attended by service managers, clinical leads, other clinical and support function managers and was chaired by the divisional director.
- The clinical lead had introduced weekly meetings to make sure there was regular oversight of serious incidents, complaint information, and audit data that could be acted on in a timely way.
- The department's clinical lead had plans to address recruitment and was able to articulate the numbers they wanted to achieve and they had recently submitted an action plan to drive this change. They had also instigated regular new meetings to improve governance in key areas.

- At each nursing handover, departmental risks considered to be of the highest priority were highlighted.
- A monthly newsletter was circulated from the CDU leadership to CDU staff, which included information on audit results, performance, incidents and the Friends and Family Test.
- A monthly newsletter was also provided for all staff within the department which communicated key issues around patient safety, governance, and departmental performance.
- We raised a concern that there was only one Band 6 nurse on their own in the paediatric department from 11pm to 7am. The paediatric services' matron said they were aware that this presented a risk to the nurse on duty as they were isolated in the department. They told us that they were reviewing the staffing during these hours. A lone worker policy was available within the trust; however, no individual risk assessment had been undertaken. The nurse on duty at night did not have access to a personal alarm.
- The departments risk register contained the expected risks for the department. There was evidence of actions taken to mitigate the risks and at present there was no risk above a medium risk on the register.
- Whilst there was evidence that the risk register was reviewed every three months, risks identified during the inspection around the major incident store, equipment and risk assessments were not identified on the risk register. We were therefore not assured that the risks were not all being addressed.
- The clinical lead told us that his top two risks for the department were recruitment and flow. They said that the introduction of the CDU had helped to mitigate this risk.

Leadership of service

- The department's matron and clinical lead have what they call a '2 at the top meeting' once a month to discuss key departmental issues.
- Nursing staff we spoke with were very positive about the leadership of the department, though it was interim, but felt that the change of matron had had a very positive influence on the way the department was run, and the standard of care that was being delivered. Staff told us that the matron leading the service was approachable and very supportive.
- Staff we spoke with in the department told us that many of the service improvements had been undertaken since the appointment of the new matron.
- The clinical lead demonstrated an inclusive approach to improvement utilising existing staff skills and expertise. They and colleagues had recently highlighted several nurses with resus experience and formulated a resus group called Red Arrow, with doctor support also, to manage risks and maintain and improve performance through shared learning.
- The clinical lead had 2.5 days dedicated to a leadership role each week.

Culture within the service

- At the end of 2014 and beginning of 2015 we were aware of concerns about a culture of bullying and harassment in the department which was having a negative impact on morale, staffing and the effectiveness of the department. The trust acknowledged that there was an issue with the culture in the department, undertook an investigation and changes were made throughout the department during 2015 to improve the culture.
- It was evident from conversations with staff that they felt there had been a positive change in the culture of the service which was a result of the changes in leadership.
- A member of the nursing staff told us that they felt that there had been a noticeable improvement in the culture in the department at senior level and that nursing leadership was very supportive. They had not felt comfortable challenging practice where they'd had concerns in the past, but said that now they would now challenge when they had concerns. They told us that they felt that there used to be an overpowering presence of the executive team in departments, which was no longer the case.
- We noted that during this inspection the staff attitude had changed and staff were very enthusiastic about their service and had clearly taken ownership of the issues identified during previous inspections and demonstrated to us that they owned the issues and wanted to make a difference to provide the right service to patients. They felt the improvements had to be led by them and that they wanted to get it right.
- Junior doctors we spoke with were enthusiastic about working in the department. One junior doctor told us that they were nervous about starting work in A&E, but said "everyone here is fantastic and have been really supportive".

- Following a traumatic event we observed during the unannounced inspection the service did not undertake any debrief or dedicated staff support sessions. However, we did identify during our announced inspection, that the department had a member of staff from a nursing background who was trained to provide emotional resilience and debriefing sessions for nursing staff. It was not clear if debriefing sessions had yet been provided for nursing staff or what provision was available for medical staff.
- We observed that the children's team and the adult team, whilst they worked well during the time of the clinically required work, did not work well to support each other after a traumatic event. We observed the matron for children's services dedicate their time to clearing, cleaning and restocking the children's resuscitation area on their own without observed offers of support from others.
- We observed that there was a real disconnect between the supportive of element of team working following an event between the children's and adults emergency department. This was further evidenced through the acknowledgement that the children's emergency department were not aware that there had been a child death in the department during the morning.

Public engagement

- We saw no evidence of active service user involvement or engagement with the public about the service.

Staff engagement

- The department engaged its nursing staff in the day to day running of the department and fed back on key issues to nursing staff.

Innovation, improvement and sustainability

- The individual currently in the matrons' post is on a secondment from a more junior role within the department, and they told us that they were unsure of their long term future in the role, as it had not yet been decided or shared with them. This meant we could not be sure that there was stable, sustainable nursing leadership, as there was a lack of clarity over the organisations' future planning for this role.

Medical care (including older people's care)

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

Information about the service

Colchester Hospital University NHS Foundation Trust provides acute healthcare services to a population of approximately 370,000 in the districts of Colchester and Tendring.

Colchester Hospital University NHS Foundation Trust provides medical services at Colchester General Hospital as part of the medicine division and cancer services as part of the clinical support services and cancer division. Specialties included: gastroenterology, respiratory, cardiology, rheumatology, neurology, dermatology, endocrinology, care of the elderly, stroke, oncology and, haematology. There were 340 inpatient beds and 36 day case beds available across these services.

Between January and December 2014 there were 39,900 medical admissions to the Colchester General Hospital. Of these, 51% were emergency admissions, 43% were treated as a day case and 1% were planned admissions. General medical admissions represented the largest number of admissions at 47%.

During our inspection we visited 10 wards including the emergency assessment unit, The Elmstead Day Unit, The Mary Barron Suite and haematology day unit, the cardiac catheter laboratory and, the endoscopy unit. We spoke with 36 patients, 27 relatives and 136 staff, including junior and senior nurses, health care assistants, junior and senior doctors, allied health professionals, nursing and medical students, bank and agency nursing staff, pharmacist staff, administrative and clerical staff, volunteers, staff from the social work department and, staff from estates and facilities.

As part of our inspection we used the Short Observational framework for Inspection (SOFI) which is a specific way of observing care to help us understand the experience of people who could not speak with us. We observed interactions between patients, their relatives, and staff, considered the environment and looked at 45 medical and nursing care records and, 43 medication prescription charts. Before our inspection, we reviewed performance information from and about the hospital.

Medical care (including older people's care)

Summary of findings

Medical care at this hospital was requires improvement overall. Safety of this was rated as inadequate because patients were not always protected from avoidable harm and abuse. Staff did not always understand and fulfil their responsibilities to raise concerns and report incidents and near misses. Safety concerns were not consistently identified and as a result there were missed opportunities to learn from adverse events. There was insufficient equipment in the endoscopy unit to safely maintain the decontamination process of endoscopes. We also found that equipment which was used for patient care was not in service date, had not always been maintained or been electrical safety tested. Systems, processes, and standard operating procedures in infection control, medicines management, patient records and, the monitoring and maintenance of equipment were not always implemented, reliable or appropriate to keep patients safe.

Nursing and medical staff did not have regular update mandatory training and we were concerned about the levels of staffing, skill mix of staff and the high use of agency and locums in medical and nursing specialties. We saw elements of good practice including the safeguarding of vulnerable adults which was given sufficient priority and staff took a proactive approach to the early identification of safeguarding concerns.

We judged that the effectiveness of this service required improvement because patients were at risk of not always receiving effective care and treatment. Care and treatment of those patients identified as having a long term conditions did not always reflect current evidence-based guidance, standards and best practice. Current local and national guidance in endoscopy and the cardiac catheter laboratory had not been implemented. The endoscopy service was no longer joint advisory group (JAG) accredited due to the accreditation being revoked in June 2015 due to concerns identified.

Outcomes for patients in some care elements stroke and diabetes were sometimes below expectations when compared with similar services. We saw where patients symptoms of pain were suitably managed and staff actively monitored the patients food and fluid intake although, support for those patients requiring assistance was not always readily available.

The care provided to patients in medical care services required improvement because there were times when patients did not feel well supported or cared for and some patients and their relatives had concerns about the way staff treated them and felt they were not always treated with kindness or respect or in a timely way when receiving care and treatment. We also observed that during handovers on wards that the staff did not see patient's privacy and dignity as a priority. We saw elements of good practice. We observed staff responding compassionately when patients needed help and support to meet their basic personal needs.

We rated the responsiveness of medical care services as requires improvement because the service did not always meet patients' needs. There were medical outliers placed in inappropriate wards and whilst care in the majority of cases met the person's clinical needs it was not responsive to their individual personal needs. The numbers of patients being moved between wards out of hours was high between the hours of 10pm and 8am. The Referral to Treatment Times (RTT) for the cancer standards was not being achieved by the trust. And we identified incidences where patients had gone for more than 100 days without treatment for their cancers.

The leadership of medical care services required improvement because the governance arrangements were not fully effective. Whilst improvements with local ward leadership were noted since our previous inspections there was a lack of awareness from the divisional and trust leads regarding the concerns that staff had in endoscopy. The culture within the service was improving and becoming more open with the majority of staff we spoke with telling us that they were happy to raise concerns.

Medical care (including older people's care)

Are medical care services safe?

Inadequate

The safety of medical care services was rated as inadequate because:

- Staff did not always understand and fulfil their responsibilities to raise concerns and report incidents and near misses.
- Safety concerns were not consistently identified and as a result there were missed opportunities to learn from adverse events.
- In endoscopy we could not be assured that the decontamination process was consistent across all areas where endoscopes were processed and protein testing was not consistently carried out.
- There was insufficient equipment in the endoscopy unit to safely maintain the decontamination process of endoscopes. At the time of our inspection only two out of four washers were available to process the endoscopes.
- Equipment which was used for patient care was not in service date, had not always been maintained or been electrical safety tested.
- Methicillin-susceptible Staphylococcus aureus (MSSA) rates were worse than the England average with eight cases recorded in medicine.
- Isolation practices for infectious patients and bare below the elbow uniform policies were not always being adhered to.
- Systems, processes and standard operating procedures in infection control, medicines management, patient records and, the monitoring and maintenance of equipment were not always implemented, reliable or appropriate to keep patients safe.
- Nursing and medical staff did not have regular update mandatory training and we were concerned about the levels of staffing, skill mix of staff and the high use of agency and locums in medical and nursing specialties.

However we also found:

- Staffing shortages were acted upon appropriately with the use of bank and agency and an effective induction process for locum, agency and bank staff ensured that patient's safety was in place.
- We saw elements of good practice including the safeguarding of vulnerable adults which was given sufficient priority and staff took a proactive approach to the early identification of safeguarding concerns.
- Risks to safety from changes in demand and disruption were assessed, planned for and managed effectively with plans in place to respond to emergencies and major situations.

Incidents

- Incidents were reported through the trust's electronic reporting system. We spoke with 28 staff specifically about incident reporting, 24 staff were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic reporting system.
- We could not be assured all staff were raising incidents appropriately. Feedback from agency staff was mixed; some agency staff reported little or no access to the online incident reporting system.
- Six junior medical staff told us they reported very few incidents, junior medical staff told us they would refer incident to their seniors. Of the six junior doctors we spoke with one told us they had used the electronic reporting system to raise an incident.
- We observed the sub- optimal care of a deteriorating patient on the emergency assessment unit; this had not been raised as a clinical incident.
- On another ward we saw where nursing staffing levels overnight did not meet the National Institute of Health and Care Excellence (NICE) guidelines of one nurse to eight patients. The nursing sister could not tell us if this had been raised as an incident.
- Issues relating to machine and equipment failures in the endoscopy unit which impacted on the running of the service were not routinely raised as an incident.
- Information received before our inspection suggested the level of harm a patient experienced as a result of an incident was not always correctly graded or, would be changed to a lower level of harm. During our inspection we spoke with 10 ward sisters who all told us the grading of incidents would not be changed without their prior knowledge. One ward sister gave us an example of where the grading of an incident would be changed and said this was usually because the incident may have been inappropriately graded as 'severe harm' by a junior, less experienced member of staff.
- We reviewed 871 incidents reported between 01 June and 31 August 2015 and identified 135 (15%) incidents

which had been incorrectly graded with 'no harm' or 'low harm'. For example a delay in a patient's treatment and escalation with the patient suffering a cardiac arrest as a result was graded as 'no harm'. Another incident where a safeguarding concern was raised about an agency nurse who forced medicines into a patient's mouth was graded as 'no harm'. Another incident where a patient was given four times the dose of a beta blocker which affects the heart and circulation leading to the patient having cardiac distress which resulted in the patient needing medical help was graded as 'no harm'.

- The medical division had reported one never event in July 2015. Never events are classified as such because they are so serious that they should never happen. The event related to the mis-placement of a naso-gastric tube; a tube that should go into the stomach via the nose.
- Staff were aware of this incident and the sister on the ward where the incident occurred was completing a root cause analysis investigation to identify any factors that may have contributed to the incident. An interim report had been completed and initial changes to practice had been put in place in this area in addition to, a trust wide email sent out following the incident, as a medical device alert.
- 77 serious incidents had been reported by the medical division between May 2014 and June 2015. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response (NHS England, March 2015). The top four most commonly reported incidents were; care for the deteriorating patient, slips/trips/falls, catheter associated infections and safeguarding.
- Staff reported getting feedback from incidents via email, staff meetings and during handovers. Serious incidents folders were available in all the clinical areas. Staff felt this was a useful learning tool which informed staff of incidents that had occurred both locally and trust wide. We saw evidence of staff signatures which indicated they had read information contained in the folder.
- The new regulation, Duty of Candour (DOC), states that providers should be open and transparent with people who use services; it sets out specific requirements when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, giving truthful information and an apology We spoke with 11 staff specifically about duty of candour. All the staff we spoke with were aware of duty of candour and we were told of many examples where duty of candour had been applied.
- Patient Safety Incidents reported with harm of moderate, severe or death require a Duty of Candour to be undertaken within 10 working days of the incident being reported. There were 28 incidents between April and August 2015 which require Duty of Candour of these 26 were undertaken within the 10 day standard. The remaining two were completed but after the 10 day standard.
- We received mixed feedback on mortality and morbidity meetings. Very few nursing staff were able to tell us if these took place within the division of medicine. Medical staff told us mortality and morbidity meetings took place monthly at divisional level and that medical staff would be 'invited' to attend.
- We spoke with six junior medical staff during our inspection about mortality and morbidity meetings and of those only one had attended since starting at the trust. Five of the junior medical staff were unable to tell us the content of these meetings or of any feedback they had received.
- Minutes we reviewed from meetings held between June and September 2015, with the exception of June, did not demonstrate where individual morbidity reviews had taken place. Mortality and morbidity meetings allow health professionals the opportunity to review and discuss individual cases to determine if there could be any shared learning.
- We asked for minutes of meetings to be provided, prior to June 2015 and none were provided to us through the information requesting process.

Safety thermometer

- The medical division participated in the national safety thermometer scheme. Data was collected on a single day each month to indicate performance in key safety areas.
- Data for the Division of Medicine dated February 2015 to March 2015 showed a harm free care rate of 97.3%, which was better than the national average of 94%.
- Safety thermometer data was incorporated into the divisional quality score card dashboard. The risks monitored by the safety thermometer and other risks

defined by the trust were part of the division's governance meeting discussions. This showed that the data was used to monitor performance and to track risk trends.
- All the areas we inspected had a safety dashboard on display, this meant patients and the public could see how the ward was performing in relation to patient safety.

Cleanliness, infection control and hygiene

- There were 41 cases of clostridium difficile (c. diff) infections between September 2014 and August 2015 with 31 cases occurring in the division of medicine. Clostridium difficile (c. diff) is an infective bacteria that causes diarrhoea, and can make patients very ill.
- The clostridium difficile (c. diff) rates were better than the national average in nine out of the 12 months; however the trust was not performing in line with their target set by the Commissioners and NHS England which was 32 for the same period.
- Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections. There were no cases recorded between September 2014 and August 2015.
- Methicillin-susceptible Staphylococcus aureus (MSSA) differs from MRSA due to the degree of antibiotic resistance. Between September 2014 and August 2015 there were 14 recoded cases of MSSA at this trust, of which eight occurred within the division of medicine. This was worse than the England average for eight out of 12 months for this division.
- In endoscopy we could not be assured that the decontamination process was consistent across all areas where endoscopes (an instrument which can be 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 micro-organisms.
- Protein testing was not consistently carried out 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.
- An electronic system to track endoscopes used for individual patients was in place. Where individual scopes were used a sticker was generated and placed in the patient's medical records. Staff told us the electronic tracking system had the ability to trace all patients between set dates that had treatment with a specific endoscope.
- However, during our inspection it was discovered that the computer had the wrong date. The default date was 05 April 2013. This meant that to search for any recent data the system could not find it as it only recognised up to April 2013, if there were any concerns with the integrity of a specific scope at any specific time, the traceability to individual patients could only be completed manually by going through the unit log books. We raised this, at the time of our inspection, with the estates and facilities department as we were not assured the process currently in use protected the safety of patients.
- Throughout medical services we observed the majority of staff to be complying with best practice with regard to infection prevention and control policies. All staff were observed to wash their hands or use hand sanitising gel between patients. There was access to hand washing facilities and a supply of personal protective equipment, which included gloves and aprons. However, not all staff were observed to be adhering to the dress code, which was to be 'bare below elbows'. We observed four members of staff wearing items of jewellery. This was not in line with the trust infection control policy and could increase the risk of spreading infection to others.
- Where it was suspected patients had an infection they were cared for in side rooms with signage to alert staff and visitors of the risk of infection. However, staff were not consistent in isolating patients at risk of spreading infection to others. On Dedham ward we saw doors left open to three side rooms where it had been identified patients might present an infection control risk to others. We raised this with staff on the ward to determine if risk assessments had been carried out. The doors were immediately closed.
- Ward cleaning audits for the reporting period December 2014 to April 2015 demonstrated an overall compliance rate of 95% and was in line with the trust target.
- Hand hygiene audits were completed on a monthly basis. For the reporting period March to August 2015, with the exception of July 2015 (91%) and August 2015 (94%), the overall compliance rate each month was greater than 95%.

Medical care (including older people's care)

Environment and equipment

- We observed patient-care equipment to be clean and mostly ready for use. Most patient equipment had been routinely checked for safety with visible portable appliance testing (PAT) stickers demonstrating when the equipment was next due for service. However on Layer Marney ward we observed six items of equipment that were overdue for testing, three of which were in use on the patients.
- On West Bergholt ward a single item of equipment was overdue for testing and in endoscopy an air conditioning unit had no servicing sticker or PAT testing sticker visible on the unit.
- There was insufficient equipment in the endoscopy unit to safely maintain the decontamination process of endoscopes. At the time of our inspection only two out of four washers were available to process the endoscopes. Staff told us they had contacted external contractors to repair the machines but had been informed the contract with the trust had expired. This was escalated immediately, the contract was renewed and the machine was to be repaired the following day. The delay had resulted in some patients procedures being cancelled.
- Seven flexible cystoscopes were normally available for urology lists. At the time of our inspection five were being repaired. The unit had one on loan from a company and one on loan from a nearby hospital. Staff were unaware of any provision for more scopes.
- We visited Birch ward during the evening. During our visit the lights did not turn off in the main corridor of the ward because they were on motion sensor timers, which due to the staff and patients moving on the ward continuously, meant that the lights were on at all times of the day and night. This had been raised at our previous inspection in July 2015; we could not see where action had been taken as a result. We therefore, raised this with senior managers within the division and we were informed after the inspection that this issue was now resolved.
- The resuscitation equipment on the wards was clean. Single-use items were sealed and in date, and emergency equipment had been serviced. We saw evidence, on most wards that the equipment had been checked daily by staff and was safe and ready for use in an emergency. However, on the stroke unit there were two occasions between August and September 2015 where there was no signature to indicate this equipment had been checked.

Medicines

- We found that the pharmacy team provided a well-established and comprehensive clinical service to ensure patients were safe from harm. The pharmacy team visited all wards each week day. There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. Within cancer services a dedicated pharmacist was employed as part of the multidisciplinary team.
- We saw that pharmacy staff reviewed and confirmed the prescriptions for patients on first admission to hospital. Members of the pharmacy team had recorded important interventions on the prescription charts to help guide staff in the safe administration of medicines.
- We looked at the prescription and medicine administration records for 43 patients on seven wards. The prescription charts were not always fully completed to record administration so we could not be sure that people were receiving all their medicines as prescribed. Staff told us that they felt that the high level of agency staff contributed to the problem. They said it had been much worse but that it was being addressed through training, and we saw audits which confirmed this.
- Two medicine prescription charts we reviewed on the emergency assessment unit had no documented reason for the omission of medications. Both medications were used in the treatment of Parkinson's disease. If people with Parkinson's don't get their medication on time, their ability to manage their symptoms may be lost. For example they may suddenly not be able to move, get out of bed or walk down a corridor.
- Medicines were not always stored appropriately. We saw a tub of food thickening powder on a bedside table, and the nurse we spoke to was unaware of the risks of choking through accidental ingestion.
- On Birch ward we observed where a patient had their intravenous fluids stopped for an hour whilst the patient was having a wash. Fluids were not recommenced until we brought this to the attention of the nurse in charge.
- We reviewed the storage and administration of controlled drugs (CD's) on six 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.

- Patients own controlled drugs were recorded in and out of the ward in the 'Patients Own CD Register'. CD's currently in use were stored in bedside lockers and recorded on the prescription chart with two signatures and a countdown of quantity. Quantities were reconciled with the CD book on discharge or discontinuation. Discrepancies were managed in the same way as ward stock. Patients who were self-administering had the key to their own locker and staff had a universal key.

Records

- During our inspection we reviewed 45 nursing and medical records. Records were paper-based and held at the patient's bedside and, in notes trolleys in the main ward corridors. With the exception of West Bergholt ward we observed notes trolleys were not stored securely and were not always in an area where they could be seen at all times by a member of trust staff. During an early morning visit to Layer Marney ward we observed unattended notes trolleys and, medical notes on top of trolleys. This meant that there was a risk of access to a patient's medical notes by an unauthorised person.
- Patient records were multidisciplinary and we saw where entries had been made by nurses, doctors and allied health professionals including physiotherapists, occupational therapists, speech and language therapists and, dietetics staff.
- Records were mostly legible, accurately completed and up to date. However, in seven of the 45 medical records we reviewed the signature, bleep number and grade of the doctor who had made an entry was not clear and, it was not always easy to determine the patient's progress through their pathway. Records were difficult to navigate, loose papers were present and records were not always stored or numbered in a chronological way.
- Daily nursing record booklets were in use. These detailed comprehensive care plans relating to, for example, the patients identified care needs and, risk assessments for falls, pressure ulcers and nutrition. On four occasions, on different wards, we saw where the patient's daily nursing record had not been completed.
- Risks to patients, for example falls, malnutrition and pressure damage, were assessed, monitored and managed on a day-to-day basis using nationally recognised risk assessment tools. For example, the risk of developing pressure damage was assessed using the Braden Scale.
- Risk assessments for patients were not always completed appropriately on admission and reviewed at the required frequency to minimise risk. Of the 45 nursing records we reviewed the risk of malnutrition had not been assessed in seven records, the risk of pressure ulcer damage in five records and, the risk of falls in one record.

Safeguarding

- Staff we spoke with had an understanding of how to protect patients from abuse. We spoke with staff who could describe what safeguarding was and the process to refer concerns. Staff gave examples of safeguarding's they had raised as a result of physical and emotional abuse.
- Staff received safeguarding of vulnerable adults training (level two) as part of their mandatory training. Completion rates for health care assistants and nursing staff were above the trust target but for medical staff 86% had completed the training against a target of 90%.
- The trust had a safeguarding lead; staff knew the name of the safeguarding lead and they told us they could approach them for advice if they needed to.

Mandatory training

- Staff received training in mandatory topics such as basic life support, infection control, information governance, manual handling, risk management, safeguarding adults (level one) and, safeguarding children (level one).
- The trust target for compliance with mandatory training was 90%. Information received after our inspection showed as at October 2015 training compliance in cancer services was; 66% nursing, 35% medical and, 84% allied health professional in basic life support. 87% nursing, 75% medical and, 94% allied health professional in infection control. 91% nursing, 55% medical and, 87% allied health professional in information governance. 68% nursing, 0% medical and, 93% allied health professional in manual handling. 78% nursing, 70% medical and, 98% allied health professional in risk management. 95% nursing, 79%

medical and, 100% allied health professional in safeguarding adults (level one). 87% nursing, 75% medical and, 94% allied health professional in safeguarding children (level one).

- Training compliance in medical services was; 81% nursing and, 100% medical in basic life support. 89% nursing and, 0% medical in infection control. 81% nursing and, 100% medical in information governance. 84% nursing and, 0% medical in manual handling. 84% nursing and, 0% medical in risk management. 96% nursing and, 100% medical in safeguarding adults (level one). 86% nursing and, 100% medical in safeguarding children (level one). There was no data provided in medical services for allied health professionals.
- Some staff reported being unable to attend or complete mandatory training due to staffing shortages. We received mixed feedback regarding the induction of medical staff new to the trust. Most told us they had attended the trust induction however, some junior medical staff told us this had not been arranged by the human resource department and they had not therefore attended.

Assessing and responding to patient risk

- Patients being treated for sepsis, a severe infection which spreads in the bloodstream, were mostly treated in line with the trust 'Sepsis 6 Care Pathway'. The key immediate interventions that increase survival comprise the 'sepsis six bundle.' This has been shown to be associated with significant mortality reductions when applied within the first hour. There is strong evidence that the prompt delivery of 'basic' aspects of care prevents much more extensive treatment.
- We reviewed the nursing and medical notes of ten patients being treated for sepsis. Eight records demonstrated patients were assessed and treated in line with good practice. In one case out of ten, the sepsis 6 care pathway was not commenced until three hours after the patient had triggered and, in another antibiotics were not administered within an hour of the patient having been identified with sepsis.
- Compliance with sepsis screening and treatment was incorporated into the divisional quality score card dashboard. Data from June to July 2015 demonstrated in most cases there was good sepsis care and patients did receive intravenous antibiotics within the hour. A total of 25 patients had been identified as septic. Of these 22 had been screened in line with the trust 'Sepsis 6 Care Pathway', 16 had received interventions in line with the 'sepsis six bundle' and, 25 had received antibiotics within an hour.
- Nursing staff used an early warning system, based on the National Early Warning Score (NEWS), to record routine physiological observations such as blood pressure, temperature and heart rate. NEWS was used to monitor patients and initiated calls to the medical staff when required.
- In the majority we saw examples of care being escalated promptly when a patient's condition had deteriorated. Where there had been no immediate action taken we saw evidence of a treatment escalation plan in the patient's records. Treatment escalation plans outline the level of intervention required should the patient's condition deteriorate.
- Compliance with NEWS scoring and escalation was incorporated into the divisional quality score card dashboard. Data from December 2014 to July 2015 demonstrated an overall average compliance score of 96%.
- The emergency assessment unit had a 'high observation bay' 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)'.
- During our inspection we saw where patients, in the majority, were moved to the high observation bay in a timely manner; however we observed two cases where this did not occur. One patient had a raised NEWS score at 00.50am but was not moved to the high observation bay until 6.45 am. We discussed this with senior staff who told us this patient was stable and was moved to the high observation bay at the earliest opportunity.
- A second patient had a raised news score at 3.30am but this had not been escalated to the appropriate staff, nor had the observations been repeated in accordance with the NEWS escalation policy until 6.30am.
- Staff in the cardiac catheter laboratory and endoscopy used a document based on the World Health organisation (WHO) safety procedures: WHO surgical safety checklist to ensure each stage of the patient's journey was managed safely.
- On the Medical Day Unit (MDU) in the emergency assessment unit (EAU) we had concerns about the length of time patients were laying on trolleys and asked

the trust if they monitored this and what actions they took to mitigate risks to patients. Data provided by the trust following our inspection showed between July and September 2015 the average time patients spent on trolleys was six hours. On arrival prior to going on to a trolley all elderly or at risk patients were assessed for the risk of developing pressure damage using the Braden Scale.

- There was no formal policy or procedure for transferring patients onto a bed at any stage. Staff told us the decision was based on their own 'nursing judgement'. With no clear process for the assessment of patients who were waiting on trolleys to be seen this meant that patients may be put at risk by remaining on trolleys for lengthy periods, staff may not always be clear about the requirements to transfer patients in a timely manner so they were comfortable and protected from pressure area damage developing.
- The services were also not assessing the condition of patients within 48 hours after being on a trolley for an extended period of time to determine if any harm, such as the development of a pressure ulcer, had come to the patients. Therefore we were not assured that this system was safe or effective because the guidelines from the National Institute for Health and Care Excellence (NICE) quality standard CG179 'Pressure ulcers: prevention and management of pressure ulcers' was not being adhered to.
- Local audit activity in endoscopy included an audit of the World Health Organisation (WHO) surgical safety checklist. Audit results for May to August 2015 demonstrated 100% compliance with this checklist.

Nursing staffing

- Over the year to May 2015, the average fill rate for day nurses was 83%. Rates were below 85% for most of the year, with a consistent gap between planned and actual hours.
- On all the wards we visited we saw where staffing levels were displayed in the clinical area. Staffing levels were mostly in line with planned levels. However, we did see a high use of bank and agency staff. On one ward there were four agency band five nurses to one trust band five nurse. These were supported by two trust Band six nurses and a band seven ward sister.
- On the same ward we saw where the night shift was covered by a band five nurse and four agency band five nurses. The trust band five nurse had been moved from another ward, had been qualified 11 months and was still in the preceptorship period of their post registration development.
- Nursing agency usage for May 2015 was noted to be between 30% and 89% across the division of medicine with one ward reporting figures of 89% of their staff shifts being filled by agency.
- In July 2015, following an inspection of medical care (including older people's care), we served an urgent notice of decision to impose conditions on the trust's registration under Section 31 (1) (2) (a) of the Health and Social Care Act 2008. During our inspection of all areas we saw where the trust was meeting the conditions of this notice.
- There was an effective system in place for providing an induction to each ward where locum, agency and bank staff, including nurses, allied health professionals and healthcare assistants worked so that the wards could be assured that those staff were suitably competent, skilled and experienced to work on that ward.
- An audit of the induction process for locum, agency and bank staff, completed in September 2015 demonstrated 100% compliance with the induction of those staff new to a clinical area.
- Four medical, 12 nursing and, three allied health professional staff we spoke with raised concerns about the use of agency nursing staff on the wards and in endoscopy. One senior nurse gave an example of where they had raised a patient safety incident as a result of poor staffing.
- Five nurses we spoke with told us they found work, "stressful" due to low staffing levels and high levels of agency staff. Results from the 2014 NHS staff survey showed the work pressure felt by staff to be worse than the national average and, had increased from 2013 results.
- We reviewed the staffing rotas on EAU for the period 24 August to 01 November 2015. We saw where high numbers of bank and agency requests for nursing staff had been requested. On some occasions bank and agency requests were in excess of the number of substantive staff on duty for the day. For example week commencing 24 August 2015 there were 30 trust registered nurses on the early shifts with 34 bank and agency requests submitted and, 24 trust registered nurses on the night shifts with 43 bank and agency shifts submitted. Across the seven day period there were three

occasions where the number of agency staff exceeded the number of trust staff for registered nurses on the day shift and, seven occasions where the number of agency staff exceeded the number of trust staff for registered nurses on the night shift.

- Most of the ward sisters told us there were not enough staff on their wards and of a heavy reliance on bank and agency staff. Vacancies varied across ward areas with vacancy rates of between 7% and 35%. The top three areas with the highest vacancy rates were; D'Arcy 35%, the stroke ward 34% and, West Bergholt 29%.
- We saw where these posts were at various stages of the recruitment process with some wards awaiting start dates for new staff and, some ward sisters in the process of interviewing.
- Within stroke services there were 5.6 whole time equivalent (WTE) specialist stroke nurses available to provide a 24-hour, seven-day service. Senior staff told us the acute stroke nurse rota was not consistently covered. This meant not all new stroke patients were assessed by a specialist stroke nurse on admission. We saw where this had been identified on the stroke services risk register with appropriate controls in place to reduce the risk of this occurring.
- On the day of our visit to the cardiac catheter laboratory we observed sufficient staff available to deliver safe care within this department.
- Staffing levels were reviewed to keep patients safe at all times through the use of an acuity and dependency tool in line with National Institute for Health and Care Excellence (NICE) guidance. Acuity audits were undertaken and results used to influence future staffing levels in ward areas. Following an acuity audit, completed daily over a period of four weeks, of medical wards in June and July 2015 nursing staff had been instructed by the director of nursing to increase their daily staffing levels by two nurses per shift.
- At the time of our inspection ward areas were in the data collecting phase of a further review using this tool and were collecting information on acuity and staff numbers for future analysis.
- On EAU acuity assessments were completed daily in accordance with the January 2015 Section 31 notice. We reviewed acuity assessments over a period of four weeks prior to our inspection and saw these were completed appropriately.
- During our inspection we observed two shift handovers taking place by the patient's bedside. Handover involved the named staff identified to care for a group of patients, this did not include all staff on duty for the shift. Whilst the nurse in charge handed over the care of all patients to the nurse in charge on the incoming shift, we could not be assured all staff had an appropriate awareness of each patient on the ward, this meant there could be a patient safety risk if a member of staff was unaware of a particular patient's needs.

Medical staffing

- There were more than the England average of consultants, middle grade career and junior doctors employed in the medical division, however the registrar grade employed doctors were 20% which was below the England average of 39%.
- On the emergency assessment unit (EAU) there were two consultants available daily from 7am until 10pm in addition to one consultant providing out of hours on-call support if needed. One consultant would work on EAU but would, alongside a second year junior doctor (FY2), review the medical outliers on a daily basis.
- EAU was covered by a registrar and two junior doctors out of hours. The two junior doctors also covered the medical wards and medical outliers. An additional registrar was also on call.
- Weekend consultant cover was provided until 8pm with registrar cover until 5pm. Junior doctors covered the whole medical service out of those hours on their own with on call support. None of the medical staff we spoke with during our inspection raised concerns regarding the level of medical cover out of hours or at weekends.
- However incidents were reported of concerns due to lack of medical cover out of hours. For example an incident reported on the EAU sated 'Cardiac arrest call in A&E following peri-arrest call. Only medical team attending were SpR and 1x SHO. This is because there were insufficient doctors on call. The cardiac arrest team was therefore 1 member down'.
- Junior doctors told us they largely felt supported by their seniors and had good access to the consultant on their teams.
- Pressures on EAU affected the workload of junior doctors. We were given examples where junior medical staff were spending between one and three days a week, during a four-month placement, with their allocated team with the rest of the time spent on EAU.

- A senior medical doctor raised concerns to us about the insufficient numbers of senior medical staff available on EAU. They told us other clinical commitments in addition to working on EAU was not making the post attractive to senior staff. We reviewed locum usage for the reporting period May 2014 to April 2015 and saw where locum usage had been greater than 40% for nine out of 12 months.
- Information received from the trust following our inspection showed medical vacancies, as of April 2015, to be four whole time equivalent consultant posts and four specialist registrar posts across medicine and cancer services. This included two vacant consultant and specialist registrar posts on EAU.
- A senior doctor raised concerns with us about the lack of medical consultant cover in respiratory medicine. They told us this was having a negative impact on patient care delivery and an increase in the waiting list for new patient referrals. We were told of one whole time equivalent vacancy and one consultant on maternity leave. The trust had responded to this with a new consultant appointed and commenced on 01 September 2015. The second consultant post was currently out to advert.
- The medical handover of emergency medical admissions occurred twice daily, seven days a week, on the emergency assessment unit. This was led by an acute medical consultant. On the day we observed medical handover there were 12 junior doctors, a nurse consultant and an ambulatory care sister in addition to the consultant. During the handover we saw where there were discussions around events that had occurred the previous day. This included for example, incidents, patients requiring a medical review, the location of patients and, the movement of patients overnight.

Major incident awareness and training

- There were arrangements in place to respond to emergencies and major incidents. Major incident and business continuity plans were in place detailing actions to be taken by ward staff in the event of a utilities failure or major incident. Plans were available at ward level and via the trust intranet. Most staff we spoke with were familiar with these plans.
- During our inspection one ward within the medical division experienced a flood due to adverse weather conditions. We saw where staff had followed the trust business continuity plans, reported the incident to relevant senior staff and, dealt with the incident appropriately.

Are medical care services effective?

Requires improvement

The effectiveness of medical care services required improvement because:

- Care and treatment of those patients identified as having a long term conditions did not always reflect current evidence-based guidance, standards and best practice. For example venous thromboembolism (VTE) risk assessments and treatment was not undertaken in 12% of cases we reviewed.
- There was no evidence of pathways in place for the management of those patients with long-term conditions for example Parkinson's or dementia.
- Current local and national guidance in endoscopy and the cardiac catheter laboratory had not been implemented. For example in the cardiac catheter lab the intravenous iodine policy was last reviewed and updated in September 2009, and in endoscopy two local guidelines and one national guideline were out of date.
- The endoscopy service was no longer joint advisory group (JAG) accredited due to the accreditation being revoked in June 2015 due to concerns identified.
- Outcomes for patients were sometimes below expectations when compared with similar services. For example whilst the sentinel stroke national audit programme (SSNAP) scored the trust overall at level C, on a scale where level E is the worst possible, access to the stroke unit was rated as level E.
- National Diabetic Inpatient Audit (NaDIA) data showed the trust performed worse than the England average in 7 out of 20 measures.

However we also found:

- There was participation in relevant local and national audits.
- We saw where patients symptoms of pain were suitably managed and staff actively monitored the patients food and fluid intake although, support for those patients requiring assistance was not always readily available.

- We saw evidence of effective multidisciplinary working with staff, teams and services working together to deliver effective care and treatment.
- Staff were qualified and had the skills they needed to carry out their roles effectively and, staff were supported to maintain and further develop their professional skills and experience.
- Consent to care and treatment was obtained in line with legislation and guidance and, deprivation of liberty was applied appropriately.

Evidence-based care and treatment

- On the stroke ward patient needs were assessed and care and treatment was delivered 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). For example, there was 24 hour access to a 'hyper acute' stroke facility, staff used a validated tool to screen for a diagnosis of stroke or transient ischaemic attack (TIA), there was 24 hour consultant and nurse specialist support to attend patients admitted to the emergency department, good access to urgent brain scanning and, a basic assessment of swallowing by the ward nurses on admission followed by a specialist assessment of swallowing within 72 hours of admission.
- Within stroke services a patient's performance in activities of daily living and, rehabilitation progress was measured using nationally recognised outcome measures. For example, the Barthel Index, the Modified Rivermead Index and, the BERG Balance Scale.
- Across the division of medicine staff followed NICE guidance (CG92) in the assessment and management of venous thromboembolism (VTE). We reviewed 43 medication prescription charts, 38 of these demonstrated where patients had received a venous thromboembolism (VTE) risk assessment and had prophylactic venous thromboembolism (VTE) medication if indicated.
- In addition to this staff on the stroke unit were using intermittent pneumatic compression (ISC) therapy. ISC is a therapeutic technique used in medical devices that include an air pump and inflatable boots in a system designed to improve venous circulation in the limbs of patients who are at risk of DVT.
- Clear disease pathways of care were observed including details regarding access to clinical trials in local services. A recent increase in clinical nurse specialist support within the service had promoted continuity of patient care. Holistic patient assessment was evident including detailed information regarding diagnosis and proposed plan of care. The service proactively conducted regular patient surveys and addressed shortfalls with action plans.
- Care pathways; multidisciplinary plans of anticipated care and timeframes; were in place for specific conditions or sets of symptoms. These included pathways for acute kidney injury, gastro-intestinal (GI) bleeding, delirium, parenteral nutrition, falls prevention and management, neutropenic fever and sepsis, non-invasive ventilation, malnutrition, sepsis and, a number of haematology and oncology related conditions.
- We did not see pathways in place for the management of those patients with long-term conditions for example Parkinson's or dementia. We could not therefore be assured care for these patients was evidence based or reflected national guidance.
- There were integrated care pathways in place for all patients admitted to the cardiac catheter laboratory. This ensured patients received evidenced based care pre and post their procedure. However, during our inspection we found that an intravenous iodine policy was out of date since September 2009; this means that patients may not be receiving care that is evidence based or following current guidance.
- In endoscopy we were not assured staff were following local and national guidance to ensure consistency of practice. At the time of our inspection local decontamination guidance dated March 2010 with a review date of 2012 and, British Society of Gastroenterology (BSG) Guidelines for decontamination dated February 2008 was available to staff in paper format. We raised this with the nurse in charge and up to date guidelines were accessed immediately via the trust intranet.
- Local policy and procedure guidelines for all specialties were available on the trust intranet and were easily accessible by all members of staff with a current access password.
- Local audits were taking place in the division of medicine. We saw where the division had an audit plan that included audits such as do not attempt cardio-pulmonary resuscitation (DNACPR) decisions on

care of the elderly specialist wards, catheter insertion in the elderly, radio-iodine administration in benign thyroid disease and, acute upper gastro-intestinal bleed.

Pain relief

- We reviewed 45 medical and nursing care records during our inspection and we saw where a patient's level of pain was recorded on the early warning score chart. Staff asked patients to rate their pain each time their physiological observations were taken. A review of 43 medication prescription charts demonstrated patients were given pain relief where appropriate at regular intervals.
- Of the 36 patients we spoke with, three raised concerns about the management of their pain. Two patients felt the nursing staff were slow to respond to their request for pain relief.
- One patient we saw was distressed and visibly in pain. A review of this patient's medical records and medicine prescription chart demonstrated where nursing and medical staff were appropriately addressing the patient's pain. However, we were not assured that any one member of staff was taking overall responsibility for monitoring and managing this patient's pain adequately. We raised this immediately with the ward staff and the matron for this ward. Following discussion with the matron, the patient and the patient's relatives we were assured the patient's pain would be managed appropriately.

Nutrition and hydration

- On one ward we observed nine patients who had been assessed as requiring support with nutrition and hydration. All of these patients had been left a menu to select their food preferences. We saw where, in order to complete their menu choice, patients had not been left a pen and, had no explanation or support to complete their choices.
- A 'red tray' system was in place at the hospital to ensure that the nutritional requirements of patients were fully met. Patients who needed help with eating were served meals on red trays and those who needed encouragement with their fluid intake to prevent dehydration were given a water jug with a red lid. During our inspection we saw where patients with either a red tray or, a water jug with a red lid were offered the appropriate level of assistance.
- Patients told us they were offered a good variety of food and drinks. Where there was any indication of a patient's difficulty in swallowing food or fluid staff followed a nil-by-mouth starter regime until an assessment could be carried out by a specialist practitioner. This meant patients could receive tube feeding with a nasogastric feeding tube within 24 hours of their admission.
- Modified meals; meals for patients who have difficulty chewing or swallowing, were available on the stroke unit. We saw where a dedicated fridge was available and meals were replenished daily.
- Food record charts were in use to actively monitor a patient's dietary intake. We saw where these had been mostly completed.
- Fluid balance charts were in use to monitor a patient's fluid intake and output. During our inspection we saw some excellent examples where these charts had been used and completed appropriately. Of the 45 nursing care records we reviewed, where fluid balance charts were in use, with the exception of one patient on Birch ward, all had been fully completed.
- On review of the incidents reported between June and August 2015 we noted that a patient was given gluten containing items to eat despite being recorded as a coeliac which they raised as a concern to staff. However the patient received this food for three days despite their known disease.

Patient outcomes

- The trust submitted data to the sentinel stroke national audit programme (SSNAP) which aims to improve the quality of stroke care by auditing stroke services against evidence-based standards and national and local benchmarks. Between January and March 2015 sentinel stroke national audit programme (SSNAP) scored the trust overall at level C, on a scale where level E is the lowest level possible. Some aspects of the audit had been scored higher, but access to the stroke unit was rated as level E.
- We discussed these results with senior nursing and medical staff on the stroke unit. They were aware of the results and told us capacity issues within the trust had meant patients not requiring stroke services had been placed on the unit during this time.
- The trust provided a 24 hour stroke thrombolysis service (this is a treatment where drugs are given rapidly to dissolve blood clots in the brain). The trust standard was that all patients admitted following a stroke were

thrombolysed within three hours of admission. For the year to date, results provided by the trust showed this target was being met with 12.9% of patients against a target of 12% were thrombolysed within three hours, and 4.6% of patients thrombolysed within three to 4.5 hours.

- In the national Acute Myocardial Infarction Audit (MINNAP) 2013 which reviewed the treatment and care of patients who had suffered a heart attack, the trust scored significantly higher than the England average in two out of three measures and slightly better than the England average in the third measure.
- In the last national Heart Failure Audit reported in 2013 / 2014, the trust scored above the England average in all four in-patient care measures, but worse than the England average for 3 out of seven discharge measures.
- The trust submitted data to the National Diabetic Inpatient Audit (NaDIA). Data reported in September 2013 showed the trust performed worse than the England average in 7 out of 20 measures.
- The trust performed better than the England average in two out of three measures in the lung cancer audit (100% pf patients discussed at multi-disciplinary meeting and 97.5% receiving diagnostic imaging before bronchoscopy).
- The readmission rates for non-elective activity in the top three medical specialties showed there were less readmissions in general medicine, clinical oncology and, stroke medicine when compared with the England average. For elective activity overall, there were less readmissions when compared with the England average, with clinical haematology having the lowest rates. Clinical oncology and gastroenterology were both worse than the England average.
- On average patients spent less time in hospital in medical care services than the national average. For emergency admissions the average length of stay was below the England average with the exception of stroke medicine where length of stay was 13 days and higher than the England average of 11.4 days.
- The endoscopy unit was not currently accredited by the joint advisory group (JAG). This is a national award given to endoscopy departments that reach a gold standard in various aspects of their service, including patient experience, clinical quality, workforce and training. JAG accreditation was lost in June 2015. Three concerns were raised regarding the unit, two related to the environment which had since been addressed and a further concern related to diagnostic waiting times.
- Since the JAG visit diagnostic waiting times were improving with weekend lists taking place and the service 'outsourcing' to an external provider. There were plans for a re-visit by JAG in early 2016 to undertake an inspection with a view to re-accreditation.
- The outcomes for patients were not monitored well in relation to mortality within medical care services. There was mixed feedback provided on mortality and morbidity meetings held within the division.
- The trust was recorded as an outlier on both SHMI and HSMR mortality indicators. At the time of the inspection the last Hospital Standardised Mortality Ratio (HSMR) for the trust was 103 and their Summary Hospital-level Mortality Indicator (SHMI) was 106.7 however their weekend mortality ratio was 113.6. Ideally these numbers should be below 100.

Competent staff

- Staff reported having access to additional training to enable them to carry out their role effectively. Junior nurses new to the trust were invited to attend a bi-monthly reflective forum as part of their professional development. Topics discussed at this forum included ward orientations, nursing documentation, pressure ulcer grading and, the trust cardiac arrest procedure.
- Nursing staff within the cardiac catheter laboratory had received additional training to enable them to perform their role and had completed competencies specific to this department. This ensured nurses working in this area had the relevant skills to care for patients in this setting.
- There were arrangements in place for supporting and managing staff new to the medicine division. On Dedham ward band five registered nurses were mentored over a six-week period before being moved to other wards within the division, work books were in place to monitor training and develop the junior nurses and, a cardiac simulator dummy had been purchased to teach electrocardiogram monitoring to staff.
- Within cancer services staff involved in the administration of cytotoxic dugs; a group of medicines

used to treat cancer, had completed a chemotherapy clinical competency assessment pack. This promoted the safety of the patient and protected the nurse in the administration of cytotoxic drugs.
- Competency packs were in place for those staff responsible for the care and maintenance of a central venous access device (CVAD) as part of their practice. CVAD is a form of intravenous access that can be used for a prolonged period of time.
- In line with national guidance for acute oncology, the service provided education to the emergency department and, the emergency assessment unit on the neutropenic pathway.
- Nurses on the stroke ward were competent in completing basic swallowing assessments, which meant that patients were assessed quickly and able to eat if it was assessed as being safe for them to do so.
- The cardiac catheter laboratory was staffed by nurses, physiologists; staff with expertise in monitoring heart and blood pressure readings, radiographers and, cardiology consultants. All staff in the cardiac catheter laboratory were trained in immediate or advanced life support; these are specialist qualifications in resuscitation.
- On the emergency assessment unit (EAU) a critical care practitioner had been employed for 12 months, to support and develop the staff on EAU with patient care.
- Staff were supported to deliver effective care and treatment through the appraisal process. Most nursing and medical staff we spoke with told us they had received an appraisal in the last year.
- Data provided by the trust indicated the number of completed appraisals within emergency medicine, cancer services, stroke and elderly care services and, general and specialist medical services were on target with the trust's appraisal plan, with all services having completion rates of greater than 50% for the year to date.

Multidisciplinary working

- There was an effective multidisciplinary team (MDT) approach to planning and delivering people's care and treatment. We saw involvement from nurses, medical staff, allied health professionals and the social work department. All staff we spoke with told us that there were good lines of communication and working relationships between the different disciplines.
- The comprehensive evidence folder from the Haematology/Oncology external peer review undertaken September 2015, demonstrated an effective multidisciplinary team with clear responsibilities and roles for each member.
- In stroke services MDT meetings were held daily Monday to Friday. Daily 'board meetings' were held in all other areas to review patients' care pathways; we observed a sample of these meetings. The patient's progress was discussed and included any discharge plans.
- Transfers of care or discharge from the stroke unit were managed collaboratively with the trust, local councils and, a local social enterprise organisation.
- On the emergency assessment unit (EAU) there was a robust system in place to ensure all team members were aware of who had overall responsibility for each patient's care. The patient care co-ordinator allocated a consultant to each patient every morning. Dependant on the patient's diagnosis the most appropriate consultant would be allocated to review the patient. To ensure continuity of care, the same consultant would see the same patient each day if they remained on EAU.
- Where it was identified that a patient had significantly deteriorated there was an outreach team who would attend the ward to provide specialist advice.
- We did not see where there was a process for accessing mental health services. One doctor we spoke with raised concerns with accessing mental health teams to review patients.

Seven-day services

- On West Bergholt Ward a phlebotomy service was available Monday to Friday to assist medical and nursing staff with completing blood sample requests. However, over the weekend this service was available to haematology patients only. The ward sister told us this was due to the commissioning of this service.
- At weekends blood sample requests for oncology patients were completed by the medical and nursing staff, with the support of a band six nurse 07.00 to 12.00 on a Saturday. Nursing staff told us this sometimes meant there were delays in completing blood sample requests and, nursing staff were taken away from other clinical duties.
- Consultant presence was not consistent across the specialties within medicine. In stroke care the consultant was available six out of seven days. In elderly care an acute geriatrician was available in-hours

Monday to Friday and, 8am to 3pm Saturdays and 8am to 12pm Sundays. Out of hours support was offered by all consultants with most junior medical staff reporting good access and support from their consultant.

- At weekends, with the exception of the emergency assessment unit and the stroke unit, patients were not routinely reviewed by a consultant unless they were admitted at the weekend or there was concern their condition was deteriorating. Medical staff told us instructions for the on call team would be written in the medical notes however, in the notes we reviewed weekend plans were not consistently recorded. However on care of the elderly wards there was a formal sheet with a sticker which allowed the medical staff to give concise information on a patient requiring a weekend review.
- On the wards consultant reviews were inconsistent with some wards reporting daily review of patients by a consultant and others reporting twice weekly reviews.
- Allied health professional including physiotherapists, occupational therapists, dieticians and, speech and language therapists worked in-hours Monday to Friday. On the stroke unit this had been highlighted as an issue with the rehabilitation of patients following a stroke and senior staff told us there were plans in place to increase the establishment of physiotherapists in order to cover a seven-day service by April 2016.
- A seven-day integrated discharge team was available. Staff told us this enabled access to community services at the weekends.
- The lack of seven day support services and availability of staff at weekend, cold directly impact the overall mortality ratios for the trust with increased mortality being noted at this trust at weekends. The trust is currently an outlier for mortality in the region.

Access to information

- Information needed to deliver effective care and treatment was available to most staff in a timely and accessible way. Procedure specific information, policies and procedures were available in paper format and via the trust intranet. However, we saw where some information in paper format was out of date and not reflecting current evidence based guidance.
- Additional information relating to current trust issues, incidents and complaints was available to staff via communication boards, a serious incidents folder and, through a monthly quality improvement bulletin.
- Patient discharge summaries were sent electronically to the patient's GP on discharge to ensure continuity of care within the community.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had a good understanding of the mental capacity act and consent. We saw consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005 and patients were supported to make decisions.
- Staff received mental capacity act training as part of their mandatory training. The trust target for this training was 90%. Information received after our inspection showed as at October 2015 training compliance in cancer services was; 93% nursing, 70% medical and, 95% allied health professional had completed level one training. 97% nursing, 70% medical and, 93% allied health professional had completed level two training. 87% nursing and, 68% medical had completed level three training. Training compliance in medical services was; 95% nursing and, 0% medical had completed level one training. 94% nursing and, 0% medical had completed level two training. 100% nursing and, 0% medical had completed level three training. There was no data provided in medical services for allied health professionals.
- We saw ten patients receiving care whilst being deprived of their liberty. We saw that the deprivation of liberty safeguards and orders by the court of protection authorising deprivation of a person's liberty were used appropriately.
- In incidents reported on the trust incident system we noted incidents of care to those under deprivation of liberty safeguards (DoLS) not being provided in accordance with requirements. For example one patient absconded from EAU despite being on DoLS. In another incident a patient who was receiving one to one care under DoLS for the risk of harm from reoccurring falls was left unattended resulting in them falling.

Are medical care services caring?

Requires improvement

The care provided to patients in medical care services required improvement because:

- There were times when patients did not feel well supported or cared for. Some patients and their relatives had concerns about the way staff treated them and felt they were not always treated with kindness or respect or in a timely way when receiving care and treatment.
- We also observed that during handovers on wards that the staff did not see patient's privacy and dignity as a priority.
- The friends and family test (FFT) performance was mixed and had not been consistent in improvement since February 2015.

However we also found:

- We observed staff responding compassionately when patients needed help and support to meet their basic personal needs.
- The friends and family test (FFT) response rate and score had improved in July 2015 with a score of 96% of people recommending the care of the service to others.

Compassionate care

- We spoke with 36 patients and 27 relatives during our inspection. Feedback was mixed with many patients and relatives commenting on how caring the staff were and how much the hospital had improved over the last year. However on Birch, Tiptree and, Langham wards, six patients and three relatives had concerns about the way they were treated. They told us staff lacked compassion, staff attitude was poor and, staff were slow to answer call bells. Two patients and one relative told us they had raised formal complaints and were waiting a response from the trust.
- Of the patients we spoke with nine patients commented on the 'lack' of nursing staff on duty resulting in delays in answering call bells and attending to patient's needs.
- During our inspection staff on all the wards were observed to be polite and courteous to patients. We observed staff responding compassionately when patients needed help, and saw a number of examples of outstanding care. For example on Birch ward we saw where a patient had fallen, we observed a health care assistant constantly reassuring the patient until they could be moved to a safer position. On Peldon ward we observed a member of staff talking with a patient about thickened fluids. The nurse explained why thickened fluids were necessary in addition to respecting the patients choice not to have their fluids thickened.
- Call bells were mostly seen to be answered promptly and patients were seen to be treated with dignity and respect. However, on Birch ward we saw where a patient was lying in bed and was not covered by the sheets; their dignity had not been met at this time. We raised this with the staff on the ward who intervened immediately to assure the dignity of this patient.
- In the discharge lounge we observed the care of six elderly patients who were waiting for discharge. There was limited interaction with these patients and not all had been offered food or drinks. One patient had arrived at 12.10pm and their transport was booked for 16.30pm.
- We spoke with the relatives of two patients with a learning disability. Both were positive about the care their relatives had received and felt the patient's individual preferences and needs had been met.
- We reviewed the NHS Friends and Family Test results for 12 wards for the period March 2014 to February 2015. The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. Results showed the average response rate to be worse than the England average of 35.6% at 28.6%. Results from this reporting period showed an average score of 77.1% of people who would be 'extremely likely' to recommend these wards against the England average of 96.6%.
- FFT data reviewed following our inspection for July 2015 showed an increase in the average response rate at 36% and, an increase to 96% of people who would be 'extremely likely' to recommend these wards which was in line with the England average.
- The trust took part in the 2014 national cancer patient experience survey. 802 eligible patients from this Trust were sent a survey, and 513 questionnaires were returned completed. This represented a response rate of 69% compared with 64% nationally.
- The Trust performed in line or better than England average on 64 of the 70 the cancer patient experience survey, however they scored in the lowest 20% of trusts in England for 6 of the 70 questions including: Patient given a choice of different types of treatment, clinical nurse specialist definitely listened carefully the last time spoken to, hospital staff gave information on getting financial help, patient's family definitely had

opportunity to talk to doctor, GP given enough information about patient`s condition and treatment and, practice staff definitely did everything they could to support patient.

- The trust scored better than the England average for the key indicators: Patient given the name of the clinical nurse specialist (CNS) in charge of their care, hospital staff gave information about support groups, patient had confidence and trust in all ward nurses, staff definitely did everything to control side effects of radiotherapy, staff definitely did everything to control side effects of chemotherapy and, staff definitely did everything they could to help control pain.

Understanding and involvement of patients and those close to them

- During our inspection we observed a shift handover taking place by the patient's bedside. Visitors present in the bay were asked to leave the bay and the bay doors closed during the handover, however the information being shared in the bay could be overheard by other patients.
- The handover information was of a sensitive nature for example if the patient was for resuscitation, information about pressure areas and continence needs. Patients were not included in this handover despite being present, nor was any attempt to communicate with the patient made during the handover. This meant that the patient's information was not kept confidential and they were not treated with dignity and respect.
- We raised our concerns with the ward sister who stated that this was common practice. We observed that this was the practice throughout the medical care wards.
- Patients told us they felt involved in the decision making process regarding their care. Feedback from the 36 patients and 27 relatives we spoke with was largely positive with only three patients and two relatives reporting inconsistent communication from the medical staff and, not knowing about their care.
- We saw where patients and their relatives had been involved in discussions around their care. On the stroke unit 'family meetings' were held with patients, their relatives and members of the multidisciplinary team to discuss the patient's progress and plans for rehabilitation and discharge.
- There were 993 complaints raised for medical services in a 12 months period with one of the main themes of complaints being staff attitude in care.

Emotional support

- Most patients we spoke with were not aware of any emotional support services available to them. However, patients and relatives did tell us they felt supported emotionally by the nursing staff. For example the relative of one patient with a learning disability told us staff were very supportive and accommodating of the patients' needs. Another relative told us staff on Layer Marney ward had a "brilliant understanding" of patients with a learning disability.
- Clinical nurse specialists were available for advice and support in a number of specialties including stroke services, cancer services and for heart failure patients.
- A counselling service offered specialist counselling at the trust to individuals affected by cancer. This was a collaborative service between a local hospice, the trust, a local clinical commissioning group and, cancer support organisation.

Are medical care services responsive?

Requires improvement

We rated the responsiveness of medical care services as requires improvement because:

- People are unable to access the care they need with 121 incidents of patients going more than 100 days without treatment for their cancers being recorded in the five months prior to our inspection.
- Inappropriate admissions to wards which increased the number of medical outliers was a concern with patients who did not have a stroke being placed on the stroke unit and female patients requiring care being admitted to the gynaecology and early pregnancy ward due to hospital capacity and flow issues, whilst care in the majority of cases met the person's clinical needs it was not responsive to their individual personal needs.
- The numbers of patients being moved between wards out of hours was high with 157 patient transfers occurring between the hours of 10pm and 8am during August 2015. Of these, 67 transfers had taken place after midnight.

- There was no dedicated service provision for those patients living with dementia which meant that we were not assured the needs of those individuals living with dementia being cared for in the hospital had their needs met.
- There were 993 complaints raised for medical services in a 12 months period, which was a high number to receive, with the main themes of complaints being staff attitude, the environment and, discharge arrangements.

However we also found:

- Services were mostly planned and delivered to meet the needs of the local population with rapid access clinics in stroke and cancer services.
- Complaints and concerns were managed appropriately at local and divisional level with evidence of shared learning as a result.

Service planning and delivery to meet the needs of local people

- Community providers were involved in planning services. The community teams attended multidisciplinary team meetings and carried out patient assessments, particularly for the frail elderly, care of the elderly and respiratory patients. The majority of the communications was done through the site management team rather than the department itself so staff on the emergency assessment unit were not always aware of what was happening in the community.
- A 24-hour telephone helpline was available to oncology and haematology patients. This allowed the rapid assessment of patients without the need for a hospital admission. A total of 330 calls had been received between January and March 2015. Of these, 52% of calls or enquiries were received out of hours and, 44% of the patients who contacted the helpline were asked to attend the hospital for assessment.
- A high proportion of patients living in more rural locations of Essex County had declined to travel to the hospital for their appointment in respiratory medicine. This had led to an increase in the number of patients waiting longer than 13 weeks for a new appointment. This had been fed back to the divisional service manager and plans had been agreed to arrange for an external company to run new patient referrals clinics at a location suitable for these patients.
- Patients who had recently received chemotherapy were provided with a 'chemotherapy alert card'. The card detailed the hospital contact details including a 24-hour telephone helpline and, alerted medical staff to the patient's current condition in the event of needing urgent treatment for sepsis.
- On Layer Marney ward a one-stop rapid access clinic was available to patients requiring a pleural aspiration; a procedure where a small needle or tube is inserted into the space between the lung and chest wall to remove fluid that has accumulated around the lung.
- A transient ischaemic attack (TIA) rapid access clinic was available on the stroke unit.

Access and flow

- The trust had a 14-bedded frail elderly unit. This was managed by the urgent care division and located adjacent to the emergency assessment unit. The frail elderly unit accepted patients over the age of 78 and had a length of stay of 72 hours. Staff we spoke with felt the frail elderly unit was a low priority area for the trust. We were told admissions to the unit were often inappropriate and impacted on those patients waiting to be transferred to the unit.
- Where the demand for beds was high in the emergency department or the emergency assessment unit patients would often be transferred from this unit to other wards in the trust to make way for new patients. Staff felt this caused an unnecessary admission for this group of patients. Once the patient was transferred to a ward other than the frail elderly unit they no longer remained under the care of this team. From June to August 2015 a total of 972 patients had been admitted to the frail elderly unit. Of these 36% were unsuitable for the unit either due to patient age or diagnosis and, 25% of patients who were suitable for the unit had been transferred to other wards within the hospital.
- During our inspection we reviewed 10 medical outliers across four wards. Medical outliers are where patients are receiving care on a different speciality ward. We saw where the trust had robust systems in place to monitor medical outliers throughout the trust. A care coordinator, based on the emergency assessment unit (EAU), checked the location of outliers on a daily basis and liaised with the trust site matron.
- Nursing staff on these wards told us outliers were mostly reviewed on a daily basis by the consultant but felt it was often difficult to get day-to-day jobs completed by a doctor.

Medical care (including older people's care)

- We reviewed the medical records of all 10 patients and saw, where applicable, patients had received a further medical review within 12 hours of their admission to the trust.
- A FY2 junior doctor was allocated to review all medical outliers in addition to, a daily review by a consultant. FY2 doctors are doctors undertaking a two year medical foundation programme which forms the bridge between medical school and specialist/general practice training.
- The average bed occupancy for the reporting period April to June 2015, across 12 areas, within the division of medicine was 92%. It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients.
- Nursing staff repeatedly told us of patients moving to the ward from the emergency assessment unit during the night. At the medical handover on the emergency assessment unit we were told of three patient transfers that had occurred after midnight. A patient told us they had been moved at 5.30am. We reviewed data for August 2015, this showed across nine medical wards 157 patient transfers had occurred between the hours of 10pm and 8am. Of these, 67 transfers had taken place after midnight.
- The trust had an Integrated Discharge Team' who were able to assist in ensuring patients with complex health care needs were discharged in a safe and timely manner and to an appropriate setting.
- At the time of our inspection we were told there were 80 patients in the trust with a length of stay of greater than 21 days this equated to 10% of the total trust beds. We were unable to determine how many of these patients were in the medical division and, the team were unable to tell us if the length of stay was due to clinical reasons or a delayed transfer of care.
- Most nursing staff we spoke with told us discharges did not always happen in a timely way. They told us there were fewer problems with medicines to take home but that discharges were often delayed due to social care packages. To assist in the progress of timely discharges we saw where ward clerks in some areas were involved in discharge meetings and, commenced continuing healthcare documents. The trust had a policy to aim to discharge patients before midday, data received for June to July 2015 showed of 1,578 discharges, 15% were discharged home before midday.
- From September 2015 the integrated discharge team were to work closely with commissioners of the service and a local social enterprise to provide a discharge service that would collaboratively work together to ensure the safe and timely discharge of patients from the trust.
- A 'discharge lounge' was available on the emergency assessment unit. This was a dedicated bay that could accommodate a total of six patients. The nurse in charge was responsible for documenting the patients who had arrived to this area, their mode and time of transport and, if they had or were waiting for medications to take home.
- Referral to treatment times (also known as RTT or as the 18 week target), as of November 2014, were being met across six out of the seven specialties with all six specialties achieving the 90% standard of admitted patients who should start consultant-led treatment within 18 weeks of referral. Dermatology had not met this standard with 75% of admitted patients starting consultant-led treatment within 18 weeks of referral.
- Information received following our inspection showed between March and August 2015, 121 incidents had been raised in oncology where patients had exceeded 100 days waiting to be seen or treated. Following the inspection we were informed that the trust were working to reduce the numbers of patients going over 100 days without treatment, however they were having difficulty meeting the required timeframes for treatment.

Meeting people's individual needs

- On one ward we reviewed the notes of an oncology outlier. Care had not been planned and delivered to meet this patient's needs. This patient had been admitted to the ward on 08 September and had not received an oncology review until 16 September. We discussed this patient with the junior doctor; they told us they thought the patient had only been on the ward for two days which was not the case.
- During an evening visit to the trust we saw where a cardiology patient was admitted to a health care of the older person ward from EAU. The patient was transferred on a defibrillator. We reviewed the patient's notes and saw that they required cardiac monitoring, a cardiac monitor had been brought to the ward, but the nursing staff on the ward were not aware of the patients' needs, we raised this with the nurse in charge, who attached the patient to the cardiac monitor. None of the staff on the ward at that time were familiar with cardiac

monitoring. We raised this at the time with the site matron who reviewed the patient with a senior doctor. The decision was taken to discontinue the cardiac monitoring as it was not deemed necessary, this meant that there had not been an appropriate handover from EAU and staff on the ward were not aware of the patient's needs.

- We noted during our inspection patient information leaflets available in clinical areas and on the trust website were all in English. We asked nursing staff if leaflets were available in other languages. Most of the nursing staff we spoke with told us leaflets could be translated if required.
- Interpreters were accessible either face-to face or via a telephone service, All the staff we spoke with told us interpreting services were easy to access.
- A learning disability specialist nurse was available in the trust. Staff told us the nurse would usually be aware of the patient's admission and would visit the patient to offer support and advice.
- On Tiptree ward we saw pictorial signs which helped those patients living with dementia to interpret the different areas of the ward and therefore help them to find their way around. However, dementia care pathways were not in place. Care records of people living with dementia did not include a plan of care guiding staff in how to deliver care to meet the patient's needs.
- We did not see where there was a process for accessing mental health services. One doctor we spoke with raised concerns with accessing mental health teams to review patients but could not give us examples of where this had a negative effect on care delivery.
- Through the use of a questionnaire, staff within medicine actively explored the experiences of carers of patients with a diagnosis of dementia to improve patient care. Results from the January to March 2015 survey were largely positive with carers feeling encouraged to share information with staff about their relative during their hospital admission and, carers kept informed about their relative's progress during their hospital admission by hospital staff.
- Wards included single-sex accommodation, which promoted privacy and dignity. For the reporting period September 2014 to August 2015 there were no reported times when male and female patients were treated in the same ward bay.
- During an unannounced visit to the emergency assessment unit we found males and female patients occupying the 'high observation' bay. There are some circumstances where mixing can be justified. For example, 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)'

Learning from complaints and concerns

- Staff would speak to anyone raising a complaint at the time they raised it. Senior managers were also available to talk to anyone with a concern or complaint. The aim was to try and resolve the problem or complaint at the time it was raised.
- Complaints were discussed at ward meetings and, local and divisional governance forums where learning points would be identified. During our inspection we attended a '12 o'clock stand-up' meeting. These were held daily with senior managers and matrons of the service. Complaints breaches; those complaints not addressed in line with the trust's policy of 30 working days for investigations and 60 working days for cases involving other organisations; were discussed and individual matrons challenged where complaints had not been addressed within the trust time frame. Alternative processes to written responses were discussed and included communicating with patients and their families, when appropriate, at the point of contact and addressing their concerns as quickly as possible to avoid a lengthy complaints process.
- Between September 2014 and August 2015 a total of 992 complaints were received by the trust. Of these 31 were for cancer services, 74 for care of the elderly and stroke services, 156 for emergency medicine and, 228 for general and specialist medicine. The top three themes for complaints within these services were staff attitude, the environment and, discharge arrangements.
- All complaints to the medicine division were 'signed off' by the Associate Director of Nursing for Medicine (ADoN). During our discussions with the Associate Director of Nursing they were able to give us examples of where they had identified trends in complaints on medical wards.
- One example was that through feedback, they had identified a consultant who had been identified as

having poor communication skills. From this feedback the Associate Director of Nursing had fed back to the divisional director for medicine and asked them to address the issue.

Are medical care services well-led?

Requires improvement

The leadership of medical care services required improvement because:

- The governance arrangements were not fully effective.
- Whilst improvements with local ward leadership were noted since our previous inspections there was a lack of awareness from the divisional and trust leads regarding the concerns that staff had in endoscopy relating to service provision, lack of reliability and availability of the equipment needed to sustain the service.
- The arrangements for governance, risk management and quality measurement were in progress though concerns within endoscopy had not been addressed.
- Morale within the service was also low with staff saying that they did not feel listened to, that they had tried to raise concerns in the past but did not feel managers were interested.

However we also found:

- There was a vision and strategy for this service which staff were able to describe to us.
- Staff reported feeling valued and respected and were committed to delivering good quality care.
- The culture within the service was improving and becoming more open with the majority of staff we spoke with telling us that they were happy to raise concerns.
- This was an innovative service with staff feeling empowered to suggest new ways of working.

Vision and strategy for this service

- There was a vision and strategy for medicine and cancer services. The strategy was supported by detailed, realistic objectives and plans over a three year period. We reviewed the strategy as part of our inspection and identified objectives already in progress within the clinical areas. For example, the pharmacy intern pilot on two wards in medicine and care of the elderly was due to commence two weeks following our inspection, daily 12 o'clock briefings were being held at divisional and service level and, working with commissioners and a local social enterprise on the delivery of continuing health care provision.
- There was a lack of awareness of staff in endoscopy with regards to service provision. For example during our inspection five out of seven flexible cystoscopies (an instrument inserted into bladder for the purpose of examination) were at repair. The department had loaned two further scopes which meant there were four scopes in use for routine lists of approximately 10-12 patients. Staff were unaware of any further provision but had heard a rumour that there may be a business case for 10 more; we were not assured that staff were kept informed of developments in this service.

Governance, risk management and quality measurement

- There was mostly an effective governance framework to support the delivery of the strategy and good quality care. Staff on the wards were involved in daily safety briefings with the nurse in charge. These involved discussions around for example, current patient safety issues, incidents and, complaints in addition to, feedback from the '2 at the top meeting'.
- Ward managers told us about clinical governance at ward level called "2 at the top" this was a monthly meeting between the ward manager and a nominated lead consultant to discuss any issues within the ward, for example discussing incident themes, complaints and any audit results. All ward managers we spoke with told us that it made them feel empowered. Attendance at these meetings was by any member of staff available on the ward.
- Minutes of the meetings were reported to the monthly divisional governance meeting to ensure any learning was shared across the division. Minutes of these meetings that we reviewed demonstrated a multidisciplinary attendance and a shared responsibility for governance within each individual area.
- A '12 o'clock stand-up' meeting was held daily with senior managers and matrons of the service. Ward staff told us they were encouraged to take issues to this meeting. We attended one of these meetings and saw a joint approach to addressing issues and concerns within the division. During the meeting levels of accountability were clearly defined with individuals taking responsibility for issues within their own clinical areas.

Medical care (including older people's care)

- Divisional governance meetings took place monthly. During these meetings, risks and actions were identified to reduce risk and improve patient safety. Minutes we reviewed demonstrated discussions around current risks for the division, patient safety, patient experience and, clinical effectiveness.
- However governance arrangements were not consistent across the service. In the endoscopy department there was no clear governance structure. Any escalations of concerns were raised through an infection control report which would be discussed every two months at divisional governance; this meant there may be a delay in raising concerns and could put patients at risk. Mortality and morbidity review meetings were not consistently applied across all specialties, this meant there were missed opportunities to review and discuss individual cases to determine if there could be any shared learning.
- The division had a lead nurse for clinical governance and risk management. This post holder supported ward staff, managers and the medical division and played a role in ensuring consistency and quality in governance matters across the division. For example they would speak to the ward nurses who had submitted an incident form to ensure the grading of harm was correct.
- Risk registers were in place for all areas and were held at both local and divisional level. This meant all staff had an awareness of risks within their areas. However, whilst risks had been identified for the endoscopy unit staff in endoscopy were not aware of actions in place to mitigate these risks. We saw where a 'task and finish' group had been established to address issues in endoscopy but could not see when these issues would be addressed.

Leadership of service

- Members of the divisional, local and trust leadership team were visible. Staff were aware of the role and functions of key board members and could identify them for example the director of nursing, chief operating officer and the assistant director of nursing for medicine.
- Ward staff told us that senior nursing staff and consultants could be seen on the wards daily and that were approachable and helpful.
- Two members of staff we spoke to in Endoscopy said they did not feel listened to, they told us they had tried to raise concerns in the past but did not feel managers were interested.

Culture within the service

- Information received before our inspection had identified the trust to be in the top 10 of all trusts in England for the number of whistleblowing concerns, with staffing concerns, the quality of agency staff and the impacts on care and the safety of patients being raised as a consistent theme for medical care services.
- There was a whistleblowing process for the trust, however this was in its infancy, and the trust divisional and executive leads were still working towards building a level of trust with the staff to improve the culture within the service to make it more open.
- We observed that staff were positive about working for the trust. Staff were committed to providing good quality care and understood the contribution they made personally to the care and treatment of patients, however most nursing staff were worried about the reputation of the trust and felt there were issues with recruitment. The high use of agency nurses were the ward managers biggest concerns.
- All of the ward managers we spoke with said they were most proud of their team.
- Most staff we spoke with told us they felt there was a culture of openness within the organisation. For example during our visit a ward manager contacted the director of nursing about an issue she wished to discuss and the director of nursing attended the ward shortly after. A nurse we spoke with told us she considered that this was typical of the organisations' approach. They explained their interactions with the director of nursing were positive about the interest they showed in their wards. We saw one ward had received an award for their dedication during difficult times of recruitment of nursing staff.
- Staff in endoscopy told us they used to complete incident forms for lack of or, insufficient equipment but, "don't bother anymore". We could not be assured that the true nature of the problem with equipment in endoscopy was escalated appropriately and that there was an open culture for raising concerns.

Public engagement

- Through the use of a questionnaire, staff within medicine actively explored the experiences of carers of patients with a diagnosis of dementia to improve patient care.
- During the 12 o'clock stand up meeting we attended, matrons and clinical leads discussed their plans to invite complainants to key meetings in order to give staff a greater understanding of the impact poor care delivery has had on these individuals.
- The trust carried out a local patient satisfaction survey to explore patient's perception of doctor's performance, assessment of patient's pain, advice on financial guidance and nurse specialist availability in haematology services. A total of 73 completed questionnaires were returned with a response rate of 61%. Results from the August 2015 survey were largely positive and demonstrated that patients regarded this service very highly.

Staff engagement

- We spoke with 136 staff from a variety of roles. Most staff were engaged and felt able to raise concerns and felt empowered to suggest new ways of working within their areas.
- Ward sisters and matrons were invited to attend a weekly meeting with members of the board. Staff told us this was an effective way to learn about current issues within the trust and also, as the meeting was trust wide, staff felt it created good networking opportunities and enabled shared learning.

Innovation, improvement and sustainability

- We were informed that new ideas and innovations were encouraged and the leadership team was open to testing them where possible, for example on one ward we saw a strategy that had been developed which identified key areas of care that nursing staff felt less confident in and wanted to improve for example oral care. Action cards were created highlighting the important points to aid staff training.
- Each action card was used during staff training to develop the skills of registered and non-registered staff over a five day period to ensure all staff had received the training. The action card was changed each week to a new subject. The ward manager had shared this project with the director of nursing and it was going to be rolled out across the medical division. There was also plans to audit the effectiveness of the programme.
- Within specialist medicine there had been a gradual decrease in the number of falls per month, with notable improvement within D'Arcy and Tiptree wards. D'Arcy ward had zero falls in July which was the first time this had been achieved in care of the elderly. D'arcy and Tiptree, closely adhere to the cohorting of patients at risk of falls. We saw visible signage on both wards detailing which staff were to remain in these bays.
- An out of hours standard operating procedure was available to all staff. This aimed to improve team working and cross cover at junior doctor level, enable efficient communication to junior doctors via a bleep system and, reduce the inequity of workload across the core specialties.
- An E learning module for oral care had been developed in stroke services. Due to its success this had been rolled out to other trusts within the east of England.

Surgery

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

Information about the service

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

The service consists of nine surgical wards, divided into elective and emergency admissions. The design of the elective care centre and surgical assessment unit facilitate patient access and flow through the hospital and allow flexibility in service provision. 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.

During this inspection, we visited all nine wards within the surgery service, all three theatre suites at the main hospital and the ophthalmic theatre at Essex County hospital. We spoke with 162 staff, including medical and nursing staff, 57 patients, and 4 relatives. We reviewed 51 sets of medical records and information requested by us and provided from the Trust.

Summary of findings

Surgery services were rated as inadequate overall with safety, effectiveness and responsiveness being rated inadequate and service requiring improvement in care and leadership. The service had recently undergone some senior divisional changes and whilst the new structure had the foundations to improve patient care, this was in its infancy.

Oversight of standards of care and governance was fragile. There was a structured governance process in place but this was not yet embedded; good practice in one area was not cascaded and the service remained very reactive. There had been a reconfiguration of the nursing team and focused effort on Brightlingsea ward and patient safety and care had improved. Similar issues and concerns regarding staffing numbers, escalation of deteriorating patients and medical review were now apparent on Mersea and Aldham wards, which indicated a lack of oversight of the service.

There was disparity with consultant and middle grade medical cover and support for junior doctors across surgery. The vascular, general surgery and urology specialties provided good support and clinical supervision. This was not the case within orthopaedics, where consultant led ward rounds occurred infrequently. Medical cover, out of hours and at weekends, was variable with consultant and middle grade staff providing support from off site.

Surgery

At ward level multidisciplinary team working was not united, nursing safety huddles had been introduced but the wider team were not included. Some operational policies and procedures were in draft form or required updating to reflect current service status. Risk assessments at local level were not robust and the divisional risk register was incomplete. There was equipment in use that was out of date for service and maintenance.

Are surgery services safe?

Inadequate

We rated safety of surgery services as inadequate because:

- There had been a significant number of never events.
- Nursing staff were aware of the incidents and learnings but this was not evident across junior and middle grade medical staff.
- Assessment and medical review of patients on Aldham and Mersea ward was not consistent and we raised concerns for patients on both wards that required clinical review.
- Nursing staffing levels on the wards did not always match the patient acuity, specifically on Mersea ward and Aldham ward.
- Support for junior medical staff was not consistent with limited middle grade and consultant presence overnight and at weekends, specifically within Orthopaedics.
- No middle or senior orthopaedic medical staff attended trauma calls. Orthopaedic junior doctors covered the ear, nose and throat (ENT) specialty out of hours but had no experience and senior support was offsite.
- On Aldham ward, we identified two patients that potentially required a safeguarding alert to be raised. The team took appropriate actions once identified but awareness by the staff to consider this was lacking.
- Security of medical records needed improvement. Storage was an issue in some areas, which presented an infection control risk when items were stored on the floor and contaminated waste storage areas were not secure.
- Medical assessment and patient review was not consistent across the surgery wards. Out of 51 records reviewed, across seven wards, only 15 patients had a daily review by a middle grade or consultant recorded.
- On Aldham and Mersea wards, we identified patients where a medical review had not taken place and the patients now required urgent clinical review.
- 30% of early warning scores checked were not completed appropriately.
- The footprint of Mersea ward was three times larger than the other surgical wards. This increased the risk to patient safety as observation capabilities were very restricted.

- Security of contaminated waste was not consistent to ensure safety.
- The fridge for storage of blood in Constable theatres was broken at the time of inspection. This meant that only one unit of blood could be requested at a time as storage was not possible. This had been risk assessed and a replacement fridge was purchased and due for commission on 28 September 2015.

However we also found:

- The quality and safety dashboard data was visible in each area
- The majority of staff adhered to trust policies and guidance on the use of personal protective equipment (PPE), and to 'bare below the elbow' guidance.

Incidents

- A system and process for reporting of incidents was in place. Staff understood the mechanism of reporting incidents, this was confirmed verbally, both at junior and senior level. The incident reporting form was accessible via an electronic online system.
- Nursing staff on each ward were aware of the incidents that had occurred locally. On Great Tey ward the notice board in the office, displayed details of the top five incidents on the ward, alongside the number of incidents for the surgical division.
- There had been a total of ten never events relating to surgery between May 2014 and August 2015. Nursing staff were aware of the serious incidents and never events. Folders were in place on all surgical areas, including Essex County hospital, which outlined the incidents, investigations and outcomes to improve patient safety. Junior and middle grade medical staff were not aware of the incidents. The folders contained signing sheets, used well by nursing staff but not at all by medical staff. This meant that learnings were not widespread across all groups.
- Three serious incidents involved Ophthalmology. These were all between July and August 2014, and were reported and investigated accordingly and changes in practice occurred as a result. The first incident involved administration of the incorrect intravitreal injection (there are two common types of injection in use). As a result, care pathways were distinguished for each injection, a defined operating process and separate fridges for storage were in place to reduce the risk. The second incident involved the re-use of a procedure pack for an eye injection. Implementation of a sign in and out process and checklist reduced the risk of this happening again. The third incident involved insertion of the incorrect strength of lens. Double checks are now in place within theatre.
- Staff in theatre were aware of the never events and safety initiatives such as “stop before you block”, an additional check before a local anaesthetic nerve block is inserted, and a checklist included in the central line procedure pack to be double-checked at the end of line insertion to ensure guidewires have been removed.
- Mandatory training data indicated that 84% of nurses had received training on investigations using root cause analysis, which meant that staff had awareness of completing investigations to ensure evidence was robust.
- The monthly surgical audit meetings included a review of patient mortality and morbidity. This meant that medical staff reviewed recent patient deaths to identify any concerns and identify potential learnings to improve patient safety. We reviewed the minutes from the meetings between January and July 2015. The minutes varied greatly in content, configuration and detail, which meant the effectiveness of learnings could not be assured.
- In nine out of the ten never events, duty of candour, where patients were told of the situation, was documented as taking place. Seven patients received investigation outcomes. Of the two patients that did not receive further information, one was patient choice not to. In only one case, the investigation found that there had been opportunity to speak to the patient prior to discharge however, this had not taken place, which was not in line with trust policy. Duty of candour conversation in this instance only occurred after the patient had re-contacted the hospital.
- Senior nursing staff were aware of the principles of duty of candour. The nursing sister on Great Tey ward provided the example when a patient had fallen and dislocated their hip. An incident report and investigation took place and full findings were shared with the patient.

Safety thermometer

- 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 MRSA, Clostridium difficile (C. diff), falls and pressure

ulcers (PU). Copford ward was the exception and staff stated that this was due to the fact it was a day unit and information was included on the neighbouring Great Tey ward.

- The National Institute for Health and Care Excellence (NICE, 2010) recommends that all patients should be assessed for risk of developing blood clots on a regular basis, and on admission to hospital. Data for venous thromboembolism (VTE) assessments in May was 77% for the surgery division. This had increased to 92% in June but dropped back slightly to 90% in July.
- Data showed that between May and July 2015 there had been no cases of MRSA within the surgical wards. There had been two cases of Clostridium difficile (C. diff), one in June on Aldham ward and one in July on Great Tey ward (both orthopaedic specialty wards).
- Performance data was included in the agenda at the "2 at the top" ward governance meetings to address any drops in performance, however not all wards were compliant with these monthly meetings. The number of falls had increased across general surgery between May and July 2015 from 8 to 14 falls. The three wards affected were Brightlingsea, Mersea and Wivenhoe. Out of these three only Brightlingsea ward had "2 at the top meetings". Wivenhoe ward had seen the highest increase in patient falls with five occurring in July.

Cleanliness, infection control and hygiene

- Some of the 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.
- Not all areas were clutter free as storage was an issue. In the admission area on Mersea ward and in the surgical procedure room (flexible cystoscopy area of the elective care centre) there were boxes stored on the floor, which was an infection control risk.
- The corridor leading to Mersea ward had seven vacant beds stored along it overnight. One of these had bed linen in situ, which could be an infection risk and fire risk due to the restriction in the passageway. A bed could fit past but only with some care.
- The majority of 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.
- Security of contaminated waste was not consistent to ensure safety. The disposal hold for clinical waste located between Aldham and Fordham wards had a keypad for access but this was latched open, which meant that the public could access this area and be at risk of contact with contaminated waste. The keypad lock for the storeroom on Great Tey ward was broken; staff had submitted a maintenance request but were uncertain when the repair would take place.
- Staff had labelled the majority of sharps bins appropriately, identifying the date, signature and location of origin. They were not overfilled, which reduced the risk of injury to staff.
- 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.
- Staff in theatre were aware of MRSA policy. Identified patients 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.
- Storage space was limited within all theatre areas, which meant that equipment was stored inappropriately in some areas. To prevent the spread of infection the patient flow through the anaesthetic room, operating room and out to recovery in one direction. Used instrument trays are removed from theatre via a separate "dirty corridor" to prevent cross contamination. Patient positioning equipment was stored in the dirty corridor within main theatre. Corridors were cluttered which was a potential fire hazard should exits become blocked.
- In Constable theatres there was no dirty corridor at all which meant used trays were covered and transported via clean areas.
- Housekeeping staff stated there had been a reduction in hours, which meant that the number of jobs completed

had begun to decline. There was no cover provided for annual leave or sickness. However, environmental audit results had remained stable, between 93 and 95% between May and August 2015.

Environment and equipment

- The environment at Essex County hospital (ECH) was beginning to look tired and in need of repair. Roof leaks had occurred and there were areas where paint was peeling and bubbling. Flooring was torn and repaired with tape. Services were due to move to Colchester University Hospital in autumn 2016. There was a maintenance team on site locally to repair any ongoing issues but with no refurbishment plan in place it was evident that investment to refurbish would not occur.
- Removal of the emergency resuscitation trolleys at ECH took place on 14 September 2015. The communication of this decision to the nursing and medical teams was poor. There had been discussion at the resuscitation committee meeting on 9th September 2015 and a memo sent to nursing staff on the 14th September detailing the changes and new checklists. The medical staff had not received this communication and were unaware of this having taken place. Medical staff stated that cardiac arrest is a potential risk associated with certain ophthalmic treatments and is part of the consent discussion. There was strong negative feeling from clinicians that this decision had occurred without full consideration for the extent of clinical procedures undertaken at the hospital. The resuscitation officer only completed a risk assessment two days after removing the equipment, after we had requested this, and the assessment did not include any clinical factors.
- The trust stated patient safety was not at risk as an automated external defibrillator (AED), suction and oxygen cylinder remained in situ. An AED is a small portable electronic device that analyses the heart rhythm and delivers a shock only when needed. Nursing staff were aware to dial 999 in an emergency and there was a daily checklist initiated for the remaining equipment.
- Staff carried out daily checks of resuscitation trolleys and emergency equipment within the surgical wards and theatres. These checks were consistent across all areas at Colchester University hospital. Checklists were in place and records were complete.
- Laser equipment used in both ophthalmic theatres at ECH and in main theatre at Colchester were visibly clean, in date for servicing, documentation records were appropriate and there was a policy in place. An additional member of staff was on duty at ECH, when required, as key holder and laser operator.
- The environment on Brightlingsea ward had improved from our last inspection in May 2015. The ward was visibly clean, tidy and odour free.
- A large proportion of equipment was out of date for servicing. These included items such as syringe drivers, infusion pumps and blood pressure monitors. Calibration of the weighing scales used for patient preassessment had not taken place for three months. Patient weight is a requirement for medication and anaesthetic administration calculations, which meant that this was a potential patient safety issue, as there was no assurance of the accuracy of the weight measurement.
- There were no consistent integrity and sterility checks in place for pre-packed sterilised items in surgical areas. A bladder injection pack was out of sterilisation date but was available on a trolley in the elective care centre. The ward sister was made aware and the item was sent for reprocessing.
- Some general maintenance was required on Fordham ward. There was a broken windowsill and the bathrooms were not fit for purpose. Refurbishment for bathrooms and counters was included on the trust programme of works but had not yet been approved pending terms of reference and business case. We were not provided with a risk assessment and there was a risk to patient safety from the current layout of the facilities should a patient fall in the bathroom. This was not on the divisional risk register.

Medicines

- The pharmacy team provided a well-established and comprehensive clinical service to ensure people were safe from harm. 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.
- The prescription and medicine administration records for 19 patients, from two wards, were reviewed. Records of administration were incomplete, with a number of omitted doses and charts not signed (particularly antibiotics, so we could not be sure that patients always received their medicines as prescribed.

- 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.
- Certain medications are required to be stored within specific temperatures to maintain their integrity. Drug fridges temperatures on the wards and in theatres were monitored and recorded daily. Checklists included details of the acceptable temperature ranges and actions required should the temperature fall out of this range but staff did not adhere to this. Temperatures had exceeded the recommendation of 25 degrees on 20 dates in August 2015 on Great Tey ward, but no actions, or escalation had been undertaken. Similar omissions had occurred on Brightlingsea ward; both were brought to the attention of the ward sisters.
- There were temporary pharmacy cupboards in use in main theatres. The current cupboards were not fireproof and could pose a risk but were not on the risk register. There were plans to turn the recessed area into a pharmacy room by adding doors but staff were unsure when this would happen.
- There was limited availability for patients to administer their own medications should they wish to. There was no pathway for self-administration (SAM) on Wivenhoe ward. On Brightlingsea ward there was only one patient on SAM pathway. The sister stated that they hoped this would increase in the future.
- Staff in the ophthalmic theatres followed the correct checking protocol prior to administration of medications such as eye drops, antibiotics and local anaesthetic.
- Security of medications in drug fridges within theatres was not defined or consistent. There was no standard operating procedure in place. In some areas, such as Elmstead day unit, staff locked anaesthetic drug fridges at the end of the list but not in the main theatre suite. This was brought to the attention of Matron.
- The fridge for storage of blood in Constable theatres was broken at the time of inspection. This meant that only one unit of blood could be requested at a time as storage was not possible. This had been risk assessed and a replacement fridge was purchased and due for commission on 28 September 2015.

Records

- There was no trust policy for a consistent approach to the accessibility and storage of patients notes. On Mersea ward, the current notes were stored at the bedside with previous notes stored on a trolley, whereas on Brightlingsea ward the current notes were stored on the trolley. This meant when staff moved to different wards there may be a delay in accessing patients' details.
- The security of medical notes was not consistent. There were notes left unattended on the reception desk in Mersea ward and Brightlingsea ward. A physiotherapists book, containing patients names, diagnosis and treatment details was unattended on the desk on Mersea ward. The member of staff was unconcerned and stated, "that as long as the book was closed it could be left anywhere". Mandatory training data showed that 86% of allied health professionals and 67% of nursing staff from surgery had received information governance training.
- There were two incidences of incorrect documentation on Aldham ward. Staff had written details of ongoing care for one patient in another patient's notes. This was identified and amended however, there was a safety risk that continued care may be inappropriate or delayed due to incorrect entry.
- Dispatch of patient records to Essex County Hospital (ECH) was secure. Staff checked the notes on arrival, normally the day before surgery, and contacted Colchester directly if any notes were missing. Notes were stored in a locked cupboard overnight and returned to the trust once discharge was complete.
- There was a potential risk to staff confidentiality at ECH. Staff competency and compliance folders that were stored in the coffee room of the operating theatre at ECH contained personal details of staff (names and employee numbers). This door was unlocked which meant there was a risk that personal data may not be secure.

Safeguarding

- Safeguarding training is mandatory for all staff. Data provided for nursing staff showed that safeguarding of vulnerable adults (SOVA) training level 1 was 99% and level 2 was 97%. Child protection training was not as good with 88% of nursing staff completed level 1 and 66% completed level 2.
- Information folders were available on the wards containing contacts for escalation. Staff provided examples when concerns had been raised and appropriate actions taken to protect the patient. For

example, there was a multidisciplinary meeting with medical and nursing staff, a safeguarding alert raised and incident recorded and investigated following a patient injury.
- On Aldham ward, we identified two patients that potentially required a safeguarding alert to be raised. The team took appropriate actions once identified but awareness by the staff to consider this was lacking.

Mandatory training

- Delivery of mandatory training was by a variety of methods including ELearning and face-to-face sessions. Training included fire safety, basic life support, health and safety, infection control and information governance.
- There was a dashboard in place to measure attendance, which used a red, amber, and green (RAG) rating to identify compliance status. Over 90% attendance achieved a green, amber 70-90% and red below 70%. Mandatory training needed to improve across surgery.
- Data showed that out of 29 topics, surgery averaged green status for only four - SOVA training level 1 and 2, the trust values “at our best” training and mental capacity act training. 10 out of the 29 were amber and 15 were red which included basic life support, blood borne virus & sharps training, dementia training, deprivation of liberties and learning disabilities training.

Assessing and responding to patient risk

- The national early warning system (NEWS) was in place across the surgical areas to identify any change in patient condition and ensure timely appropriate escalation for deteriorating patients. We reviewed 51 nursing and medical notes and in 33 cases the NEWS score was completed appropriately.
- There was an ongoing investigation into a patient death following admission to Brightlingsea ward via the emergency department, and surgical assessment unit. Initial findings indicated that there had been a delay with diagnostic screening, medical review and NEWS escalation protocol had not been followed.
- Medical assessment and patient review was not consistent across the surgery wards. Out of 51 records reviewed, across seven wards, only 15 patients had a daily review by a middle grade or consultant recorded.
- On Aldham and Mersea wards, we identified patients where a medical review had not taken place and the patients now required urgent clinical review.
- One patient had become unwell and had not had a specialist review as requested. The patient had a complex medical condition, had become drowsy and developed a swallowing problem. Despite this, 48 hours after referral, review by the medical team, specialist nurse or speech and language therapy team had not taken place. The patient had not received the anticoagulation medication or medicines required for their condition for three days or had blood tests done for nine days. We escalated our concerns regarding this patient and a medical review was undertaken.
- Another patient had become confused, agitated and unwell overnight. The patient was elderly, diabetic and had joint replacement surgery. Investigation into the causative factors for the deterioration in condition did not occur in a timely manner. Monitoring of the patients’ blood sugar had not taken place as prescribed; the patient had received multiple doses of opioids for pain and despite a urinalysis that indicated a urinary infection it took over 24 hours for antibiotics to be prescribed. There had been no recorded review by a consultant postoperatively and there had been written amendments in the patient records following incorrect entries.
- One patient on Mersea ward was visibly distressed and in pain. The diagnostic scan had been postponed twice. We informed the ward sister of the patients increasing discomfort and escalation to the medical team and a review of the patient was undertaken.
- 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 were bed shortages. The footprint is three times the size of other surgical wards such as Brightlingsea ward; this increases the risk to patient safety, as observation capabilities are very restricted. There had been six patient falls reported in the month of July 2015.
- Blood tests, x-rays and requests for medical review were booked via the computer system and reviewed, prioritised and allocated by the duty matron. This meant that the doctors attending the ward were not always from that speciality, for example, it may not necessarily be an orthopaedic junior doctor attending an orthopaedic ward. Staff stated that generally, they would receive a response to a request within an hour,

but there had been incidences where staff were waiting a much longer length of time for a doctor to come and see a patient. Staff could bleep medical staff directly if they had any serious concerns.

- Medical cover for ear, nose and throat (ENT) patients out of hours was a risk. The trauma and orthopaedic first or second year clinician provided cover for ENT, with support only provided from a senior registrar who was off site. The two medical staff we spoke with had limited or no previous experience in dealing with ENT procedures. We requested the risk assessment for this decision but this was not provided.
- The five steps to safer surgery and world health organisation (WHO) checklist is utilised and audited in all theatres. All aspects were observed including team briefing, sign in, time out, sign out and debrief.
- Staff in theatre completed instrumentation checks against tray checklists however; the check was not recorded correctly on the checklist. Four checklists were reviewed and none were completed. This meant that should there be a query regarding a missing instrument there was no way of tracking at what point this occurred.
- Certain items of equipment were out of date on the difficult intubation trolleys within main and constable theatres. Staff stated that they were aware of this however were delaying replacement as new guidelines were expected in November. Initial response from staff was to remove these items with no awareness of the potential risk to patient safety that might result from these items being missing. We brought this to the attention of Matron, the items were ordered and the current stock labelled clearly as waiting replacement.
- The trust had responded to concerns raised during our last inspection in May 2015 and reviewed nurse staffing and patient numbers on Brightlingsea ward. Nursing establishment had increased to four registered nurses and four healthcare assistants during the day. Four registered nurses and three healthcare assistants during the night. The number of patients had reduced due to the closure of four beds.

Nursing staffing

- There was ongoing nurse recruitment across the surgical areas. Where nurse vacancies existed agency and bank staff were utilised to bridge gaps. Between March and August 2015 a total of 18.5% agency and bank were utilised across the surgical wards. The three wards with the highest percentage of temporary staff during this period were Mersea ward, Brightlingsea ward and Aldham ward at 33%, 25% and 20% respectively. All of these wards were areas where there had been concerns with care.
- Recent appointments from staff overseas had begun to improve numbers. Eight new band five nurses from Europe had all started on the 1st July 2015 and been allocated to Mersea ward. The staffing establishment had increased and the new recruits now meant that the ward was at full establishment however, staff stated that the challenge now was supporting new staff with competencies and communication.
- An acuity tool is utilised to assess nurse-staffing requirements on each ward, however, this did not include environmental factors such as the size of the ward. Mersea ward has a footprint three times greater than other surgical wards but there was no consideration of additional staffing due to the layout and inability to observe all patients easily.
- Staffing on Mersea ward on the evening of 17 September was insufficient. There were five registered nurses, one of which was agency and two healthcare assistants for 29 patients plus an additional three patients that were late admissions. Two patients required one to one nursing and eight patients required intravenous antibiotics. When we escalated our concern with the staffing levels, the trust stated that there should have been an additional two nurses on the ward.
- Night staff were aware of the process for escalation of concerns to the matron, night sister and outreach team should help be required.
- Staffing levels with the operating theatres were compliant with national guidelines however; vacancies within theatres were a concern for staff. Between March and August 2015 a total of 9% agency and bank were utilised across theatres.

Surgical staffing

- Vacancies for medical staffing within surgery at the time of inspection equated to 30 whole time equivalent posts with 13 recruited. Eleven are consultant positions with six recruited awaiting pre-employment checks. Vacancies varied across specialty, six posts were from general surgery, three orthopaedics, two urology and two anaesthetics. Recruitment was ongoing.
- Consultant cover and support across the surgery service was specialty dependent and not consistent. Cover

within vascular, urology and general surgery was good and daily consultant ward rounds occurred within these specialties. However, engagement by other teams, such as orthopaedics, was poor. Staff on Fordham ward stated consultant ward rounds occurred three times a week, with the other days covered by the senior registrar and junior house officer. One patient on Aldham ward stated that they had seen their surgeon, for the first time, two weeks after surgery. The nursing staff confirmed this. Out of 17 records reviewed from Aldham ward, none had a daily review by a senior member of the medical team recorded.

- We observed a ward round on Aldham ward on the 18 September, which was attended by the consultant on call. The consultant was not engaged, did not participate or say a word, and nothing was written in the patients notes.
- There was one consultant ortho-geriatrician in post. Staff stated that this recent appointment had been greatly appreciated and effective for patient care. We observed one incident on Aldham ward where the staff nurse made three separate attempts to contact a member of the medical team (junior and registrar) for an unwell patient. When this was unsuccessful the consultant ortho- geriatrician supported the team, saw the patient and spoke with the relatives.
- At night there is one junior doctor covering the surgical wards, one covering emergency services and surgical assessment unit and one surgical registrar covering theatres. Junior doctors stated they felt unsupported on occasions and at times, it was difficult to get hold of a more senior colleague for advice.
- One junior doctor provides medical cover at the weekend for general surgery and one for urology and vascular. The junior doctors participated in an on call system and middle grade staff worked Monday to Friday on site and were on call at the weekend.
- Junior medical staff on the vascular team felt supported, contact telephone numbers were available and consultants reached when required. Junior medical staff stated the urology consultants worked well together.
- The general and colorectal consultants had altered their job plans to allow for on call commitments. There was a registrar review of patients on both Saturday and Sunday mornings.
- Support and engagement from senior medical staff and consultants within orthopaedics was limited. The Foundation Year 2 doctor (FY2) was the only person that attended from the team when a trauma call occurred in the emergency department. The orthopaedic FY2 covered the wards and the emergency department at night and also covered Ear, Nose and Throat (ENT) patients. Two junior doctors stated that the workload was not sustainable and they felt very disillusioned. At times they felt more like administration assistants "completing discharge summaries and chasing clinical results and pathology".
- Trauma and orthopaedic locums covered the Foundation Year rota. Locum staff had limited access to data systems, which could mean an increased risk of delays to patient care. Staff stated that one locum, contracted for a month, had left after only two days. Data requested for the percentage of locum medical staff used within the surgery service over the last six months was not provided.
- There was no recorded evidence of appraisal for junior doctors submitted to us.
- There was support and senior medical cover provided at Essex County Hospital with regular departmental teaching arranged.

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.

Are surgery services effective?

Inadequate

Effectiveness of surgery services was rated as inadequate because:

- Whilst guidelines and procedures were available on the intranet not all staff had awareness of or could demonstrate how to access them.
- There was no system in place to ensure that patients going to surgery in the afternoon had appropriate hydration.
- Patients were at risk from extended periods of fasting.
- The monitoring of patient outcomes and use of local audit to improve quality of care was not consistent across all surgical areas.

- When local audit did take place dissemination of information from results was inconsistent.
- Staff appraisal was lower than 60% in the majority of areas and significantly poor on Mersea and Brightlingsea wards with rates of 4%.
- Patient review took place three times a day, at the ward board rounds, but these were attended by nursing staff and should be extended to include doctors and allied health professionals to maximise the opportunity for a full patient review.
- Staff shortages within the therapy department meant that patient rehabilitation was reduced at the weekend and the lack of occupational therapy impacted on patient discharge and risked patient outcomes.
- Staff knowledge and adherence to mental capacity assessment and deprivation of liberty safeguards was not consistent.
- The system for online requests and prioritisation of tasks overnight by matron may cause delay for less urgent patients.
- The national hip fracture audit data for 2014 showed that the trust had performed worse than in 2013.

However we also found:

- Practice guidelines were available to staff on the trust intranet to ensure practice remained in line with national guidance.
- Monthly local spot check and environmental audits occur throughout the surgical wards.
- The national early warning system (NEWS) was in place across the surgical areas to monitor acutely ill patients in accordance with NICE guidance CG50.
- Patients confirmed that they had received their medication and pain relief in a timely manner.

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 however not all staff could identify and demonstrate the ability to access relevant guidance from the intranet.
- Monthly local environmental audits occur throughout the surgical wards. Data for the months between February and May 2015 showed results as consistently above 90%.
- On Brightlingsea ward there was a monthly spot audit undertaken of patient records, which included patient rounds, medication omissions, oxygen therapy, fluid balance recording, pain score, early warning score, consent to care and mouth care. The audit in August had highlighted VTE scoring as red, only 36 out of 46 had been completed. The ward sister stated this was to be actioned with the lead ward consultant to target improvement.
- Monthly audit of world health organisation (WHO) checklist compliance has been in place since April 2015 with all five steps to safer surgery monitored. Data showed compliance at 100% in April and May, 99% in June, 96% in July and 98% in August 2015. The decrease has occurred in the team brief and sign in phase.
- The national early warning system (NEWS) was in place across the surgical areas to monitor acutely ill patients in accordance with NICE guidance CG50.
- All vascular patients were reviewed in preassessment by an anaesthetist, in line with NICE guidance.

Pain relief

- Patients confirmed that they had received their medication and pain relief in a timely manner.
- The system for online requests and prioritisation of tasks overnight by matron may cause delay for less urgent patients. One patient on Great Tey ward had been in pain for several hours. Nursing staff had made a request for a doctor to review the medication prescription via the online system. The patient was not priority due to a low NEWS score and they were not seen until several hours later at 06:30 in the morning.

Nutrition and hydration

- There was no system in place to ensure that patients going to surgery in the afternoon had appropriate hydration. Three patients on Copford ward had been nil by mouth from the evening before surgery, had arrived as requested at 7am, and were still waiting for surgery at 2.30pm. One of the three patients did not go to theatre until 4pm. Another patient stated that they had been nil by mouth for 20 hours prior to surgery for a hip replacement. This meant that patients were at risk of dehydration and extended periods of fasting.
- Patients gave mixed reviews of the food provided. Some stated the choice was limited and another patient stated that a relative brought food for them into the hospital, as it was not appetising. The

malnutrition-screening tool (MUST) is a five-step screening tool to identify adults at risk of malnutrition and compliance with the care plan is monitored via the patient dashboard. Between May and July 2015, data for Mersea ward was only submitted once (100% July). Brightlingsea ward had improved from 50% in May, 33% in June to 100% in July.

Patient outcomes

- Monitoring of patient outcomes and use of local audit to improve quality of care was not consistent across all surgical areas. No audits had taken place in the surgical assessment unit since it opened in March 2015. Staff stated that data collection took place but there was no time to collate or assess results.
- In areas where local audit did take place dissemination to ward staff was not consistent. There was no evidence of medical clinical audit on Brightlingsea ward, which meant that a review of patient outcomes was not effectively taking place.
- The trust participated in a range of national audit including, hip fracture audit, bowel audit, laparotomy audit and lung cancer audit. In 2014, the trust performed slightly better than the England average in the bowel cancer audit.
- In the national emergency laparotomy audit 2015 the trust scored less than 49% in three measures; consultant surgeon review within 12 hours of emergency admission, direct postoperative admission to critical care and assessment by medicine for care of the older person (MCOP) specialist for patients over the age of 70.
- The national hip fracture audit data for 2015 showed that the trust had seen no improvement in performance from 2013 or 2014. Out of 10 measures provided by the trust, only three were better than the England average, and seven measures showed that they were performing lower than the England average. Of these seven however five showed an improving trajectory on 2014 with only two indicators showing a decline in performance since 2014. This included best practice tariff and pressure ulcers. Time to admission to an orthopaedic scored much better than the England average.

Competent staff

- Induction and competency assessments were in place for new, temporary and agency staff across all areas. There was an attempt to book regular agency staff as they were familiar with the areas, paperwork and systems at the trust, which reduced the risk of compromised patient safety.
- Overseas nurses received a three-week induction programme that included trust induction, clinical skills and English language training.
- The physiotherapy team provided regular supervision with new staff to ensure learning and competence.
- Within the ophthalmic theatres Essex County hospital, there were staff education notice boards that included a nursing timetable, curriculum and mentor details along with an escalation of concerns protocol. Nursing staff received an induction, had individual named mentors, and clinical competencies to complete.
- There were competency assessments in place for theatre equipment and a record of completion held by the training and development lead. This improved patient safety, as staff were knowledgeable about equipment prior to its use.
- There was no rolling programme for development for band six theatre staff. Staff felt this was a contributing factor to staff vacancies and raised this to the associate director of nursing at the July 2015 theatre meeting.
- Staff appraisal was on an annual rolling programme. Data showed that in the majority of surgical areas staff appraisal was below 60%. The exception being Fordham ward at 87%. Staff on Fordham ward received six weekly supervision and first appraisal at six months. Records of continuing development were in place.
- The worst areas for staff appraisal were Mersea ward at 4% and Brightlingsea ward at 6%.
- Staff on the wards confirmed that there were training opportunities available. One healthcare assistant, recently appointed to Copford ward, had attended theatre to observe a joint replacement and expressed that this had been beneficial as they were now aware of the complete patient journey and felt they could support the patients more.
- On Great Tey, ward consultant feedback questionnaire data was displayed on the staff notice board in the office. Those consultants used this as evidence towards their revalidation.
- Staff in the outsourcing office received a monthly developmental review with their manager and had coaching support locally. Development is encouraged and one member of the team was undertaking an NHS leadership programme.

- Stanway is predominantly a gynaecology and breast surgery ward with some medical 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

- The consistency and quality of multidisciplinary team (MDT) ward rounds varied across the surgical wards. For example on Wivenhoe ward, MDT working was good and included doctors, nurses, therapists and dietician. In contrast, on Aldham and Great Tey ward, the ward round was predominantly nursing staff.
- A safety board round, referred to as a "safety huddle", occurred on each ward three times a day to monitor patients and discuss any changes of condition. There were missed opportunities to discuss the complete patient pathway as this huddle consisted of nursing staff but did not include any medical or therapy staff. We raised this with the ward sister on Great Tey ward.
- There was a daily night handover attended by the matron, junior medical and surgical staff and member of the critical care outreach team. Staff stated that there could be variable attendance at this handover.
- 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. This included review of every overnight admission and teaching for junior doctors.
- There were weekly MDT meetings within each specialty. Each had a generic agenda that included incidents, audit, risk and mortality and morbidity audit.
- Attendees at the vascular MDT included consultant, medical staff, trainees, nursing and pathology staff and clinical support staff. The meeting linked with telemedicine service at another provider. There were full and open discussions for each patient reviewed amongst the multidisciplinary team. All protocols for the management of vascular patients were available on the intranet. The orthopaedic MDT on 16 September was structured and prepared although there were no trainee or middle grade medical staff that attended.

Seven-day services

- The outreach team provide a 24 hour service seven days a week. Staff could bleep the outreach team directly for support.
- The physiotherapy service was available seven days a week. The team were actively recruiting with the aim to have one physiotherapist for each ward. Current staffing vacancies meant that there were two physiotherapists covering four wards, which meant that there were limited resources to provide complete care.
- At weekends, the staffing meant that focus was on new patients as opposed to rehabilitation patients. Some orthopaedic patients had surgery on Friday but did not mobilise until the Monday. To mitigate the risk the inpatient team met every morning to prioritise care and provide cross cover and support. Staffing meant that it was not possible to have one therapist to each ward.
- Occupational therapy (OT) provision was Monday to Friday with no cover for weekends. Occasionally one therapist would do overtime dependant on capacity and manager agreement. The lack of OT support over the weekend resulted in delayed discharge. Nursing staff had been advised to submit incident reports should this occur to provide data to build a business case for extra staff recruitment. Staff stated there had been two reports completed however, when we requested the data the trust responded that there were no incidents relating to occupational therapy cover.
- Pharmacy service was limited at the weekends and closed at 12:30pm on a Saturday. There was a pharmacist on call out of hours.

Access to information

- Substantive 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 access patient information including test results, diagnostics and records systems.
- Overnight the duty matron prioritised all clinical requests logged via the computer system using an iPad. All junior doctors received an iPhone to accommodate the system. This meant that doctors could receive tasks whilst moving around the hospital.
- A junior doctor used an iPhone application to send x-ray imaging results to a senior colleague, who was offsite, for review. Patient identifiable details were removed to maintain confidentiality however, it was unclear whether the clarity and image quality were sufficient to enable clinical review. This is not a recognised method

of data sharing and is not in accordance with the trust information governance procedure that stipulates the use of NHS.net or the image exchange portal to send images.
- Locum medical staff and agency nursing staff did not have access to the computer system, which could compromise patient care due to inability to request or review information. One member of agency staff stated that they had worked at the trust for two years yet still had no log in. Long-term agency staff in theatre could access the electronic blood tracking system and email.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patient consent prior to surgery should ensure that the patient has sufficient time and information to make an informed decision. Staff stated that consent for 90% of inpatients occurred on the day. This meant that there was very limited opportunity for patients to consider all the information prior to the procedure-taking place.
- Four patients admitted for day surgery on Copford ward stated information was provided before admission. They had discussed the surgery and signed the consent form at preassessment, which meant that there was a sufficient amount of time before surgery for them to consider all options. This was then reviewed and re-signed on the morning of surgery.
- One post-operative patient on Aldham ward had become distressed and confused and had started to throw items at staff. Staff were concerned that the patient was in danger to themselves and the other patients present in the bay. Security staff restrained the patient for a very short period to allow staff to move any other items, such as the bed locker and drip stand, away. The security staff were calm, spoke with the patient throughout and restrained in an appropriate manner for the shortest period possible. This patient had a mental capacity assessment in place however the documentation had not been completed fully and had errors. There had been a consent form 4 completed, which is a best interests consent form. The patients' relative had given verbal consent over the telephone for surgery however not all the information sections were completed in full by the medical staff.
- Two patients on Fordham ward had MCA and DoLS assessments in place. These were completed and recorded appropriately. One patient was at risk of falls, the falls assessment pathway was in use, one to one nursing and a low-rise bed were in place.

Are surgery services caring?

Requires improvement

Caring required improvement across the surgical wards and theatres because:

- The process of nursing handover at the patient bedside compromised patient confidentiality.
- Involvement of relatives and family varied and was not consistent.
- The capacity constraints within the surgical assessment unit meant that relatives might not be able to accompany patients if the unit was full.
- Staff did not provide adequate communication or emotional support to all patients affected by an incident on Aldham ward.
- Patients stated that delays in care did occur, especially at night and not all interactions with patients were kind and considerate.

However we also found:

- Staff treated patients with dignity and respect and the majority of patients said that nursing staff were caring and helpful.
- Results from friends and family data showed that most patients would recommend the service to their relatives and loved ones.

Compassionate care

- The majority of patients said that nursing staff were caring and helpful and that staff treated patients with dignity and respect.
- Patients stated staff shortages meant delays to care at times which was worse overnight. Patients from three wards, Mersea, Great Tey and Brightlingsea, provided information that suggested nurses at night were less caring, seemed fed up and could be rude. One patient referred to a "nasty nurse" overnight and another had

reported to the ward sister that the agency nurse at night "had been frightening" They said that the sister had dealt with the situation and informed the patient that the nurse would not be booked again.

- There was an incident on Aldham ward where a patient had become confused and started throwing items. The focus of all the staff s attention was completely on the individual despite the situation occurring in a six-bedded bay. At no point was support or care given to the five other patients. Staff made no verbal communication to the other patients, even when the curtains were drawn around them when security attended; we brought this to the attention of the ward sister the following day.
- Average response rate for the friends and family test was poor at 27%. August results where patients would recommend the service to friends and family included 83% Copford ward, 95% Great Tey ward and 92% Fordham ward. Data was not available for July or August from Aldham ward.
- There was positive feedback from the friends and family test for Essex County hospital. Patient satisfaction scores were 100% for August 2015. Patients felt informed throughout their surgery and on discharge. The risks and benefits were explained prior to the procedure and patients knew how to contact the hospital with any concerns post operatively.
- In some areas, such as the surgical assessment unit and Copford ward, patients were on trolleys for significant amounts of time, one patient had been on a trolley for eight hours. Trolleys were narrow, could be uncomfortable and meant that the patient could not change position as easily, which might increase the risk to pressure areas.

Understanding and involvement of patients and those close to them

- Patient confidentiality was compromised during the nursing handover, which took place beside the patient's beds. Handover included a full description of past medical history and the summary of current care. This was loud enough for other patients in the bays to overhear. On Great Tey ward staff requested that a relative leave the bay whilst handover was taken, however had no regard for the fact that the four patients in the bay could hear each other's medical information in detail.
- The capacity within the surgical assessment unit (SAU) did not allow consideration for patient relatives to remain with them. The unit had seven trolleys and six chairs which when full meant that there was no space for relatives.
- Involvement of patients and relatives in decision making regarding care varied. Some patients said this was good and they felt fully involved whilst others did not. One patient stated that doctors asked their relative to leave when they came to review them, without asking if the patient wished for them to remain.

Emotional support

- At Essex county hospital patients undergoing local anaesthetic eye surgery went to theatre in their own clothes to maintain their dignity and were encouraged to keep their valuables with them. During the procedure, a member of staff held the patients hand, for two reasons, to give comfort and to act as communication. The patient would indicate by squeezing the hand that there might be a problem. The staff member would then inform the surgeon who would remove the instrumentation from the eye before speaking with the patient. This maintained safety as the eye can move when the patient speaks.

Are surgery services responsive?

Inadequate 

Surgery services were not responsive were rated as inadequate because:

- The trust did not submit referral to treatment (RTT) data between December 2014 and April 2015. Since reporting resumed in May all standards have been below target, which meant patients were not receiving treatment within recognised deadlines.
- Theatre utilisation needed to improve; operating lists overrunning accounted for 34% of patients cancelled between January and July 2015 however only 28% of lists start on time.
- Reformatting of theatre utilisation information in March 2015 now meant that trend analysis did not take place.
- Admission of patients from day surgery to overnight admissions was high, and management of this was not improving.

- Increased hours in Elmstead day surgery meant that unplanned patient admissions often took place late in the evening.
- Appropriate discharge was not consistent; readmission rates within 48 hours of discharge were high.
- The aim of the surgical assessment unit (SAU) and clinical decisions unit was to improve patient flow from the emergency department; however, multiple areas meant that for some patients there were four transfers between arrival at the hospital and admission to a ward.
- Staff on SAU recognised the limited capacity, for 13 patients, was a risk but this was not on the divisional risk register.
- Delay with discharge summaries, especially at weekends, affected timely discharge.
- Handling of patient complaints and information provided to staff was not consistent across all areas.

However we also found:

- There were clear processes in place for outsourcing patients to other providers.

Service planning and delivery to meet the needs of local people

- Colchester Hospital does not provide a separate maxillofacial service but works as part of a hub and spoke model with another provider. Two clinical fellows provide oral surgery outpatients and minor clinical procedures at Essex County hospital.
- Actions taken to address delays within ophthalmology included additional Saturday operating lists throughout September and November 2015. Nursing staff, with ophthalmic competence, operate a triage phone service between 8am and 7pm. The service takes referrals and provides advice to postoperative patients, out patients, GPs and Colchester emergency department and there is a glaucoma service for follow up patients.
- Preassessment, situated within the elective care centre (ECC), was open from 7am to 7pm. Most preassessment clinics were nurse led and nurses received training in cardio-pulmonary assessment. There was an anaesthetist allocated to the ECC two days a week to review patients that might require a more complex medical assessment. This reduced the need for additional appointments.
- The team in the elective care centre (ECC) had also identified a theme for delays when a patient required an echocardiogram. To mitigate this there is a sonographer in preassessment to enable this to take place immediately.
- There were clear processes in place for outsourcing patients to other providers. Certain specialties such as, pain, foot and ankle, oral surgery are outsourced when a capacity issue identified. A dedicated administration team organise and ensure completion in a timely manner, with procedure protocols in place. There is a minimum data set form completed with each set of notes to ensure completion. Outsourcing patients from general surgery was an issue due to difficulties with gaining the consultant agreement to refer patients to other 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.
- The trust did not submit referral to treatment (RTT) data between December 2014 and April 2015. Since reporting resumed in May all standards have been below target. The RTT for admitted pathway patients, where treatment has ended with admission to hospital either as inpatient or day case, had fallen dramatically from 72% in November 2014 to 59% in May 2015. Data shows a continued downward trajectory with results being 63% in June, 61% in July and 60% in August 2015 against a target of 90%. This meant a large number of patients were not receiving treatment following diagnosis as soon as possible or within the recommended 18 weeks target. The two specialties with the highest number of patients affected are ophthalmology and orthopaedics.
- Between February and July 2015, 29 patients had their operation cancelled and not rebooked within the 28-day target. Total numbers of patients affected fluctuated each month, the highest, being ten patients, occurring in June 2015. Pain, vascular and urology were the three specialties with the highest number of patients affected during this time.
- Between February and July 2015,136 patients operations were cancelled on the day of surgery for

non-clinical reasons. Reasons varied; 47 cases were due to lists overrunning, 20 were due to unavailable ward or overnight beds and 23 were due to staffing issues (nursing and surgeon availability). Only 20% of operating lists in May 2015 started on time, this had improved to 28% in August. Of the 75 lists in August that were late starting, 26% were delayed by more than 30 minutes.

- Reporting of theatre utilisation in its current format had commenced in March 2015 and was still evolving. Having six months of information now meant that data analysis was possible to begin to indicate trends. Information is reviewed at the monthly theatre management group. Responsibility for rebooking of cancelled patients remained with the individual specialty service to rearrange.
- There was a traffic light system introduced in theatre for the emergency surgery cases. Green indicated patients that were ready for theatre, amber indicated patients that required further tests and red indicated patients that had been booked for more than 24 hours. This system meant that patients remained in the system and status was highly visible and identified on handover.
- The recovery area had the capacity for two beds to provide extended stay when intensive care beds were not available. One of these beds could be pre-booked through consultant anaesthetist and intensive care consultant agreement. This was normally utilised for patients expected to be ready for step down to the ward within 24 hours. Each patient had a risk assessment and review by the medical team three times during the 24 hours. An average of 19 patients a month stayed overnight in recovery between January and August 2015.
- The second bed was utilised for unexpected emergency recovery. Patients received one to one nursing care. Only one member of the recovery team had an intensive care qualification to care for fully ventilated patients. To mitigate the risk all recovery staff rotate through the intensive care unit and spend one month on the unit during their induction programme. The clinical educator for the intensive care unit worked half a day in recovery and had responsibility to complete competencies with staff. The outreach team were available for support. A draft standard operating procedure had been developed but had not been yet been approved. The adjoining doors into intensive care remained open at night when patients remained in recovery. This meant staff in recovery had access to additional support and visibility from ITU.
- The aim of the surgical assessment unit (SAU) was to provide rapid assessment, stabilisation, interventions and first line treatment for surgical referrals. Patients were admitted either directly from GP referrals or transferred from the emergency department to improve flow through the hospital. The unit had limited capacity, with provision for only 13 patients (seven on trolleys and six on chairs). Staff recognised capacity issue was a risk but this was not on the trust risk register. The unit had extended its opening hours in January 2015 from 10am to 10pm and included weekends however this was not updated in the standard operating procedure.
- The Clinical decisions unit (CDU) opened in March 2015 to provide care for patients needing observation, investigations or treatment and avoid unnecessary admission. Prolonged patient pathways could occur due to the multiple transfer areas. For example, a number of patients had four transfers between arrival at the emergency department (ED) and final ward admission (ED, CDU, SAU and then ward).
- Copford ward was an elective orthopaedic day unit, which closed at 21:30pm. Patients were transferred to the neighbouring Great Tey ward for admission should they not be fit for discharge. The nursing staff rotated between the two wards to provide continuity of care.
- The Elmstead day surgery unit had extended operating hours until 10pm. This meant that if a patient was not fit for discharge the transfer often occurred late in the day. Data for the admission of patients from day surgery to inpatient wards showed that between March and August 2015, 821 patients had required overnight admission, on average between 140 and 150 a month. Unplanned admissions add pressure to bed capacity and staffing. There had been an increase of cases from May to August indicating that management of this was not improving. On the 17th September one patient was transferred from Copford to Great Tey ward at 9pm and three patients were due to arrive on Mersea ward after 22:30pm.
- Utilisation of Copford ward (day surgery) was poor. The ward capacity was 20 beds however there were generally only 13 to 14 beds occupied. The ward was open Monday to Friday with the potential to admit 100 patients a week, at full capacity. Data showed that

between June 2015 and August 2015 there had only been 172 patients admitted to Copford in total in the three-month period. This meant that the average utilisation for this period was 13%. There were plans to convert part of Copford ward into a pre-assessment area to improve utilisation and provide services in one location. Patients received a telephone call the day before surgery to confirm that they were still attending.

- Staff in Mersea ward stated that there had previously been issues with getting some medical teams to review the medical patients. This had improved with the introduction of a medical co-ordinator. The ward now bleeps the co-ordinator who then chases the appropriate team to attend.
- The number of patients post fractured neck of femur that were seen by an ortho-geriatrician within 72 hours of admission was improving. Data showed this had improved from 88% in April to 97% in August 2015. The trust was confident that this was sustainable following the appointment of a registrar based on the orthopaedics wards and supported by a team of consultants.
- Appropriate discharge was not consistent. Data from July to September 2015 showed that readmission rates within 48 hours of discharge averaged 130 patients a month. One patient, on Brightlingsea ward, had been discharged two days after a hernia operation. They were then readmitted two days later with an obstruction of the bowel and further surgery was required. The relatives felt uncertain as to the condition and progress of the patient. We informed the senior nursing staff and they arranged that for a doctor to speak with the family.
- Discharge planning was a concern for staff. Junior doctors struggled to complete the discharge summaries in a timely fashion, which meant that patients that had been identified as fit for discharge in the morning often did not leave until the afternoon due to waiting for letters or medications.
- There had been a number of bed closures in response to staffing shortages with Brightlingsea ward going from 30 beds to 26, and Wivenhoe ward, now a specialist vascular surgery ward, had reduced from 28 to 20 beds.

Meeting people's individual needs

- The patient care pathway for local anaesthetic surgery at Essex County hospital included a section for recording any disabilities and adjustments. For example, if the patient was frail, they were transported on a trolley rather than walking with assistance to and from theatre.
- Theatre staff discussed any specific learning disabilities and adjustments required for patients on the list as part of the team briefing within the world health organisation (WHO) surgical checklist.
- The trust had a translator service known as "the big word" and staff were aware of how to access this service. There was a list of interpreters available on Wivenhoe ward that staff could contact when required.
- Staff in preassessment did not complete early dementia screening. The trust dementia protocol stated that all patients over the age of 70 received a dementia assessment within three days of admission. There were two dementia nurses within the trust and named nursing leads for dementia, delirium and learning disabilities on the wards. Out of 10 patient notes reviewed on Wivenhoe ward all assessments for patients living with dementia had been completed.
- Staff gave an example of individualised care planning for a patient with learning disabilities that recently underwent a hip replacement. Preassessment identified adjustments required, the patient had a side room and was accompanied by parents or carers at all times.
- All post-operative ophthalmic patients were contacted by the nursing staff via telephone within 24 hours of surgery. This provided support to the patient and identified any early concerns.

Learning from complaints and concerns

- Handling of patient complaints and information provided to staff was not consistent across all areas. On Great Tey ward, complaint information was displayed in chart format on the staff notice board.
- Staff stated that complaints folders had been in place. The folders had contained details of complaints, responses from the trust and actions taken which meant that staff could learn from the issues raised. However these folders were removed as data was not completely anonymised. Staff felt this had reduced the opportunity to learn from complaints and said that the folders had been kept securely in the ward office.

Surgery

- Patients felt they could raise concerns with staff. The patient advisory liaison service (PALS) was not widely known however they would look on the website to get the necessary information to forward a letter of complaint should the need arise.
- One complaint received into the elective care centre from a patient was regarding chaperoning. In response, the team have asked the patient to come and advise the unit on how to improve the patient experience

Are surgery services well-led?

Requires improvement

Surgery services required improvement in leadership because:

- The service had recently undergone some senior divisional changes and whilst the new structure had the foundations to improve patient care, this was in its infancy.
- Oversight of standards of care and governance was fragile. There had been a structured governance process introduced but this was not embedded or consistent across all areas.
- Not all operational policies and procedures had been agreed or formalised
- Changes to improve practice in one area were not cascaded and the service remained very reactive.
- Documentation of meetings was not consistent to ensure issues were effectively managed and progressed.
- Robust local risk assessment was not in place and there was no evidence that risks were being identified, reported and managed in a timely manner.
- There was a lack of staff and clinical leadership in the orthopaedic service.
- Staff engagement and morale within the therapy services and theatre was declining due to recruitment pressures.

However we also found:

- The increased visibility of the director, executive buddy and matrons clinically were all positive actions in improving the leadership of the service.
- The vascular, general surgery and urology specialties provided good clinical supervision and leadership.
- 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.

Vision and strategy for this service

- A draft strategy document for the surgery division was in place, which aligned to the trusts clinical strategy. This document was not yet embedded as it had been only been created in September 2015. It outlined four areas of focus; new leadership team, culture, embedding of governance structures and clinical performance.
- The surgical services vision was based on the trust wide vision of caring and was to be the most caring and innovative provider of emergency and elective surgical services. Staff stated a variety of principles for the service vision including patient safety, achieving the best outcomes and patient centred care.

Governance, risk management and quality measurement

- There was a governance structure in place. At ward level there was a “2 at the top” monthly meeting 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. However not all wards were compliant with these “2 at the top” monthly meetings. Evidence of the monthly divisional meeting was not provided with the last minutes submitted being February 2015, which was the final meeting chaired by the previous divisional director of surgery.
- Documentation from all meetings was not consistent. The divisional director, associated director of nursing and associate director of operations met weekly on a Friday; however, these meetings were not formalised or minutes taken.
- Weekly band seven matron meetings were also in place every Friday to discuss issues and learnings. Matrons from Essex County hospital attended to ensure communication occurred between the two sites. There were no minutes or action logs produced to ensure topics were effectively managed. Therefore, discussions, risks, issues or actions identified were not evidenced or measured.
- Response to patient risk was reactive with minimal oversight to consider similar areas of potential concern. This meant an increased risk to patients as situations

were considered in isolation. For example, previous inspection had raised concerns on Brightlingsea ward. Staffing was reconfigured; support from matrons provided and patient care had improved. However, similar issues around staffing numbers, clinical assessments and patient care were now identified on Mersea and Aldham wards. This meant that improvements were not cascaded across the service.
- Local risk assessments were not robust. Staff awareness of risks for their own ward areas was apparent however the risk assessment process was not completed in many cases and reported risks were minimal. Staff knowledge of the risks on the surgical divisional risk register varied.
- Not all operational policies and procedures had been agreed or formalised. The standard operating procedure (SOP) for the surgical assessment unit had not been updated and staff stated that the SOP for patients held in recovery over 24 hours was in draft format but this was not provided to us. The theatre operational policy had been drafted, approved at the theatres management group but again was awaiting final approval.

Leadership of service

- There was a defined surgical divisional structure. There had been recent appointments within the current team, which meant that team dynamics were in their infancy. Two vacancies remained outstanding; one for an associate clinical director and one for a service manager with anaesthetic and technical services.
- The divisional director had been in post six months, the associate director of nursing 13 months and the associate director of operations less than three months. Despite being a relatively new team, the individuals were cohesive in their approach to the strategy for surgery although this had not yet become embedded.
- There was a defined nursing strategy, with remodelling of the senior nursing structure to provide three nursing matrons to support all areas. One covered orthopaedics, two for general surgery and one for critical care and theatres.
- The skill mix deficit and high level of junior workforce was a recognised concern. The surgical matrons were available to work alongside middle grade nursing staff to provide support and the supervisory framework "tree" was introduced to help clearly identify the escalation process.
- Clinical leadership for medical staff was inconsistent with disparity across specialties. The vascular, general surgery and urology specialties provided good support however, consultant input and clinical supervision in orthopaedics needed to improve.
- There was an "executive buddy" initiative in place. Members of the executive team were nominated to wards and visited the specific areas every four weeks. Staff welcomed this and stated that it had begun to have a positive impact. On Great Tey ward, staff had repeatedly requested damaged keypad locks to be fixed, this had been mentioned to the executive buddy during a visit and the repairs were quickly carried out. Additional blood pressure, pulse and temperature monitoring equipment was approved following a similar visits when the lack of these items was explained to the buddy.
- 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. Band seven staff received regular supervision with their line manager.

Culture within the service

- The new surgical lead team identified that staff engagement was a challenge and were keen to involve staff in discussion. There had been changes to the senior nursing structure in the division to provide visibility of senior individuals, which was beginning to have a positive response from staff.
- The associate director of operations was widely known and had visited all areas, both administration and clinical, and staff stated this had improved morale.
- Theatre morale was low. Staff stated that operating department practitioner (ODP) numbers, skill mix and limited career pathways were all reasons for recruitment difficulties. There had been several changes of service manager, which staff stated was difficult to then raise and resolve any issues. There had been a substantive appointment offered with the manager due to start in October 2015. The individual had worked in the department previously and staff were hopeful that this would improve the situation and provide some stability.

Staff engagement

- Staff in theatres at Essex County hospital felt supported by their line managers on site. However, communication surrounding the proposed closure of the services by

autumn 2016 was poor. Staff strongly expressed the decision surrounding the removal of the resuscitation equipment as an example where decisions affecting clinical services were made without the involvement of the staff concerned.
- Three physiotherapy staff stated that morale was declining. Hard work was not met with gratitude and staffing vacancies were taking their toll

Innovation, improvement and sustainability

- The trust was making a bid to become the Essex urology cancer centre.
- Establishment of the vascular centre at the Trust with provision of care for vascular patients from other providers had started in 2012 and was continuing to build.
- The surgery division were keen to become part of the National Surgical Quality Improvement Program (NSQIP). NSQIP collects data that provides fair, in-depth and insightful analysis, helping surgeons and hospitals better understand their quality of care. This would need investment and the team was developing a business case to put forward to the board.
- The Matron for theatres stated that there were plans to extend and improve the PICC line service to three sessions a week hopefully by the end of the year.

Critical care

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

Information about the service

Colchester Hospital University NHS Foundation Trust's Intensive Care Unit is a specially staffed and equipped, separate and self-contained area of the hospital dedicated to the management and monitoring of patients with life threatening conditions. The critical care service has 14 beds. However, they are only funded to have 13 beds operational at one time. They deliver 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.

We spoke with a full range of staff (47), including consultants, doctors, trainee doctors, different grades of nurses and a health care assistant. We met the clinical lead (lead consultant), matron and lead sister for critical care. We spoke with physiotherapists, nurses from the outreach team, the lead pharmacist, the nurse educator and the lead for medical equipment in critical care and members of the administrative team. We met with nine patients who were able to talk with us and10 of their relatives and friends. We observed care and treatment and looked at 12 sets of care records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Critical care

Summary of findings

We rated the service as requires improvement overall Whilst there was adequate equipment in place to ensure safe care. On the visual inspection of 164 pieces of medical equipment, a number were found to be soiled (18) and there was a lack of evidence of medical servicing. Some medical and nursing staff were observed not washing their hands between patients. 'Bare below the elbow' practices were adhered to by all nursing staff. One doctor was noted wearing a wristwatch during a patient consultation. Doctors and facilities staff were observed to enter and leave the unit without using hand sanitising gels. There were sufficient nursing and medical staff on the unit at all times. Incidents were reported and learnt from appropriately.

Critical care services were effective. Treatment and care was delivered in accordance with best practice and recognised national guidelines (ICNARC) NICE and care bundles. There was a multidisciplinary approach to assessing and planning care and treatment for patients. Patients were at the centre of the service and were the main priority for staff. The unit contributed to the national data bases and critical care occupancy was at or around the England average. The unit performed within the expected range for all indicators in the Annual Quality Report 2013/14 for adult critical care.

Critical care services were caring. Feedback from people using the service including patients and their families was very positive. Staff ensured patients experienced compassionate care and their privacy and dignity needs was protected at all times. For example, curtains were drawn around patient's beds and doors or blinds closed in side wards. Voices were lowered to avoid confidential information being overheard. The NHS Friends and Family Test rated the care as "excellent" in the 15 questionnaires completed by patients.

Critical care services were responsive to patient's needs. The majority of patients were discharged from unit in a timely way (within four hours) and complaints were handled appropriately. Where suggestions had been made by patients and relative's actions had been taken by staff to improve care services. For example, a telephone line in the relatives room to enable families to have direct contact with the nurse's station in the unit.

Patients said staff were responsive to their care and support needs and often knew what they needed before the patient expressed it themselves. Follow up services were in place to support patients discharged from the unit.

Critical care services required improvements to being well-led locally. The local leaders were aware of the risk within the department but mitigating actions had not been taken. Whilst governance systems were in place these were not robust and did not address all issues affecting management of the unit and performance. There was no auditing of the outreach service to ensure that this was appropriate and effective. The leadership of the unit were visible and staff reported they were supported. Patients said "this is an excellent well-run unit". There were systems in place to learn from and make improvements following serious incidents and staff were able to tell us about specific examples. The critical care unit was innovative and focused on quality improvements. We saw examples of where the unit supported post registration teaching programmes and had a good track record of publishing research undertaken in critical care.

Critical care

Are critical care services safe?

Requires improvement

Critical care services at Colchester General Hospital required improvement because:

- There was a lack of evidence of servicing and maintaining electrical equipment on the unit and these risks had not been identified on the risk register.
- We inspected 164 pieces of medical equipment selected at random, including mechanical ventilators, renal replacement machines, volumetric pumps, feed pumps and syringe drivers and found 36 pieces (22%) of equipment lacked evidence of medical servicing and/or portable appliance (PAT) testing.
- Equipment was not always clean and we found 61 pieces (37%) of equipment that were unclean or soiled.
- Medical and nursing staff were observed not washing their hands between patients and it was noted that one doctor was wearing a wrist watch during a patient consultation.
- Mortality and Morbidity meetings had been cancelled for three months due to a lack of attendance.

However we also found:

- Following a recent Never Event the service had fully investigated this incident, identified lessons to be learned and demonstrated what practices had changed since the incident to inspectors.
- There were sufficient nursing and medical staff on the unit at all times.
- Records reviewed evidenced that pressure ulcers (PUs) venous thromboembolism (VTE), and urinary tract infections (UTIs) risk assessments were being undertaken.

Incidents

- A Never Event (an event that is so serious that it should never happen) had occurred in critical care in 2014/2015. We saw this had been fully investigated by the trust, identifying the root causes of the error and a comprehensive action plan (LEAP) developed as a result. The action plan had been completed and we saw evidence of where practices had changed. For example, labelling of equipment and checklists for undertaking the clinical procedure had been put in place. Staff were able to tell us about the changes and the affected patient had been advised of the event and the outcome of the investigation.
- Staff said they were encouraged to report incidents and were aware of how to complete the online incident reporting tool. Feedback was given to the matron and lead sister in the unit who confirmed themes from incidents were discussed at staff meetings and we saw evidence of this in the minutes (June and July 2015) which were displayed in the staff coffee room.
- Patient mortality and morbidity was reviewed in critical care. We saw a review of the minutes of the mortality and morbidity meetings in 2014/15 which said, “The majority of deaths discussed were patients that had a poor prognosis prior to disease progression or significant comorbidities prior to admission to the unit. These patients had clear ceilings of care in place that were communicated to patients and relatives”. This meant that treatment was agreed with the patients and relatives.
- There were action points on the review but they were not attributed to any member of the critical care team for action or sharing of information and learning. This meant it was unlikely that actions would be undertaken and learning was unlikely to take place.
- In the critical care governance meeting (September 2015) we noted the monthly mortality and morbidity meetings for the last three months had been cancelled due to a lack of attendance and an action to ensure that future meetings took place was recorded.
- Duty of Candour had been introduced in critical care. From November 2014, NHS providers were required to comply with the Duty of Candour Regulation outlined in the Health and Social Care Act 2008 (Regulated Activities). Senior staff in critical care were aware of the new regulation to be open, transparent and candid with patients and relatives when things went wrong. Junior staff in critical care had heard of Duty of Candour but were unable to explain it to us. The investigation report for the serious incident discussed above had recorded the conversations and the explanations given to the patient and their family.

Safety thermometer

- Patients were assessed on admission and during their stay for the risks of harm. There were assessments in

place for all patients for risks from the most common harms These included: falls, pressure ulcers (PUs) venous thromboembolism (VTE), and urinary tract infections (UTIs).
- In the records we reviewed in critical care we found assessments were complete and were clearly displayed in the main corridor of the unit. The trust was performing within the expected range for these measures. Risk assessments for all patients were being completed appropriately on admission and we saw evidence of this.

Cleanliness, infection control and hygiene

- Rates for unit-acquired infections were low. There had been no unit-acquired methicillin resistant Staphylococcus aureus (MRSA) infections in the three years to the end of 2014 as evidenced by the Intensive Care National Audit and Research Centre (ICNARC) Annual Quality Report 2013/14).
- The unit appeared clean, bright and uncluttered. The majority of nurses and doctors washed their hands and used hand sanitising gel between patients and wore disposable gloves and aprons at the bedside. However, some staff did not adhere to the trust hand hygiene policy and the 'Bare below the elbow' policy when they were within the unit. We saw doctors wearing ties (not tucked in) and a doctor wearing a wrist watch.
- Each bed space had an apron colour coding system to ensure the appropriate personal protective equipment (aprons and gloves) were being worn when delivering care at the bedside. Sharps bins and clinical waste bins were available in all clinical areas including in the near patient testing room and in all bed spaces. We observed these were regularly emptied by clinical and domestic staff.
- The unit had multiple side rooms which could be used for isolating infected or immunocompromised patients. We were told the side room which had positive/negative pressure control, was rarely used and was currently being used as a storage facility due to a lack of storage space available to the unit.
- The nursing hand hygiene audits for May to July 2015 reported 95% and above compliance. For doctors for the same period it was 91% and above. The infection control audit (April 2015) had identified concerns around poor hand hygiene practices in the unit and an action plan for the unit had been implemented. We saw in the staff room on the unit reminders to all staff around compliance to the hand hygiene policy and this was also included in the nursing handovers we observed on the unit. Doctors and facilities staff were seen to enter and leave the unit without using hand sanitising gel.
- Cleaning audits for the unit for the period July to September 2015, scored between 95% and 92%.

Environment and equipment

- Access to the unit by staff was by key card or remote CCTV access for visitors. There was no easily identifiable location where visitors could be welcomed by the unit by staff. Access to the unit led directly to the main corridor of the unit. Visitors were observed to "be buzzed in" and to make their way to a bed space and this did not appear to be controlled. We were informed by a patient about their relative who had visited the previous day, had become distressed as they thought an unconscious patient was there relative. This was raised with the lead sister at the time of the inspection.
- Each bed space had a pendulum system to mount electro medical equipment. We inspected 164 pieces of medical equipment selected at random, including mechanical ventilators, renal replacement machines, volumetric pumps, feed pumps and syringe drivers and found 61 pieces (37%) of equipment that were unclean, duty or soiled and 36 pieces (22%) of equipment lacked evidence of medical servicing and/or portable appliance (PAT) testing. The oldest being a Braun spacestation, which was last checked in 2010.
- We also identified one oxygen flow meter which was leaking and raised this immediately with the person in charge who had this item removed and replaced. Equipment to be deemed unsafe was removed by the lead sister of the unit.
- There was no replacement programme in place for equipment and service contracts were limited, for example for ventilators. Asset registers for equipment under £5,000 were not in place in critical care (or in other clinical areas across the trust). We saw evidence of where the lead sister had commenced an asset register for the unit.
- We inspected the cardiac arrest trolley on the unit and noted it was stocked in compliance with the trust resuscitation guidelines. There was evidence of daily checks using a check list being undertaken.

Medicines

- Medicines, including those requiring cool storage, were stored appropriately. Records showed medicines were kept at the correct temperature, and so would be fit for use. Refrigeration temperatures were checked daily and recorded. Medicines were stored in a locked room in a clinical area and were well organised. Controlled drugs were locked in a standard metal cabinet and keys to access the controlled drug cupboards were held by the shift team leader in order to minimise confusion as to where they were.
- There was a dedicated pharmacist for the unit who had a visible presence on the unit. Staff told us they were well supported by the pharmacy service and there appeared to be sufficient pharmacy staff to meet the care and support needs of patients on the unit.
- The disposal of medicines in the unit was deemed to be unsafe as an unsecured medicines disposal container was found in the sluice of the unit. The matter was dealt with appropriately by the units matron who removed the container and ensured it was sealed and replaced it with a secure container for the safe disposal of future medicines.
- Safety Thermometer data informed us there had been three missed doses of medicines in the three month period from June to August 2015. This was due to signatures not being recorded on the drug sheets for the administration of a prophylactic ointment to patients in the unit which was kept at the patient's bedside. We saw evidence of where the lead sister had investigated the errors and had taken the appropriate action. We saw reminders to staff were recorded in the staff room on the unit.

Records

- Patient's notes were well organised and completed in the main to a high standard. For example, entries were clearly documented and were signed dated and timed. However, there was evidence in two sets of notes we reviewed where documentation was incomplete. For example, an incomplete mental capacity assessment form and safety checks undertaken by nurses that had not been completed for two days. This could lead to the delivery of inappropriate care and support to patients in the unit.
- We reviewed 12 sets of patient notes in the unit for their medical content, nursing records and physiotherapy records. The patient's treatment plans were clear and could be followed through the records. This included the prescription of medicines, which were then tracked to the drug chart.
- All records were in paper format and all heath care professionals were documenting in one folder which were stored safely at the end of each patient's bed space.

Safeguarding

- Staff were well trained to recognise and respond in order to safeguard a vulnerable patient. This included any children admitted to the unit or associated with a patient or visitor. Mandatory update training was delivered and nursing staff were up to date with their knowledge. Compliance at the end of August 2015 was 100% for Level 1 and 90% for Level 2.
- There were policies, systems and processes for reporting and recording abuse. 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 clearly described the responsibilities of staff in reporting concerns for both adults and children, who were subject to different procedures within the policies.
- Senior staff in the unit 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.

Mandatory training

- We looked at staff mandatory training records. The matron and lead sister in partnership with the units educational facilitator monitored staff attendance by accessing the trust electronic training records and addressing any shortfalls in staff compliance.
- The trust had a target for each division to achieve 80% compliance. Records confirmed that 90% of staff were up to date with their mandatory training.
- The outreach service delivered "Vital Signs" ward based training and ALERT (advanced life support training) to staff including foundation doctors and we saw evidence of this.

Assessing and responding to patient risk

Critical care

- The nursing team and medical staff assessed and responded well to risk. In the unit there were two ward rounds led by consultants on duty each day, morning and evening.
- There was input to the ward rounds from unit-based staff, including physiotherapists, trainee doctors, pharmacist and nurses. Other allied healthcare professionals were asked to attend when required.
- We observed there was a full range of clinical indicators available in patient's notes. These included blood results, radiology results, observations, and physiological data. Patient care was discussed in a structured manner and involved the patient wherever it was possible to do so. Information from the patient's records was used to support the discussion. This included the management of invasive lines, tracheostomy management, respiratory levels, neurological indicators, nutrition and fluid input and output, skin wounds and infection control.
- The trust had a 24/7 critical care outreach service in place across the main Colchester Hospital site. They also delivered acute care training on ward training days and support the delivery of trust wide advanced life support training (ALERT).
- The team reported that they visited up to 3,000 patients a year which included repeat visits.
- Team members could be contacted by any member of staff and their contact details were clearly displayed on all wards as well as on the observation recording document. The team would see all discharges from the unit within 24 hours.

Nursing staffing

- There was a safe level of nursing staff in the unit. All Level 3 patients were nursed one-to-one, and Level 2 patients one nurse to two patients. The nurse staffing levels were based upon the dependency (acuity) levels of patient care. This followed the Faculty of Intensive Care Medicine Core Standards' (FICMCS) recommendations for safe nurse-staffing levels.
- There were currently nursing vacancies as staff (five) had left critical care in the last three months due to the relocation of service families. The nursing fill rate had dropped from 91% in May and June 2015 to 86% in July 2015. To ensure safe staffing levels, the unit was using a combination of their own bank staff and staff from local agencies. All agency staff had completed an induction competency checklist and we saw evidence of this.
- Patient care was not compromised by unacceptable high levels of bank and/or agency staff. The FICMCS recommended there was never more than 20% of any shift staffed by agency or bank staff workers.
- Senior nursing staff were not counted in the staffing numbers (supernumerary) in order for them to manage the nursing teams. The FICMCS recommended a supernumerary clinical coordinator on duty at all times for a unit with greater than 10 beds. This standard was only partially achieved, at evenings and weekends, Peer Review (Critical Care Organisational Delivery Network) February 2015. This would be addressed when the current round of nurse recruitment had been successfully completed.
- At the time of the inspection the educational coordinator was supporting this role and sufficient agency /bank staff (1-2 each shift) had been deployed to enable a band seven supernumerary nurse to be on duty at all times.
- The nursing team were flexible with their working patterns and were able to meet the acuity and number of patients in the unit. The matron and lead sister told us staff would put the safety of patients first. The lead sister described the nurses as a "fantastic team who went the extra mile"
- Recruitment was ongoing to increase the number of critical care nurses in the unit. We were told newly qualified nurses had expressed an interest in working in the critical care environment.
- There were detailed patient handover sessions held each morning for nursing and medical staff using a detailed handover checklist. This ensured all aspects of the patients care and treatment were communicated effectively. For example, checking for changes and updates or results of any diagnostic or screening from the previous day or night.
- The team of six WTE (whole time equivalent) band 7 nurses responded to deteriorating patients across the trust. There was no medical staffing on the team and the outreach nurses call on the intensive care units doctors for support if it is required. The team were managed by the matron for critical care.

Medical staffing

- There was a consultant clinical lead for the unit supported by 12 consultants who were all trained in intensive care medicine. Two new consultant grade doctors had recently been appointed to the unit.

Critical care

- The Critical Care Organisational Delivery Network (CCODN) Peer Review report of February 2015 highlighted that the overnight medical staffing required review. The medic to patient ratio should not exceed 1:8 however this ratio was not maintained overnight as at present there is only one anaesthetic based trainee on duty. This person supports both the critical care unit and the outreach team.
- Consultant cover was provided in blocks of seven days by two consultants to ensure continuity of patient care in the unit. Outside of these hours the consultant was on call and able to attend within 30 minutes and the consultant covering the unit had no other clinical responsibilities.
- The consultant to patient ratio for the unit should not exceed a range between 1:8 – 1:15 (CCODN) and the unit were not achieving this. In the long term the unit is likely to lose trainee doctors (which is a national problem) and the role of Advanced Critical Care Practitioners was being explored by the consultant clinical lead.
- All admissions to the unit were discussed with a consultant and all new admissions were reviewed in person by them within 12 hours of admission (ICNARC 2013/14). Consultants conducted 12 hourly ward rounds on the unit to oversee patient assessment and management plans.
- Junior doctors told us there were adequate numbers of junior doctors on the unit both in and out of hours and consultants supported the resident trainee/ middle grade doctor and other doctors in the unit with the clinical work.

Major incident awareness and training

- The hospital had a major incident plan. Staff knew how to access and distribute the policy and in what circumstances it was relevant. Staff on the critical care unit were aware of their action card and key roles in the event of a major incident.
- A current critical care escalation procedure was in place which was next due for review in June 2016. The purpose of the escalation procedure was to provide guidance to staff in the event of there being more patients requiring Level 2 or Level 3 care than there were resources available within the critical care unit.

Are critical care services effective?

Good

Critical care services were rated as good for effective because:

- The unit's mean average length of stay for all admissions to critical care was 4.8 days compared with the national mean average of around five days.
- Care bundles (evidenced based procedures) were in place for the use of ventilators, management of sepsis, central lines and monitoring of sedated patients and organ donation.
- The unit performed within the expected range for all indicators in the Annual Quality Report 2013/14 for adult critical care.
- The unit contributed to the ICNARC database which had identified adult critical care bed occupancy was at or around the England average. The mortality ratio for the unit was within statistically acceptable limits.
- 70% of nursing staff had obtained a post-registration award in critical care against the national target of 50%.

However there were some areas that could be improved because:

- There was no local evidence of outcomes for patients who use the critical care outreach service.
- There was no dietician or occupational therapy input available at weekends.
- Patients in the unit were required to be screened for delirium using a recognised screening tool (CAM-ICU), however of the patients on the unit none had been scored for delirium (NICE CG83).

Evidence-based care and treatment

- The critical care unit used a combination of National Institute for health and Care Excellence (NICE), Intensive Care Society and Faculty of Intensive Care Medicine (ICSFICM), Intensive Care National Audit and Research Centre (ICNARC) and the East of England Critical Care Operational Delivery Network (EECCODN) performance and outcome data to determine the effectiveness and outcomes of the treatment they provided.
- The unit's mean average length of stay for all admissions to critical care was 4.8 days compared with the national mean average of around five days (ICNARC 2013/14).

- Decisions about admissions to the unit were made at senior clinician level and followed the trust operational policy (2014). Careful consideration of patient's wishes were taken into account (where it was possible to do so) and the likelihood of sustained benefit being gained from admission to the unit.
- Standard Operating Procedures (SOP) followed best practice and evidenced-based guidance. For example, the CHUFT's SOP for tracheostomy insertion and management followed the national study and recommendations of the 2014 National Confidential Enquiry on Patient Outcomes and Death (NCEPOD: On the Right Trach?).
- Care bundles (evidenced based procedures) were in place for the use of ventilators, management of sepsis, central lines and monitoring of sedated patients and organ donation. Patients in the unit were required to be screened for delirium using a recognised screening tool (CAM-ICU). Of the 12 sets of patients records reviewed no delirium screening had been undertaken. A patient who was prescribed a medication which could have side effects (hallucinations) was not being scored for delirium (NICE CG83).

Pain relief

- Pain relief was well managed. Patients we were able to speak to within critical care said they had been asked regularly by staff if they were in any pain. Nursing staff said, and we observed, patients who were awake were regularly checked for pain. Observations were recorded and formal assessments made at regular intervals.
- Pain was managed with different protocols depending on the patients' treatment. For example, a patient may have patient controlled analgesia (PCA) managed through an infusion pump.
- Three patients we spoke to in the unit said they were regularly asked if they had any pain and this was scored on a pain chart. This enabled patient's pain to be managed effectively in the unit. Patients said any pain or discomfort had been attended to promptly by staff both in the daytime and at night.
- Patients who were unable to communicate received multi-modal analgesia including continuous intravenous infusion of opiates and routine oral medicines via the nasogastric route. Regular analgesia was prescribed for patients who were sedated and was clearly prescribed on the patients medication sheet. The choice of analgesia reflected current best practice and was appropriate for the patient's needs.

Nutrition and hydration

- Appropriate guidance and protocols were followed to ensure patients had the right levels of hydration and nutrition. The dietician assessed, implemented and managed the appropriate nutritional support for each patient in collaboration with the multidisciplinary team and we saw evidence of this in the patient's records. For example, intravenous fluids (IV) and artificial nutrition through a percutaneous endo gastromy tubes (PEG).
- For patients able to take their own fluids, drinks were available and within reach. Patients who were able to eat were brought menus and were able to choose their meals.
- The volumes of food and fluids were monitored and recorded to ensure patients maintained a healthy balance. Unconscious patients had their circulatory fluid volumes continuously monitored by nursing staff through central venous pressure (CVP) lines.

Patient outcomes

- The unit contributed to the ICNARC database which had identified adult critical care bed occupancy was at or around the England average. The mortality ratio for the unit was within statistically acceptable limits.
- The trust performed within the expected range for all indicators in the Annual Quality Report 2013/14 for adult, general critical care. It performed significantly better in "unplanned readmission within 48 hours".
- There was no evidence available to support a trust wide review of the effectiveness of the outreach service. This would have enabled the trust to be benchmarked against external standards to ensure service quality.

Competent staff

- Appraisals in the unit were not meeting the trust's target of 80% as there had been a change in the trusts appraisal timetable. Appraisals had been completed in the first quarter of the year (2014) and had been changed to a 12 month rolling programme in 2015. To date 60% of appraisals had been completed and the remainder had been arranged for later in the year and we saw evidence of this.

- All staff knew who was responsible for their appraisal and staff in lead roles knew who was in their team and was due an appraisal. This was recorded and available on the electronic staff system.
- The unit met the core standard (ICSFICM) for nurse education (50%) as 70% of nursing staff had obtained a post-registration award in critical care, 45% the intensive care course and 35% high dependency course. Three staff were currently on the intensive care course.
- The educational facilitator in critical care was responsible for co-ordinating education, training and the development of a continuing professional development programme (CPD) for registered nurses and pre-registration students.
- The CPD programme was a core pathway which included induction and aided the development of a range of professional competencies within a specified area and based on national guidelines (National Confidential Enquiry into Patient Outcome and Death). For example, venepuncture and peripheral vascular cannulation. A programme of clinical supervision and mentorship ran alongside the CPD programme.
- The CPD programme applied to all nursing staff in critical care, recovery and outreach. This ensured that nurses in critical care were confident and competent in their ability to deliver safe and appropriate care to patients and their families.
- Approximately one paediatric patient a month was admitted to the unit who required short term admission for ventilation and stabilisation prior to retrieval by the Children's Acute Transport Service (CATS) who provided the safe transfer of a child to a dedicated Paediatric Intensive Care Unit (PICU) as soon as possible.
- Paediatric equipment was centrally located and was planned in partnership with a paediatric intensive care nurse. Paediatric patients were cared for by nurses with an intensive care course who were usually the most senior nurse on shift. Nurses of band 6 and above had completed the paediatric Intermediate Life Support Course. During a paediatric admission to the unit a paediatrician and paediatric nurse attend the unit and stayed with the patient. There was a dedicated paediatric link nurse for the unit who worked Monday to Friday and was based on the paediatric ward (in the trust).
- Trainee doctors were very enthusiastic about the training they received and praised the informal teaching they received at the patient's bedside during the ward rounds.

Multidisciplinary working

- There was strong and cohesive collaborative working from all staff contributing to the unit at the trust. We observed a common sense of purpose and commitment to safe effective care amongst the staff. The Peer Review undertaken in February 2015 by the East of England CCDON said "The unit has an excellent ethos of multidisciplinary working and a collaborative approach to patient care".
- There was a daily ward round which had input from nursing, microbiology, pharmacy, physiotherapy and a dietician. At weekends, the microbiological and pharmacy support were available by telephone.
- There were sufficient physiotherapists available to undertake the rehabilitation components of care for patients and we saw evidence of this in the12 sets of patient notes we reviewed.
- A progress tool was in place (CPax) led by physiotherapy, which enabled patient's rehabilitation outcomes to be assessed and tracked the progress from the acute sector into primary care. Although this was documented on the patients multidisciplinary discharge plan there was no follow through pathway to the community.
- Each patient was required to receive a rehabilitation assessment within 24 hours of admission to critical care. This was only being partly achieved (amber) in the Peer Review in February 2015. A number of assessment processes had been trailed in the unit but an appropriate assessment tool had yet to be agreed.
- There was a dedicated team of non-specialist physiotherapists and occupational therapists (OTs) for the unit.
- The respiratory physiotherapist attended the morning ward round and treated any urgent patients and undertook respiratory treatment and rehabilitation daily as required. They provided an on call service for deteriorating respiratory patients in the unit out of working hours.
- There was critical pharmacist allocated to the unit. All patients with a tracheostomy were assessed by a speech and language therapist (SALT).

Seven-day services

Critical care

- Routine radiology was available at weekends when the consultant radiologist was on site from 9am to 5pm. Computerised tomography (CT) scans were available alongside a limited ultrasound service and access to magnetic imaging (MRI) was available at evenings and weekends.
- Pharmacists were in the hospital from 8am until 1pm on both Saturday and Sunday. Out of those hours there was an on-call pharmacist available on the phone.
- There was no dietician or Occupational Therapy input available at weekends. The dietician provided guidelines for initiating nutrition support out of hours.

Access to information

- Patient's records were usually available in good time. Staff said records were provided relatively quickly for emergency admissions. All patient records were paper based for patients coming from other wards or new admissions.
- There were clear lines of decision making and information available to staff in a timely and accessible way to ensure the delivery of effective care and treatment to patients in the unit.
- An electronic critical care clinical system was under development. This would support the delivery of best practice and provide prompts for care interventions leading to opportunities for improving the quality of care, efficiencies and documentation and improving the data input for ICNARC.
- All patients discharged from the unit were transferred to the receiving ward using a formal handover document. The discharge was undertaken by the referring nurse in the unit to the receiving nurse and took place in the clinical area.
- All patients discharged from the unit had a discharge summary which included a rehabilitation plan and were followed up by the outreach team within 24 hours of being transferred to the ward.
- Any patient who was ventilated for more than five days was followed up by the critical care follow up nurse. This was a service to patients who may have memory gaps and questions and concerns about their ongoing treatment and recovery following their critical illness.

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

- Patients gave their consent when they were mentally and physically able. Staff acted in accordance with the law when treating an unconscious patient, or in an emergency.
- Staff said patients were told what decisions had been made, by whom and why, if and when the patient regained consciousness, or when the emergency situation had been controlled.
- Patients were assessed in line with the Mental Capacity Act 2005. We reviewed 12 sets of patient's records and there was a capacity assessment in place for each patient.

Are critical care services caring?

Good

Critical care services at the unit were rated as good for caring because:

- Feedback from people using the service, including patients and their families was very positive throughout the inspection.
- We observed how staff supported patients to do as much for themselves as possible within the limitations of their critical illness. For example, supporting patients to take their first steps after a period of high dependency on the critical care unit.
- The NHS Friends and Family test for the period August to September 2015 showed that the unit had received 100% positive feedback.

However there were some areas that could be improved because:

- The use of patient diaries in the unit appeared to be inconsistent. A diary was commenced on a ventilated patient following our discussion with the lead sister on the use of patient diaries during our inspection.

Compassionate care

- Patients and relatives we met spoke highly of the compassionate care and support they received in the unit. We spoke to nine patients who all told us how kind the staff were and how thoughtful and caring they were to their friends and families. We saw many examples of complimentary comments from patients and relatives. One patient said "You have given me my life back and I can never thank you enough for that". Another patient

said "Although I was frightened at times the staff were always there to reassure me whatever time of the day or night it was". Visiting times for relatives were flexible and were supportive of each individual patients care and support needs.

- We observed that staff were attentive to patient's privacy and dignity needs. We saw curtains were drawn around patient's beds and doors or blinds closed in side wards. Voices were lowered to avoid confidential information being overheard.
- The nature of most critical care units meant there was often limited opportunity to provide a single-sex ward or area. Staff were aware of the limitations and endeavoured to place patients as sensitively as possible in relation to their privacy and dignity needs.
- We saw the results of the NHS Friends and Family test for the period August to September 2015. 15 completed questionnaires had been received and 100% of patients said the service was "excellent". People said "I could not have been cared for better" and "They take good care of you and they looked after my family very well. They told me everything about what was happening to me".
- Patients told us staff were caring and they received "excellent" care in the unit. A patient told us "It is a wonderful unit and I will be writing a letter of commendation when I am discharged to the Chief Executive". Another patient said "I have never had any concerns since I was admitted here and the staff seem to have an instinct about what you need before you know you need it yourself".

Understanding and involvement of patients and those close to them

- Wherever it was possible patients were involved with their care and the decisions that were taken. Those patients who were able to talk with us said they were informed as to how they were progressing. They said they were encouraged to talk about anything that was worrying them.
- Friends and relatives of patients were kept informed and involved with decisions when appropriate. They told us they were able to ask questions and could telephone the unit whenever they were anxious or wanted an update on their relative's condition.
- One relative told us "I was very anxious in the early days of my relative's admission to the unit and I often contacted the unit. The staff were always kind and helpful no matter how many times I called which really kept me sane and I can never thank them enough for that".
- Staff told us they were aware the unit could be very daunting for friends and family and therefore they would give information as sensitively as possible.

Emotional support

- The unit had implemented some innovative ideas to support patients and families during their stay in critical care. For example patient diaries were used to support patients who were sedated and ventilated and often suffered memory loss and experienced psychological disturbances post discharge.
- Diaries are said to help fill the memory gap and provide a caring intervention for patients. The lead sister told us patient diaries were used in the unit and had proved to be beneficial to patients in the past. Photographs of patients were taken and stored on a secure drive (following discussions with relatives) and were shown to the patient when they were ready to see them.
- The use of patient diaries in the unit appeared to be inconsistent. A diary was commenced on a ventilated patient following our discussion with the lead sister on the use of patient diaries during our inspection.
- A bereavement follow-up service (led by a nurse on the unit) provided ongoing and open ended bereavement support to relatives to progress through the grieving process following the death of a relative in the unit. The service (4.5 hours per week) was provided to relatives either face to face or over the telephone.

Are critical care services responsive?

Good

The critical care service were rated as good for being responsive to patient's needs because:

- Out of hours discharges from critical care to the wards were below the network threshold of 6.3% and were reported as 4.9%.
- All patients in the unit who had been ventilated for five days or more were able to self-refer to the critical care follow-up/rehabilitation service.

- The service provided patients with weekly clinics and enabled access to medical staff, physiotherapy, speech therapy, a dietician and psychologist.
- There was an effective process for learning complaints within the critical care unit.

However there were some areas that could be improved because:

- The East of England CCODN identified in the Peer Review in February 2015 that critical care were not within the network threshold of 57%. This trust was reporting delays of 66% leaving the unit within four hours. The trust were auditing these results and working on plans to reduce delayed discharges from the unit .

Service planning and delivery to meet the needs of local people.

- Adult critical care bed occupancy was at or around the England average. In quarter 2 (July – September 2015) the units bed occupancy was 87.5% compared with a national average of 85.7%. This meant that the unit was generally busier than other units in England.
- The unit has one critical care bed for every 11,150 adult population it serves.

Meeting people's individual needs

- All patients in the unit who had been ventilated for five days or more were able to self-refer to the critical care follow-up/rehabilitation service. Information about the service was provided in the 'After Critical Care' leaflet given to all patients leaving critical care. The service provided patients with weekly clinics and enabled access to medical staff, physiotherapy, speech therapy, a dietician and psychologist.
- The service was created by the trust to support patients through the recovery phase of their critical illness and to help patients to understand why they might have certain symptoms and give them reassurance and advice on how to deal with them. Feedback from patients using the service was overwhelmingly positive.
- A bereavement follow-up service (led by a nurse from the unit) provided ongoing open ended bereavement support to relatives following the death of a relative in the unit. The service (4.5 hours a week) was provided to relatives as either face to face or over the telephone.
- Support for people with physical and learning difficulties was available, if needed. The lead sister told us patients with a learning disability required a longer period of time and support when they were being weaned from a ventilator. Each patient had a care passport and would be supported by a carer who would be involved in planning the care and support in the unit.
- Nurses in the unit had received training in supporting patients with a diagnosis of dementia. The lead sister told us staff provided additional support to patients, their families and other members of the care team who may not be up-to-date in providing specialist dementia care.
- Translation and interpreter services were available, both by telephone and in person and patient information was available in different languages.
- The specialist nurse for organ donation (SNOD) in the trust had links with the unit. Difficulties had been experienced over recent years between the doctors on the unit and the SNOD and there were concerns over low referral rates to SNOD. Matters were now improving. We were told that most patients from whom care is withdrawn are now referred to SNOD. As there were only small numbers of patients who were actually suitable for organ donation it was difficult for the unit to assess the data.
- The critical care service ensured that relatives and carers were supported by appropriate facilities in the unit. For example, two relative's rooms were in place with sufficient seating and sleeping arrangements with easy access to toilet facilities and a drinks vending machine. Information leaflets were available and included for example, guidance on the unit, and its routines, support services, complaints and compliments and organ and tissue donation. The area was safe and fit for purpose.

Access and flow

- Discharge from critical care to a ward should be within four hours of the decision to discharge. The East of England CCODN identified in the Peer Review in February 2015 that critical care were not within the network threshold of 57% and were reporting delays of 66%. Audits of delays were ongoing in critical care and were reported to the trust executive team. We were told the trust was reviewing the system wide process for capacity management alongside patient flow both into and out of critical care. Therefore, the consultant clinical lead would like to develop a step down unit in the future which would enable more timely patient discharge.

Critical care

- ICNARC showed that delayed discharges as a statistical outlier at greater than 20 %.
- Out of hours discharges from critical care to the wards were below the network threshold of 6.3% and were reported as 4.9%. All patients admitted to critical care should be seen within four hours of the decision to admit and this was being achieved (ICNARC 2013/14).
- The level of delayed discharges (12 hour delay) was higher than the average value for acute trusts in England and similar for delayed discharges of 24 hours for acute trusts in England.
- There was a standardised discharge document that was completed by the critical care unit prior to discharge of patients to the ward. This outlined the treatment received whilst on the unit as well as a decision regarding whether readmissions to the unit would be appropriate. Discussions with the patient and relatives were recorded on the document.
- Prior to discharge, the critical care registrar would verbally hand the patient over to the accepting team's registrar. Nursing staff would perform face-to-face handover on the receiving ward.
- The unit has a staffing capacity for six Level 3 and 6 Level 2 patients. However, this is flexible and the actual number and levels of patients that can be admitted is dependent on nurse: patient ratios. The physical limit of beds within the unit is 14.
- In the event of there being more patients within the hospital requiring Level 2 or Level 3 care the critical care escalation procedure (June 2014) would be implemented. For example, patients in the unit would be assessed by the intensive care consultant in liaison with the lead sister/shift coordinator in the unit to ascertain if any patients may be stepped down to general ward care. Transfer to the appropriate clinical environment would be arranged in conjunction with the site matron supported by a traffic light system discharge tool to enable patient's level of fitness for discharge from the unit to be appropriately assessed.
- Further beds would also be opened in the unit if additional nurses could be sourced. For example, cancelling non- clinical activities (study days etc.), obtaining agency staff or redeploying staff from other clinical areas.
- In the event of the unit being at capacity, the intensive care consultant anaesthetist would assess in liaison with the lead sister /shift coordinator, the appropriateness of discharging patients early from the unit with the support of the outreach team in order to accommodate further critically ill patients.
- If there remained no ability to increase resources to cope with additional patients, the intensive care consultant in liaison with the lead sister/shift coordinator would arrange the non-clinical transfer of the most stable Level 3 patient in the unit. The patient would be transferred to the nearest Level 3 bed using the Inter Hospital Transfer of the Critically Ill Adult Patient Protocol (document 061) in liaison with the Emergency Bed Service (EBS) within the East of England network.
- If no Level 3 could be identified or if the risk of non-clinical transfer outweighed the benefits, for example, insufficient staffing, and local arrangements would be implemented to accommodate the patient. For example, the redeploying of outreach staff or recovery staff to provide support within the unit or recovery. Where the decision was made to care for critically ill patients in recovery the appropriate service line managers would be consulted as there could be implications for theatre activity which may result in the postponement of elective surgery.
- Discharges from the unit at night (10pm – 7am) were avoided wherever it was possible to do so to support the continuity of patient care. The out of hours discharge rate where discharges out of hours were avoided was of 99.8% (ICNARC 2013/14) which was much better than expected.
- Non clinical transfers were in line with the England average for both non clinical transfers into and out of the unit. This meant that patients were only admitted if they required the services of the unit and not transferred out due to non-clinical reasons.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. The lead sister told us if patients or their families wished to make an informal complaint they would speak to the shift manager. If they were unable to deal with the matter in a satisfactorily they would be directed to the Patient Advice and Liaison Service (PALs). If they still had concerns following this, they would be advised to make a formal complaint. This process was outlined in leaflets available in the relatives' waiting area.

Critical care

- There were two formal complaints in critical care in the last 12 months. The complaints were both around staff attitude and had involved the same member of staff. The complaints had been investigated by the lead sister in critical care in line with the trust policy. The staff member had been supported through the complaints process and the learning outcomes were documented in the staff record.
- Themes from both formal and informal complaints were collected and were shared at monthly staff meetings and we saw evidence of this in minutes of staff meetings.
- We saw examples of where issues had been raised by patients' and relatives and the actions that staff had taken to address them. For example, patients had said the days seemed very long when they were starting to recover in the unit. The critical unit had responded by providing portable television sets with a DVD player and a selection of DVDs
- Relatives had also raised concerns around not knowing what was happening when they were in the relative's room. This had been addressed through the provision of a telephone link directly through to the nurses station in the unit. This demonstrated that staff were listening to patients and their relatives and were involving them in the delivery of services in critical care.

Are critical care services well-led?

Requires improvement

Critical care services were rated as requires improvement at a local level in terms of being well led because:

- There was no formal clinical strategy for the development of critical care services in the trust.
- Governance systems were not robust to ensure that risk were being proactively managed within the department. The lead sister did not have access to the trust risk register. Staff were aware of the risks but no action to mitigate these had been taken.
- The risk register for Anaesthesia did not highlight the specific concerns identified regarding the service, maintenance and cleanliness of equipment, however it referred to an overarching risk on the trust risk register regarding equipment. Equipment was discussed as a risk and minuted at governance meetings. The service was not auditing outreach services to ensure the effectiveness of this service.

However we also found :

- The trust's vision was visible throughout the wards and corridors and staff were able to tell us about the vision for the trust.
- We saw evidence of the governance meetings that were held monthly. Within the minutes of these meetings we saw examples of incident reporting, infection control, electronic discharge summaries and mortality and morbidity.
- Nursing and medical staff felt well supported in the department and all staff within critical care spoke positively about the service they provide to patients and relatives.
- The critical care unit was innovative and focused on quality improvements. We saw examples of where the unit supported post registration teaching programmes and there was a good track record of publishing research undertaken in critical care.

Vision and strategy for this service

- The leadership and culture in critical care were used to drive and improve the delivery of high-quality person centred care. All the senior staff were committed to their patients and staff and had a shared purpose. There was no formal clinical strategy for the development of critical care services in the trust. We were told this was under development and was being led (in critical care) by the clinical lead (consultant) and the matron and lead sister.
- The trust's vision was visible throughout the wards and corridors and staff were able to tell us about the vision for the trust.

Governance, risk management and quality measurement

- There was a critical care operational policy in place for the trust with clear guidelines around admissions, discharges, safe staffing levels, contingency planning, organ donation and bed closures. The policy was the responsibility of critical care and was written in June 2014. The next review was due in June 2016.
- Critical care services were within the anaesthetics directorate. We saw evidence of the governance

meetings that were held monthly in copies of the governance minutes for June 2015 (May's data). We saw examples of incident reporting, infection control, electronic discharge summaries and mortality and morbidity and equipment and maintenance issues. There was evidence of critical care representation at the governance meetings.

- For example, "Concerns regarding the servicing of equipment in critical care and theatres stated "EBME (medical electronics) at present compiling list of all equipment / service needs". This demonstrated that the clinical division and the wider governance framework in the trust were aware of the issues associated with the maintenance and servicing of equipment.
- The lead sister did not have access to the trust risk register. This was being addressed at trust board level as training was being rolled out to senior clinical staff to enable them to understand the risk arrangements in place across the trust.
- The lead sister told us the unit had raised concerns about the inconsistent approach to the servicing of equipment with the trust board. We reviewed the risk register for Anaesthesia which identified an incomplete risk on equipment and referred only to the trust wide risks of equipment and was not specific to critical care.
- The trust had entered onto the risk register in February 2015, Suboptimal Medical Devices Management. The original risk score on entry to the risk register was 20.
- Internal quality auditing was being undertaken and was evidenced in the anaesthetic directorate minutes. For example, hand hygiene, National Patient Safety Audit (NPSA) MRSA and CDiff screening, daily audits of compliance to ventilator, central line and patient safety bundles.
- In the critical care governance meeting minutes (held monthly) actions supporting "data quality and activity" identified that following the serious incidents (reported in safety) enhanced equipment checks and labelling of equipment had been put in place. This demonstrated that learning from incidents had taken place within critical care.

Leadership of service

- There was a consultant lead for the service who allocated clinical lead roles to consultant colleagues and monitored and supported colleagues with this work. Junior medical staff told us they were supported by their consultants and confirmed they received feedback from governance and service meetings.
- Nursing staff told us they were well supported by the lead nurse and matron for critical care and said "I can always share any concerns with the managers and I know I will be listened to". The lead sister and matron had a visible presence in the unit and were on shift Monday to Friday. There was a band seven sister on every shift to coordinate and run the unit.
- There was a lack of leadership both on a local and executive level to drive the vision and strategy for the unit. The leaders were aware of the issues but there were no plans to lead changes. For example there were no audits to evidence the demand and use of level 2 beds, the usage and availability of medical staff to the outreach team or evidence to support a business case for the expansion of the service. This meant that whilst leaders were supporting staff there was limited leadership of the service.

Culture within the service

- Staff within critical care spoke positively about the service they provide to patients and relatives. Staff described a great sense of teamwork and mutual respect. They reported a sense of pride and commitment within the department, and told us they felt there was a caring and supportive culture at all levels. For example, we observed a senior nurse supporting a junior member of staff to undertake a clinical procedure they were unfamiliar with. This was undertaken with kindness and support and a genuine insight into the anxieties expressed by the more junior member of the care team.

Public engagement

- The intensive care unit steps is a national intensive care patient support charity that was founded by ex-patients, their relatives and the unit staff to support patients and their families on the road to recovery from critical care illness. The trust supports the intensive care unit steps programme through the provision of a drop in support group which is ongoing and open ended.

Staff engagement

- The unit had close links with the military. Staff who worked with the military in the unit reported this in a

positive light as they felt they benefited from the staffs military expertise. The military personnel told us the intensive care staff were very supportive to their clinical training needs and went out of their way to help them.
- We saw examples in the staff room on the unit of how staff were being kept informed of developments on the unit. For example, the actions being taken by the lead nurse and matron around the recent nursing shortages were clearly communicated to all nursing staff.

Innovation, improvement and sustainability

- The critical care unit was innovative and focussed upon quality improvements. For example, the publication of research articles in relation to NICE guidance CG83 – rehabilitation after critical illness and contributing to the scoping meeting for NICE guidelines for "Short-term interventions for regaining independence" was undertaken by a nurse in critical care.
- The unit supported post registration teaching of students at three local universities. Three patients who had experienced a critical illness in the unit had participated in the teaching sessions in 2015.
- Critical care nurses had presented at international and national critical care and infection control conferences and had published their results in national critical care journals.
- The nurse educator had developed a series of competency packs supported by a competency answer pack to help reduce variation and meet clear standards across the unit.
- An in-house training programme for nurses and doctors has been developed to support the safe transfer of patients in the unit.
- In response to a previous serious incident involving the intubation of a patient in the unit intubation and extubation checklists had been implemented to ensure the safe intubation and extubation of all patients on the unit.
- The critical care outreach service was developed in 2000 at the trust. Its purpose was to provide a resource to provide support and guidance to staff on the wards in relation to the deteriorating patient. The service also provides information and training to nurses and medical staff. For example, ALERT (advanced life support training and the doctor's induction programme). The service is funded from the critical budget and is a stand-alone service.
- To enable improvements in service delivery (Keogh review concerns) and ensure sustainability a business case was developed by the matron for critical care in 2014. The outcome of the business case has yet to be determined by the trust.
- There were no succession planning arrangements in place to support the outreach service and staff (who had received the appropriate training) would be allocated to the team from the unit.

Maternity and gynaecology

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

Information about the service

The Trust provides maternity and gynaecology services to the populations of Colchester, Harwich, Halstead, Clacton and the areas within North East Essex. The trust also provides community midwifery services across the north Essex area. During 2014 the service had a birth rate of 3,719 births.

The Colchester General Hospital maternity service consists of a maternity triage department with five couches/chairs and two single rooms. Lexden ward consists of mixed antenatal and postnatal care with 28 beds, the delivery suite has eight birthing rooms and two fully equipped Obstetric Theatres to support consultant led care, with a four bed midwifery led birthing unit for women identified as low risk of complications in labour. All these services are located on the ground floor or first floor of the Constable Wing of the hospital. There is also an early pregnancy assessment unit co-located with the Stanway ward, which provides gynaecology inpatient care for up to 16 women. Lexden ward consists of mixed antenatal and postnatal care with 34 beds. One six bedded bay area when not required by Lexden ward is utilised by Stanway ward when the Trust has increased activity.

During the inspection we spoke with 47 midwifery/nursing staff, nine doctors and 22 patients.

The 47 midwifery/nursing staff included specialist nurses, midwives, health care support workers, administration and allied health staff. The nine medical staff included obstetrics and gynaecology staff as individuals on ward observations and in focus groups or at the audit meeting held within the directorate. We inspected all maternity and gynaecology services at Colchester General Hospital. We examined the records of 25 women who used the service and spoke with 47 midwifery/nursing staff, nine doctors and 22 women.

Prior to the inspection we held a dedicated focus group for women in the community who had used Colchester General Hospital's maternity services over the past 12 months who requested to speak with us. This was well attended by more than 30 women and some partners who shared their experiences of the care and treatment they received.

Maternity and gynaecology

Summary of findings

We rated maternity and gynaecology services as requires improvement overall. With the service being rated as good for effectiveness, responsiveness and leadership but requiring improvement in safety and caring.

Safety in maternity services required improvement because the environment within the unit was not secure and meant that there was a risk of child abduction or absconsion of vulnerable women, which the service had not identified. The mandatory training rates for both medical and nursing/ midwifery staff in maternity and gynaecology were poor in subjects including Safeguarding Children and adult and paediatric life support. Equipment that was in use throughout the department was not always serviced or calibrated. The midwife-to-birth ratio was in line with the recommended average and at times was better than the England average as was the number of consultant hours provided to the service, which was positive.

The service was rated as good for being effective because outcomes for women who used services were in line with or better than expected when compared with other similar sized services. The termination of pregnancy process followed all elements of national guidelines and legislation. The service took part in national audits and completed a range of local audits as well as reviewing their service in line with nationally published recommendations through the Kirkup report.

The service was rated as requiring improvement for the care provided to women who use the service. Feedback from people who use the service, those who are close to them and stakeholders was mixed about the way staff treat women. Women were positive about some of the care provided however we received several comments through our dedicated women's focus group about poor attitude of staff providing care to mothers on the postnatal ward.

The service was rated as good for being responsive to the needs of women because it had responded to the changing demand for the service. Access to the service was through a simple route, which enabled women to be seen by the medical teams soon after arrival. The waiting times for emergency and elective gynaecology were good and meant that patient's pathways were generally delivered within 18 weeks. Bed occupancy for the service was consistently better than the England average. However the service needed to improve the processes in place for investigating, responding to and managing complaints.

The service leadership locally was good. Staff spoke positively of the clinical leads for the service and how involved and approachable they were which created an open culture. Governance and risk management systems within maternity and gynaecology were well established but required some refinement to link into the trust board and also with regard to learning from incidents and complaints. The service worked well with engaging with the women who live within the catchment area and link up with the local and mother and baby groups to seek feedback on services provided by the hospital.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

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

- The environment within the unit was not secure and meant that there was a risk of child abduction or absconsion of vulnerable women, which the service had not identified.
- The mandatory training rates for both medical and nursing/ midwifery staff in maternity and gynaecology were very poor in subjects including Safeguarding Children Level 3, Advanced life support for adults and also newborn and paediatric life support.
- The quality of the root cause analysis investigations into serious incidents for maternity was not of a good standard with the terms of reference not always clearly picking up the key issues from the incident. The investigations were not undertaken by trained investigators and root causes were not always clearly identified in each case with clear learning points.

However we also found:

- There was a clear process for the reporting, recording and investigation of incidents.
- Lessons were identified and shared throughout the service and the Duty of Candour was implemented where the incident severity required it.
- The midwife-to-birth ratio was in line with the recommended average and at times was better than the England average which was positive.
- The ratio of midwives to Supervisor of Midwives (SoM) was 1:15 in line with the recommended ratio.
- The gynaecology service had very clear processes for the delivery of a safe service across all recognised gynaecology pathways.
- The number of medical staff in the service enabled a higher number of consultant hours than recommended by national guidance to be provided to deliver the maternity and gynaecology service, which was positive.

Incidents

- The trust had an electronic incident reporting system in place. Staff we spoke with about incident reporting who told us that they could access the system through any hospital computer.
- Staff understood their responsibilities to report incidents and were able to describe to us what constituted an incident and when they would raise one.
- Within maternity and gynaecology there had been two never events reported between April 2014 and March 2015. Never Events at that time were defined are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- We spoke with staff about both never events which occurred. They were able to detail to us changes in practice following the incidents, for example tampon swabs are no longer available within the maternity ward or used in perineal repair packs.
- Agency staff were not able to access the incident reporting system so were required to ask a trust staff member to complete on their behalf, which was not good practice
- The service reported 30 serious incidents within maternity and gynaecology services between 01 April 2015 and 31 August 2015. The most common reported serious incidents were unexpected admissions to neonatal unit, unexpected maternal admission to intensive care and intrauterine deaths and medical patients who fell on the gynaecology ward.
- We reviewed three full root cause analysis investigations completed into serious incidents which occurred in maternity. The investigations were comprehensive, however were not always completed by trained investigators.
- The investigations in maternity did not clearly identify the root cause of any of the three incidents, the investigators root causes were contributory factors rather than direct root causes.
- In one maternity investigation the risk of using the medicine Propess to induce labour in a woman who had previously had a caesarean section had not been included as part of the terms of reference for the investigation. The use of this medicine, the policies and procedures of use had not been considered as a contributory factor or root cause of the woman's haemorrhage, despite published articles

contraindicating the use of this medicine in women who have had previous caesarean section deliveries. We found that no changes or learning points had been implemented since this incident.

- Four staff we spoke to about learning from these incidents were able to tell us what serious incidents had occurred what improvements had been made to the service as a result. We were shown the 'women's stories' monthly newsletter which included details of learning and improvements in service. For example a woman who experienced a delay in review following an incorrect clinic booking and procedure was used to review the clinic booking pathways to change how women could access this service.
- Mortality and morbidity meetings were held every other month and we saw minutes of these meetings, which were last held in June and August 2015, with attendance from medical, diagnostic, and midwifery staff. The mortality and morbidity monthly audit and governance meeting was led by the neonatal team.
- We spoke to seven staff who described the Duty of Candour requirements to inform women when things go wrong, although three staff did not use the term "Duty of Candour" they spoke of openness and transparency regarding incidents.
- The trust had a dedicated patient information leaflets for Duty of Candour and being open.

Safety Thermometer

- Maternity services used the NHS Safety thermometer tool in conjunction with the maternity clinical dashboard instead of the maternity safety thermometer. The Maternity Safety Thermometer allows service providers to determine harm-free care indicators but also records the number of harm(s) specifically associated with maternity care.
- The trust also has six contracted places at a local university for newborn and infant physical examination (NIPE).
- We reviewed the July 2015 maternity dashboard and found that there was monitoring of key areas of care, clinical outcome indicators, staffing, risk management and patient safety.
- The use of the NHS Safety thermometer (which allows service providers to determine harm free- care) was displayed on the gynaecology inpatient ward, Stanway ward, for women and their relatives.
- At the entry points of Stanway ward there were safety crosses which showed monthly patient activity with number of days since last patient fall, healthcare acquired infections (HCAI), medicine errors and when safe staffing numbers were not achieved.

Cleanliness, infection control and hygiene

- There were cleaning schedules in place and we observed cleaning taking place throughout the inspection. The maternity and gynaecology services we visited were visibly clean.
- We observed dated and signed 'I am clean stickers' on equipment that regularly had to be decontaminated. This meant clean equipment was identifiable.
- We saw one intravenous pump did not follow infection prevention and control decontamination policy as the 'I am clean' sticker remained on the machine whilst in use by a patient. This meant there was a risk that the intravenous pump would not be cleaned after patient use. This issue was discussed with the staff who removed the sticker immediately.
- Staff were observed to have good hand hygiene, used personal protective equipment appropriately, and were bare below their elbows.
- In November 2014 Stanway ward scored an overall 73% on their infection control audit with a score of 65% on hand hygiene techniques. In February 2015 the delivery suite scored an overall of 73% on their audit. Lexden ward scored an overall score of 73%, with 65% scored on hand hygiene and standard precautions and 70% on peripheral vascular devices in December 2014.
- Spot check audits had been carried out by the services since the main audits were undertaken which showed an improved score of up to 98% across the services. There was an action plan in place to address the issues identified and work to complete these items were still ongoing.
- 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.

Environment and equipment

- Equipment had portable appliance testing (PAT) with appropriate dates. A PAT test is an examination of electrical appliances and equipment to ensure they are safe to use.

- Staff were not aware of an equipment replacement programme although they acknowledged that the Cardiotocography (CTG) had been recently replaced. CTG equipment is used to monitor a baby's heart rate and a mother's contractions while the baby is in the uterus.
- We looked at Cardiotocography equipment on the delivery suite. The CTG equipment we examined had been checked and labelled with the date of the maintenance check.
- We reviewed the maintenance records for equipment on Stanway ward, Lexden ward, theatres, gynaecology and antenatal areas which identified several items of equipment which was out of service and maintenance date. The trust were made aware of these issues and took action immediately during the inspection to make areas of high risk, including maternity safe on equipment use. However concerns relating to equipment being out of service date were identified during our previous inspection in May 2014.
- Stanway ward had a joint access corridor next to Lexden ward, which had signs of damage to the lower part of the doors and walls had, dents and paint removal marks and was in need of repair. Staff informed us that this had been reported and plans for repair and refurbishment were in place, though no plan was available to view.
- On the first day of the inspection we looked at adult and new-born resuscitation equipment across maternity and gynaecology services and found that these had been checked daily with no issues or concerns identified.
- We identified that the door between the postnatal and antenatal ward (Lexden) and gynaecology ward area was not secure. This meant there was a risk of patients and visitors moving between both wards which presented a risk of abduction or a vulnerable patient absconding. We raised our concerns about security to the most senior person in charge who called estates to repair the fault. Subsequent checks (out of hours and at different times of day) found the doors to be secure.
- Staff stated that visitors did hold the ward entrance door open for others increasing the risk of future abductions. The CCTV was put in place following the removal of the baby tag security system though this was not monitored at all times.
- We were not assured from the inspection and feedback from women and their partners that the maternity unit was secure and monitored at all times. During our community focus group for women using maternity services and their partners, one partner told us, “I don’t think security is great. You have to buzz to get in the ward but it’s easy for anyone to tail you and get in. I saw secure documents (files) in the reception area, which anyone could have picked up. There is a door between bay D and bay E, which connects two wards, which should have been locked but was being used by staff and patients. I was worried about my baby’s safety”.
- A woman also told us about their discharge process from the labour ward which they felt was taking a long time, “I just left and no one said anything to me”.

Medicines

- We examined the controlled drugs registers and the storage of controlled drugs within the delivery suite and Stanway ward. We found that the controlled drugs were accounted for and appropriately recorded, including being double signed for by nursing staff.
- We checked medicine fridge temperatures across the directorate. The temperature was monitored daily and recorded in line with requirements to ensure medications stored were at the correct temperature.
- We observed that IV medicines were securely stored away and were not accessible to the public. This meant that the risks associated with tampering of IV medicines were managed appropriately.

Records

- We examined 12 sets of records from the antenatal clinic, Lexden ward and early pregnancy assessment unit. The records included relevant information such as health assessments, learning difficulties screening tool, assessments of social circumstances, mental health and information about referrals to other agencies such as mental health services.
- We examined the risk assessments used on women admitted for delivery which included weight, pregnancy history and venous thromboembolism risk and all records were clear and completed. The pathways of care were clear on all the records reviewed.
- Risk assessments for venous thromboembolisation (VTE) were undertaken and an audit undertaken by the service showed 98% of women had been assessed and treated for the risk of a thromboembolism on admission.

- We saw the records were accurately completed including hourly observations, medicines administered and CTG records. All entries were signed and dated.
- Within the early pregnancy assessment unit we examined three records which included discussions regarding contraception and the risks of VTE, which is required by best practice guidelines.
- The recording and documentation regarding the termination of pregnancy in the six records examined found that were good. The service was able to demonstrate how they met the requirements of the Abortion Act 1967 and associated guidelines through the recording of care. All notes were signed and dated, legible and clear records of discussions were maintained.

Safeguarding

- There were up-to-date safeguarding policies and procedures in place, which incorporated relevant guidance and legislation. Staff demonstrated that they could access these via the intranet.
- We spoke to 20 staff across maternity and gynaecology specifically about safeguarding and all were able to explain safeguarding arrangements, what constituted a safeguarding concern and how they would report it.
- We examined the training records, which showed that within maternity and gynaecology services 95% of all staff had received safeguarding adults training and 95% had received safeguarding children training to level 1.
- Child protection level 3 training had not been completed by any of the medical staff in maternity and gynaecology and only 6% of nursing and midwifery staff. Safeguarding level 3 core update for children had been attended by 38% of medical staff and 53% of nursing and midwifery staff.
- Staff we spoke with could describe how to escalate a safeguarding concern and knew whom they needed to speak to for information or advice, all we spoke with were aware who the midwife with a lead for safeguarding was.
- Staff were aware of potential safeguarding concerns for women for which this hospital was not their booked hospital of choice. This meant that staff were confident in raising any safeguarding concerns and knew the process to follow.
- The Trust is not currently providing the Daisy programme, which looks specifically at the risks associated with domestic violence. Domestic violence training is part of the Mandatory safeguarding training provided.
- The Rose programme is a local new initiative providing domestic violence aware, the Community midwifery team have linked in with the programme as part of their service.

Mandatory training

- Records of training showed that 85% of mandatory training had been completed, however this was below the trusts target of 95%. Mandatory training included subjects including health and safety (95%), fire safety (92%), moving and handling for patients (92% nursing and 0% medical staff) and information governance (90% nursing and 81% medical staff).
- We were informed that maternity staff received additional mandatory training which led by the practice development midwives and included topics such as obstetric emergencies, breastfeeding and Cardiotocography training, however there were no records of these training sessions available.
- There was an induction programme for all new staff including agency staff to the ward or birthing units. We examined records of induction, which evidenced that temporary staff were inducted.

Assessing and responding to patient risk

- We observed maternity staff confidently dealt with a major incident (code blue) incident on two separate occasions.
- The gynaecology ward, Stanway ward, provided care to women with gynaecological conditions as well as female medical patients who were outlied to the ward due to capacity pressures within the hospital. We examined the training records which showed that 100% of nursing staff had received training on the National Early Warning Score (NEWS) system.
- On Stanway ward the National Early Warning Score (NEWS) system had been implemented and was used by staff to monitor the risks of deterioration to a patient's condition. We examined the records of five women, which showed that the National Early Warning Score (NEWS) system was being used appropriately and calculated correctly.

- On Stanway ward three nursing staff expressed concerns that they did not feel able to care appropriately for those women with medical conditions who were outliers to the ward. Staff felt they may not be able to respond to the needs of non-gynaecology women on the ward.
- A member of the senior management told us that medical patients within the gynaecology ward were not seen until after the medical ward rounds were completed. Staff were able to call the medical staff in an emergency.
- On Stanway ward there was a standard operating procedure for the admission of a non gynaecology women to the ward. At the time of our inspection we observed that this was not being followed by the service, for example a patient at high risk of infection and a high risk of falls were observed to be on the ward.
- Two staff described how the preadmission criteria was not always followed when the trust had increased patient activity for example, a patient was admitted to the area with a previous history of falling prior to this inspection.
- In maternity services the Maternal Early Warning Score (MEWS) and Paediatric Early Warning Score (PEWS) system were in place for women and babies. We examined the MEWS of four women on Lexden ward and all records were complete with actions taken as necessary.
- Several serious incidents had been reported relating to the misinterpretations of Cardiotocography (CTG) results. This was a risk highlighted on the directorate's risk register since 2014. All staff attend annual training day, which includes CTG training. However there were no formal assessments to evidence staff competency after this training and we were not assured that this risk was being appropriately managed.
- The 'World Health Organisation (WHO) Surgical Checklist, Five Steps to Safer Surgery' was in place in maternity and gynaecology. The maternity dashboard showed compliance rates ranging from 94-100%. We examined the records of four women where safer surgery checklists were required and found that they were appropriately completed.
- Within maternity and gynaecology we reviewed the training records for advanced life support for adults and found that 50% of medical staff had received training. There were no records of nursing and midwifery staff receiving advanced life support training though 92% had received basic life support training.
- We reviewed the training records within maternity services for Newborn Life Support (NLS) and found that 4% of doctors and 38% of midwives had been trained. In Paediatric Advanced Life Support 13% of doctors and no nursing and midwifery staff had been trained. In Paediatric Basic Life Support 72% of doctors and 89% of nurses and midwives had been trained.

Nursing/Midwifery staffing

- The midwife to birth ratio was 1:28 which met the national average. 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 midwife to birth ratio was assessed monthly and reported to the board. The trust uses a nationally recognised (Birthrate plus system report) matrix for assessing the ratio based on the numbers of births expected in the unit.
- On Stanway ward there were no nursing vacancies as they had recently recruited into all vacant posts. To ensure that staffing levels were maintained when the shared bay was opened the service relied on the use of bank and agency staff. We saw that agency staff had been obtained to cover the opened shared bay during this inspection.
- We observed the evening handover between maternity day staff and their colleagues. The handover covered key risk information in sufficient detail to alert the labour ward to anticipate arrival of labouring women and any increased risk factors.
- Within the Clacton midwifery team there were 9.53WTE midwives employed against an establishment of 13.9 and in Harwich midwifery team there were 4.18 WTE employed against an establishment of 7.46 in February 2015. The team were working to increase their community midwifery ratios.
- The ratio of midwives to Supervisor of Midwives (SoM) was 1:15 in line with the recommended ratio of 1:15.
- The staff sickness ratio for maternity and gynaecology services peaked at 5.20% in May 2015 reducing to 1.60% in July 2015, which was below the trust target of 3.50%.

Maternity and gynaecology

Medical staffing

- The trust employs 28 WTE doctors including 8.5 WTE consultants to work in the obstetrics and gynaecology service and there was a good skill mix on duty at all times.
- The service had 18% of junior medical staff, which is higher than the national average of 7%. Registrar rates were 41% against the national average of 50% and middle grades were 9% against the national average of 8% and consultants at 31% against the national average of 35%.
- Colchester General Hospital had 3,719 last year and an average of 78 hours of consultant presence on the delivery suite was provided per week. This meant that the service was meeting 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 told us that consultants often provided additional cover out of hours and had been contacted and responded to requests for help at weekends.
- Consultant medical and anaesthetic cover was available 24 hours a day seven days a week for both maternity and gynaecology services.
- There was an allocated consultant who termination of pregnancies which took place weekly for both medical and surgical procedures.
- Consultant ward rounds took place daily and all new patients seen within one hour following their admission.
- An additional ward round occurred with medical (outlier) patients on Stanway ward not being seen until after the medical ward rounds had been completed.
- The divisional director told us that the trust had worked hard to attract junior doctor trainees. Trainee feedback had been good and the deanery had recently agreed an increase in trainees. We spoke with four trainee doctors who worked in the service and all told us support was good, consultants are accessible and approachable, including out of hours.
- Junior doctors told us they had been given a comprehensive induction for obstetrics and gynaecology. They also told us that teaching and learning opportunities happened weekly and they felt supported.

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.
- 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.
- There was no evidence that staff had received up to date major incident training in maternity or gynaecology, this was a theme trustwide with major incident training not forming part of the core mandatory training requirements.
- There was no abduction policy on the trust intranet although a draft policy had been completed in February 2014 this meant that there was a risk of staff being unaware of the risk of abduction.

Are maternity and gynaecology services effective?

Good

We rated the service as good for being effective because:

- Outcomes for women who use services were in line with or better than expected when compared with other similar sized services.
- The termination of pregnancy process followed all elements of national guidelines and legislation.
- Consent to termination of pregnancies was undertaken in line with national guidance.
- The service had a clear focus, plans and procedures in place to deliver a natural birthing pathway to all women and reduce their overall caesarean rates.
- Women were encouraged and supported to deliver naturally and commence breast feeding post birth.
- The service took part in national audits and completed a range of local audits as well as reviewing their service in line with nationally published recommendations through the Kirkup report.
- Staff working within the service went through regular appraisal and personal development with the option to undertake further education where requested and available.

However there were some areas that could be improved because:

- Whilst the trust monitored most data sets some areas of development of their maternity dashboard were required, including the monitoring of women who had planned to have a vaginal birth after having a caesarean during a previous birth (VBAC).
- The MBRRACE reports that nationwide the country is an outlier for perinatal mortality compared to the rest of Europe. The North-East Essex (NEE) region was reported as an Amber Outlier – up to 10% above the national rate.
- The Service had higher than expected admission rates of babies to Neonatal Intensive Care and mothers to adult intensive care.
- The service training compliance on the Mental Capacity Act 2005 including Deprivation of Liberty Safeguards, learning disability and autism and dementia awareness were below the trust expected target of 95%.

Evidence-based care and treatment

- All policies and procedures used within gynaecology and maternity were in accordance with the National Institute of Health and Care Excellence guidelines or those from the Royal College of Obstetrics and Gynaecology. The standards and newly issued guidelines were discussed at monthly audit and governance meetings, which were minuted to demonstrate how the service met the minimum national standards.
- There was a process in place for audit activity for still birth, ante natal records, post-partum health records, antenatal management of reduced foetal movement, management of multiple pregnancies, management of 3rd and 4th degree perineal tears and consent in termination of pregnancy.
- Audit meetings were held monthly and learning from the audits were shared with staff at the multidisciplinary handover and governance meetings held within the service.
- The trust's Cardiotocography policy reflected the "The National Institute of Health and Care Excellence; Intrapartum care 2014" guidelines. Staff were prompted to ensure their practice was in line with the policy and were familiar with this guidance.
- The maternity service is adhering and closely monitoring The National Institute of Health and Care Excellence standard number 32: Caesarean sections. The hospital was above the England average (26%) on caesarean sections with a rate of just under 28% between January and December 2014. The rate of emergency caesareans was 16% and elective caesarean was 11%.
- Data submitted for July 2015 showed the current rate at 24% with 16% emergency caesarean rate and 8% elective caesarean rate.
- Of the six records examined three women were receiving post-natal care. The care received was in accordance with 'The National Institute of Health and Care Excellence quality standard number 37: post-natal care.'
- We examined the notes of three women receiving antenatal care and specifically looked at the compliance with 'The National Institute of Health and Care Excellence 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. In the cases we examined both had been seen in accordance with the standards.
- Within gynaecology staff assessed patients and provided care and treatment in line with recognised guidance, legislation and best practice standards. In gynaecology the termination of pregnancy care was delivered in line with the "Abortion Act 1967" and supporting guidance issued by the Department of Health.
- The process for undertaking termination of pregnancy at this hospital was good. We examined the records of two women in the termination of pregnancy service and found that all aspects of care provided met the required guidelines and that the legislation was being adhered to. The entries in the women's records was good and we were assured that women using the service received care in line with national standards.
- We spoke to specialist infant feeding staff who told us they supported new mothers to breastfeed their new babies. This showed that the trust follows National Institute of Clinical Excellence (NICE) guidelines on encouraging new mothers to breastfeed.
- The trust had identified audit activity around NICE guidelines and senior midwives or consultants were allocated this work. The directorate participated in the Growth Assisted Protocol programme to help minimise the number of stillbirths. It involves each mother having a customised growth chart and offered extra ultrasound scans to check the baby if the growth falls outside of the normal range.

- The service had reviewed the external 'Kirkup review' into women's services at the University Hospitals of Morecambe Bay NHS Foundation Trust. Learning from this review had taken place and the service had produced a comprehensive action plan following their analysis of the service and were commencing the implementation of actions to improve the care for women and babies.

Pain relief

- We spoke to five women on the postnatal ward, and five women on the gynaecology ward specifically about pain relief. Patients told us that staff assessed their pain regularly, offered them choices of pain relief when required and that these medicines were given in a timely manner.
- During our focus group for women who used services one told us about their postnatal care, "I had to ask twice for pain killers and the second time no one answered the call bell so I staggered to the Nurses station and asked there."
- We examined the medication administration records of five women and found that pain relief had been administered as required by the prescription.
- We examined birthing plans in maternity care records, which included discussion about analgesia during labour.
- The Hysteroscopy service was accessible through the gynaecology clinic and is run by a clinical nurse specialist and doctor. Pain relief was administered alongside a general 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.

Nutrition and hydration

- There were regular mealtimes with a variety of food choice. Patients all had a jug of water beside them and told us that food choice and availability was good with snack boxes offered between meals. One woman we spoke with confirmed that the food was good and she was able to ask for extra snacks, food or food when required.
- Antenatal records confirmed that staff discussed infant feeding choices and the intrapartum record included when feeding was initiated by time and type.
- 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 when applicable. We examined the records of six patients on Stanway ward which evidenced that malnutrition assessments were undertaken and food and fluid intake was being recorded.

Patient outcomes

- There were no outliers relating to maternity and gynaecology care. An outlier is an indication of care or outcomes that are statistically higher or lower than would be expected. They can provide a useful indicator of concerns regarding the care that people receive.
- The Maternal Newborn and Infant Clinical Outcome Review Programme (MBRRACE) Report for 2014 reports that nationwide the country is an outlier for perinatal mortality compared to the rest of Europe. The North-East Essex (NEE) region was reported as an Amber Outlier – up to 10% above the national rate.
- The trust monitored how many new mothers chose to breastfeed their babies on the maternity dashboard. The numbers of mothers who had chosen to breast feed was 79% between April and June 2015 but slightly less in July than the trust's target of 75% at 74% but this was higher than the England average of 66%. The four postnatal women we spoke to told us they had received good support with breast-feeding.
- National Neonatal Audit Programme (2013) shows the trust performed better than the England average on four out of five measures. The measure they did not achieve was 90% instead of 100% for a first retinopathy of prematurity screening for infants below 32 weeks gestation or the baby weighing 1501g at birth.
- Audit results for antenatal care demonstrated that 93% of women were seen for antenatal screening at 12 weeks compared to the required standard of 90%.
- Of the 3,719 births last year 483 (13%) of these were delivered in the midwifery led unit and 74 (2%) were home births. Community midwifery staff told us they were working hard to improve the choice of home birth, out of hours and at weekends.
- Between April 2015 and July 2015 there were four stillbirths. Each stillbirth was reviewed at the maternity audit meeting and as part of the annual audit on

stillbirths. All identified clear reasons for the stillbirth and lessons to be learned. The process for the review of stillbirths and post delivery bereavement was robust and well evidenced.

- Of the eleven quality indicators set by the Royal College of Obstetrics and Gynaecologists Colchester General Hospital was performing in line with or better than the England average on 9 of the 11 indicators. The service performed better than the England average with 16.3% emergency caesarean section rates (England average 17%), 11.3% elective caesarean rate (England average 12%), 11% instrumental deliveries (England average 24%), 4% third and fourth degree tears (England average 7%)
- The trust does not currently monitor or submit the data for emergency maternal readmissions within 30 days of delivery.
- The ventouse delivery rates with 57% were worse than the England average of 49%.
- Between January 2015 and April 2015 there were 1,175 deliveries, of which 44 (just under 4%) of these cases had a post partum haemorrhage.
- The service monitors the number of haemorrhages, which take place in the service through the maternity dashboard and assess themselves against the RCOG Management of PPH (No. 52) 2009. Between January and July 2015, the service rates were between 8% and 12% with July 2015 being the highest reported month against their local benchmark of 15%.
- 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 conversion rate for women planning to have a vaginal birth after caesarean (VBAC) was not available to us during the inspection.
- Between January and July 2015 there were nine recorded cases of sepsis in maternity. All cases were investigated and presented at the maternity clinical audit meeting for learning.
- The gynaecology ward Stanway ward's sepsis rates and audits are monitored through the trust dashboard. The only cases to have occurred on the ward over the previous 12months were for medically outlied patients with no cases being reported for gynaecology patients.
- Between May 2014 and April 2015 there were nine unplanned or unexpected admissions of new mothers to intensive care. These cases are reviewed within the maternity services clinical audit meeting and declared internally as serious incidents requiring investigation. The learning from these investigations is then shared through governance meetings.
- Between May 2014 and April 2015 there were 209 unexpected admissions to the neonatal intensive care unit (NNU). The service has a local benchmark of 12 admissions or less to the neonatal intensive care unit (NNU) per month, however the service did not achieve that at any time between January and July 2015. June was the highest reported month with 21 unplanned admissions to NNU.
- The service was a Level 3 baby friendly initiative (BFI) maternity service.
- The hospital scored above the national average for cleanliness and food and hydration in the Patient Led Assessments of the care environment (PLACE).

Competent staff

- Records confirmed that 95% of staff currently working in the service had completed an appraisal within the past 12 months. Of those that were not on the list and had not had an appraisal it was for reasons such as long term sickness or maternity leave.
- The ratio of midwives to Supervisor of Midwives (SoM) was 1:15 in line with the recommended ratio of 1:15.
- Practice development midwives (PDM) provided evidence of completed midwife training including emergency skills and drills training.
- We saw a template for midwifery support worker orientation, training and competency assessment manual. This meant the service prompted staff insight into their required development opportunities.
- Staff told us about the creation of a specialist midwifery team to support patients with particular vulnerabilities including a perinatal mental health maternity lead and a CTG midwife trainer, due to commence after the inspection.
- Staff on Stanway ward had received specialist training in areas identified to care for patients from medicine or surgery.
- The clinical nurse specialist staff were trained in providing procedures in the gynaecology clinic; for example in family planning and administering termination of pregnancy medication.
- Staff told us that they were supported to gain additional qualifications and to maintain their professional development.

- The midwives had commenced monitoring and supporting midwives to go through revalidation with the Nursing and Midwifery Council (NMC).
- All medical staff within maternity and gynaecology were appraised and had undertaken revalidation with the General Medical Council (GMC).
- Community midwives had provided cover for the wards when they were short staffed and busy. This meant that Community midwifery staff were able to maintain their skills and knowledge when working within the hospital environment.
- There was individualised care plans which identified what care should be given. This meant that agency nurses who were new on the wards had access to information on how to care for the patient.

Multidisciplinary working

- We observed that staff worked effectively together, both internally and in the community. There were detailed multidisciplinary team meetings, which ensured effective care and treatment plans.
- During the inspection a multidisciplinary handover was observed on the delivery suite which supported patient care and handover was comprehensive.
- We spoke with staff from other directorates about working relationships with maternity and gynaecology services and found they worked well together. There are established networks
- What about working relationships with community services and trusts?
- Staff reported to us that their working relationship between the service and Clinical Commissioning Group (CCG) had improved and shared their plans with the CCG with us as an example of how they were trying to work together.
- The gynaecological ward staff described good engagement with medical staff but confirmed delays in the patients outside of gynaecology services being seen until all ward rounds were completed across the trust.

Seven-day services

- The midwife led birthing unit was open seven days per week and was located within the main maternity service.
- Community units in Harwich and home births were also available at weekends and out of hours dependent on community staff availability.
- Medical staff were on call 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 (COW).
- There was an obstetric trained anaesthetist available on site seven days per week and on call out of hours at all times.
- Antenatal services were only available Monday through Friday. The emergency pregnancy assessment unit was open seven days per week with support from the emergency department. There was a supervisor of midwives (SOM) available 24 hours a day, seven days a week through an on-call rota system. This ensured that midwives had access to a SOM at all times.
- 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 a on call pharmacist to dispense urgent medicines.

Access to information

- Staff had access to computer systems including test results, diagnostics and records systems.
- IT access included access to policies and procedures for internal staff.
- Records were readily available to staff to refer to during the time of a woman's admission.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We spoke with five women in maternity services who confirmed they had received clear explanations and guidance about the surgery and said they understood what they were consenting to. However one woman in maternity told our focus group, "I was told I needed surgery and was bombarded with information which at that point I couldn't fully understand. I was given a consent form to sign but quite honestly I didn't know what I was agreeing to".
- Stanway ward staff were clear about 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.
- Training on consent, the Mental Capacity Act, Deprivation of Liberty Safeguards (DOLs) and learning disability was part of mandatory training for all staff. The training records showed that 62% of medical staff and 73% of nursing staff had receiving training in learning

disability and autism. For mental capacity training 81% of medical staff and 49% of nursing and midwifery staff have received training. Deprivation of Liberty Safeguards training had been attended by 80% of medical staff and 81% of nursing and midwifery staff. Dementia awareness training had only been received by 57% of medical staff and 25% of nursing and midwifery staff.

- The trust had policies in place regarding these subjects and they were accessible to staff via the intranet.
- Within gynaecology we examined two consent forms for women who were schedule to undergo either surgical or medical termination of pregnancy. This process occurred over two appointments and allowed the women to make an informed decision by allowing them time to think about their options.
- Of the two consent forms examined both had followed the trust's policy on decision making, all were signed by the consultant and all were signed by the women. The women then had a further discussion with the doctor prior to proceeding with the procedure.
- We asked the trust for their most recent audit on consent for termination of pregnancies however we were informed that one had not been completed.

Are maternity and gynaecology services caring?

Requires improvement

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

- Feedback from people who use the service, those who are close to them and stakeholders was mixed about the way staff treat women. Women were positive about some of the care provided, however we received several comments through our dedicated women's focus group about poor attitude of staff providing care to mothers, particularly on the postnatal ward.
- We held a dedicated focus group for 30 women in the community who were first time mothers/mothers nearing due date to share their experience of using services with us within the last year. Of those we spoke with 10 women and their partners raised concerns about the care provided to them following the birth of their child.
- The feedback received from the women was mixed about their experience.
- The service has a gone through phases of receiving good comments and negative comments about care on the Friends and Family Test and the feedback from women over the last year has not been consistent.
- The response rate at 11% for the Friends and Family test was also lower than the England average of 22%.

However we also found:

- The care we observed during the inspection showed women being treated with dignity and respect. Women told us they felt informed about their care and they were given written information about their choices.
- The 2015 maternity survey results were in line with the England average on all areas.
- On Stanway ward and in the gynaecology service we observed that the staff providing gynaecology care were dedicated, compassionate, caring and tried to deliver the best experience possible for the women despite the pressure the service was under.
- Women, their partners and families were active partners 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 good with clear process, systems and access to specialist support services available.

Compassionate care

- The maternity service Friends and Family test was based on a response rate of 11%, which was significantly lower than the England average of 22%.
- The scores demonstrated that the service performance on the friends and family showed a score of 100% scored on the antenatal experience, 96% on post-natal care, 100% on postnatal care in the community and 94% on labour/ birth experience. Overall 94% of people would recommend this service to their friends and family.
- The CQC maternity survey results published December 2015 showed that the trust performed about the same on all questions when compared to other trusts in England.
- On Stanway ward there was a 40% response rate to the Friends and Family Test in July 2014 with 99% of people recommending the service to their friends and family.

Maternity and gynaecology

- We spoke with 20 women who used the maternity services at Colchester General Hospital during our inspection, all of whom told us staff were caring, respectful and friendly.
- We held a dedicated focus group for 30 women in the community who were first time mothers/mothers nearing due date to share their experience of using services with us within the last year. All had used services and given birth at Colchester General Hospital including ante natal/delivery/post natal/appointments for check-ups and /or investigations.
- The feedback received from the women was mixed about their experience. Women spoke highly about their antenatal care and the care received during labour and the birth in the majority and we were told, "My experience of the Delivery Suite was wonderful", "Triage is good and they have time for you and listen", "The midwives I had went the extra mile I thought", "I think the care I got was wonderful".
- Other comments included, "I wanted a water birth and the support was amazing. I was asked if a trainee could attend and I agreed. It was all positive", "The student midwife saved me – she used to be a breast feeding counsellor and she knew how to put me at ease so I wasn't under any pressure and took time to talk me through and helped me", "the consultant reassured me all the way through. Everything was explained to me to make sure I understood", and "I was allocated a specialist diabetic midwife who was exceptional", My experience was really good".
- However concerns were raised to us by ten of those women about their experience. One woman told us, "My baby was having difficulty latching on. The night Midwife said to me 'you're going to have to cope, you're a mother now' I was very upset and hurt by her lack of care and compassion for me, another new mother came to comfort me."
- Another woman told us, "I know there had been pressure all the way through to breast feed and they talked about a 70% target. I could not stay any longer and so I discharged myself. It felt like a prison".
- Another woman told us, "This Midwife was quite grumpy and wouldn't let anyone pick up my baby even though I said they could. I couldn't pick her up so I needed help. As it was my first time I felt overwhelmed".
- Another woman told us, "Over 6 days I saw lots of people and it was tiring and intrusive. I got upset and frustrated. Copious notes but no one read them".
- Another woman shared with us, "The midwives/nurses wouldn't listen to me. I had been taking tablets, which they took off me, the Doctor wanted me to have them back the Nurses didn't and they argued about it over my bed – I was appalled. No one asked me what I wanted."
- Another woman told us that they were concerned for the shape of their babies head and said, "I have not been getting the reassurance I need."

Understanding and involvement of patients and those close to them

- We spoke with four women within the service who were able to identify their named midwife and confirmed that they had been accessible throughout their pregnancy.
- Patients and their families said they had been fully involved and felt included in caring for their family member.
- Patients said that the doctors had informed them of their diagnosis and were fully aware of what was happening.
- All patients were complimentary about the way in which they had been treated and spoken to.
- We observed doctors and nurses introducing themselves to patients using the "my name is" approach.
- We received some mixed feedback from women who used the service during our focus group held in the community, one woman told us, "I was induced on the Ward and not much was happening so they said I had to stay in overnight. I asked if my partner could stay with me and they said no, I was awake all night. It was the scariest and loneliest night of my life."
- Another woman told us, "There is too much variation in the information being provided by different midwifes. They don't seem to communicate with each other about the patient and their specific needs".
- Another woman shared with us, "At 11pm I was getting strong contractions and my partner called one of the midwife's. She didn't even check me, said I couldn't be in labour and gave me some paracetamol. At 12.30am another midwife came and after checking me said 'you're in labour you should have gone down an hour ago' I knew I was in labour but she didn't believe me. The staff on the ward didn't listen to us".

Emotional support

Maternity and gynaecology

- We observed kind, caring compassionate interactions by the midwives who were clearly trying to provide the best experience possible to delivering the care the women need before during and after their birth whilst we were inspecting.
- Within gynaecology the service provided women with the opportunity to meet the staff and discuss their case prior to making decisions regarding a course of treatment or termination of their pregnancy. The women were able to hold further discussions with staff and ask any questions they may have regarding the procedure or process prior to agreeing the best course of treatment. This meant that it was clearly understood what the woman wanted.
- Within maternity, gynaecology and the termination of pregnancy service staff had thought and considered all aspects of emotional care and support that would be required to women who lost a baby.
- The dedicated specialist bereavement midwives work with the obstetrics and gynaecology counsellor to offer bereavement support. A midwife was allocated to care for the woman and family on a one to one basis. Individual and cultural practices were respected in relation to the bereavement. We saw memory boxes and 'when a baby dies' and 'Goodbye' parent information leaflets when visiting the Rosemary suite.
- A counselling service could be accessed for staff and patients. Staff had been trained in counselling techniques to help 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.

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:

- The service had responded to the changing demand for the service by refurbishing the environment including adding an additional theatre to meet the needs of women electively and in an emergency.
- Access to the service was through a simple route, which enabled women to be seen by the medical teams soon after arrival.
- The waiting times for emergency and elective gynaecology were good and meant that patient's pathways were generally delivered within 18 weeks.
- Bed occupancy for the service was consistently better than the England average, though some concerns were raised about the length of time a woman stayed in hospital prior to being discharged home with their baby.
- The service offered a range of birthing options to women including a new hypno birthing technique which offers natural birthing with limited medicinal input to pain relief, water births and home births.
- The service had good access to the specialist nurses available to support learning disability and mental health needs and in gynaecology the team received support from the Dementia specialist nurse.

However some improvements were required because:

- The service needed to improve the processes in place for investigating, responding to and managing complaints. The service monitors its complaints and offers a response however the responses were not always personalised or showed a level of care or understanding to the to the women's concerns to find a suitable resolution.
- Lexden ward providing care to both ante and post natal women in the same environment is not always responsive to individual needs.

Service planning and delivery to meet the needs of local people

- The service was continually monitoring its birth rates through the maternity dashboard, and had recently undergone an extensive refurbishment programme to cope with the increased demand in service need.
- Women had a choice of planned care which was set up to meet the needs of the local people. This included community services on the coastal areas, in the traveller communities and in the more urban areas to reach those groups defined as 'at risk'.
- Women had the options of midwife led care, for low risk or consultant led care for high-risk pregnancies. A home birth service was available to enable people who use the service to have a birth choice.

Access and flow

Maternity and gynaecology

- The care pathway was decided at the first booking appointment and dependent on what was the most appropriate form of care women were enabled to change their pathways of care throughout their pregnancy between midwife led, water births, home births or consultant led births. This was discussed regularly based on the needs of the woman throughout their pregnancy.
- Women who presented through emergency department out of hours were referred to the Early Pregnancy Unit (EPU) where support from gynaecology was available 24 hours per day. Women who require gynaecological care or early pregnancy care were sent to Stanway Ward.
- During an operational bed meeting we observed discussions between the leads for gynaecology and the operational management about bed space. We observed that women with gynaecological conditions were prioritised to be admitted to Stanway ward, which was positive.
- Within the community the maternity team knew with each general practice (GP) surgery who their named community midwife and health visitor was. We spoke with four women and all knew who their named midwife was and confirmed they had been able to contact their midwife for advice during their pregnancy.
- Bed occupancy for the service has mostly been in line with or better than the England average (65%) since 2013 with an average occupancy of 61%. Their lowest occupancy was 59% in quarter 2 of 2012/13 and their highest was 66% in quarter four of 2014/15.
- The service has closed to admission in one occasion for 36 hours within the last 12 months which was due to capacity issues within the Neonatal service.
- There was no definitive policy for appropriate times for women to be discharged home from the maternity unit. Women could be discharged at any time of the day with their agreement and confidence after a newborn successful feed, a full postnatal check and any identified parent support required.
- We requested for the numbers of women discharged between 10pm and 7am however this data was not provided.
- During our focus group for women who used the service one woman told us, “Although I was expecting to leave as soon as I possibly could but it was a surprise that they discharged me at 5am in the morning. I was not happy to be discharged at 5am; and the fact they did not show me how to breast feed him. I wasn’t happy they gave him formula milk”.
- We asked about women who attend the service who are from outside of the north Essex catchment area and we were told the delivery suite would contact the patients ‘booked’ hospital. This ensured staff liaised with other agencies who may be involved in a woman’s care.
- The refurbishment of the delivery suite created one additional obstetric theatre area, which meant that if an emergency occurred whilst an elective procedure was taking place the emergency was not delayed.
- Maternity and gynaecology services have access to the critical care outreach team and intensive care services should a woman’s condition deteriorate.
- The Referral to Treatment Time (RTT) for admitted and non-admitted gynaecological patients in August 2015 was 93%. Referral to Treatment Times (RTT) mean that patients have the right to start their NHS consultant-led treatment within a maximum of 18 weeks from referral and the England benchmark to for each trust to achieve is 92%.

Meeting people’s individual needs

- The service offered a dedicated class and birth pathway for women using ‘hypnobirthing’ techniques which supported pain management with minimal medicinal support offered. The service was well received by women who used the service.
- Lexden ward is a mixed ante and postnatal ward at times of high demand. This mix of patients groups in the same environment would not be responsive to the needs of women who may be emotionally affected their conditions.
- In the event that a patient’s first language was not English staff had access to language line and could access an interpreter service twenty four hours per day.
- Leaflets for patients were 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.
- To support patients who live with Dementia who are admitted to Stanway ward all trust employed staff on the ward have had Dementia awareness training.

- The specialist team consists of midwives who lead in the areas of safeguarding, vulnerable woman and teenage pregnancies.
- Four staff spoken to on Stanway ward and Lexden ward 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, which enabled staff to meet their needs.
- Staff on the postnatal ward described how women whose babies had to be looked after in the neonatal intensive care unit (NNU) were looked after in allocated side rooms to reduce further distress from other crying babies and allowed for them to rest.
- Staff described how bereaved parents were looked after within the Rosemary suite based on the delivery unit. For example a family recently stayed in the Rosemary suite with their older child who wanted to say goodbye to their still born sibling.
- Termination of pregnancy clinics were only available one morning per week which meant that there were limited options and choices available to women.
- The termination of pregnancy service was medically offered up to ten weeks and then surgically up to 14 weeks. Terminations post 14 weeks were outsourced to a private healthcare service in the area.
- Women who miscarry are admitted to Stanway ward, however we received several concerns prior to and during the inspection from women who did not feel it was appropriate to be on a ward miscarrying with medical outliers in the same area with different needs. For example one women explained to us (who was medically outlied to the ward) that they could not call for help or "make a fuss" about their pain because of the woman in the bed next door who was emotional from miscarrying their baby.
- We reviewed the processes for the ethical disposal of products of conception as part of this inspection. A clear protocol had to be adhered to, to ensure that the products could be disposed of in line with national guidelines. This process ensured that the service had agreed with the women what they would choose as a process for their product of conception.
- Options of cremation and burial were offered as options and where a woman chose not to be involved in the decision the trust chose cremation of remains as the preferred route.
- The service had been inspected by the Human Tissue Authority in September 2014 on the management of remains and products of conception, this review did not identify any concerns in relation to this process.
- Staff wore coloured role specific lanyards but no visible signage identified the uniforms explaining their role for patients and visitors.

Learning from complaints and concerns

- Literature and posters were displayed across all wards, advising patients and relatives how they could raise a concern or complaint either formally or informally. However one woman told us during a focus group, "I felt I had been treated badly" but did not want to complain about the service as they worried how this would impact on their future care in the service.
- Reported complaints were handled in line with the trusts policy. Staff directed patients to the patient advice and liaison service (PALS) if they were unable to deal with their concerns directly.
- Between February and July 2015 the service had received 18 complaints. The complaints raised related to staff attitude and patient information. The majority of the complaints from patients were related to poor communication or delays in treatment.
- We saw that complaints about gynaecology, maternity and early pregnancy assessment unit were investigated and responses were written and sent to the complainant. However on review of the complaints the tone of the responses, the level of empathy and understanding shown to women was not consistent and therefore the way in which complaints were dealt with was not always responsive. The trust has recognised that responses to complaints was an area which requires improvement throughout the trust.
- Learning from complaints was shared through the directorate and staff could articulate complaints that they were aware of. One staff member discussed the recently closed case with the Parliamentary Health Service Ombudsman (PHSO) complaints at the time of our inspection this complaint was closed but not resolved.
- We spoke to the Head of midwifery about complaints and concerns and they informed us that governance system in maternity including complaints was a priority area for improvement.
- The approach described by maternity and gynaecology staff when dealing with women showed that staff had a

genuine desire to provide appropriate care and address any concerns before they escalated to complaints. This was made more difficult as observed during the inspection when PALs staff did not escalate a relative concern immediately back to the ward staff.
- Lessons learned from complaints were shared in the monthly publication of 'Women's Stories' which featured the complaint as relayed by the patient in their own style of language

Are maternity and gynaecology services well-led?

Good

The maternity and gynaecology service leadership locally was rated as good because:

- Staff spoke positively of the clinical leads for the service and how involved and approachable they were which created an open culture. Staff told us they felt supported and inspired in driving the service forward and described how their objective was to be an outstanding service.
- The service worked well with engaging with the women who live within the catchment area and link up with the local and mother and baby groups to seek feedback on services provided by the hospital.
- There was a vision for the trust which was called 'At our Best' and this was displayed throughout the hospital during our inspection.

However there were some areas that could be improved because:

- Staff we spoke with throughout maternity and gynaecology they were not all familiar with the values of the trust or the 'at our best' principles.
- There was no specific strategy for maternity and gynaecology services there was a link for the service to the overall trusts strategy but further work to define this was required.
- Governance and risk management systems within maternity and gynaecology services were well established but required some refinement around aspects of governance arrangements to link into the trust board and also with regard to learning from incidents and complaints.

Vision and strategy for this service

- The trust's vision and values posters were displayed throughout the walls of the services we visited. The trust used a campaign called 'At our best' which was to encourage staff to be at their best.
- Staff were not all familiar with the values of the trust or the 'at our best' principles and the trust had provided them with small printed cards with these printed on to act as a reminder to staff and to share with the inspection team.
- All staff expressed a positive attitude to the CQC inspection and showed us the trust cards given to them to remember the trust values and vision.
- Maternity services had benefited from investment in the in-patient environment and there was a maternity services objective, which linked into the trust's quality improvement strategy.

Governance, risk management and quality measurement

- The service risk register we examined dated August 2015 identified 10 current risks. These risks were monitored and featured in the maternity services risk management newsletter for all staff awareness.
- Of the risks six were related to maternity and four were related to gynaecology, the gynecology specific risks included three related to staffing levels and one related to the termination of pregnancy service.
- The risks identified out of date equipment and equipment, which has not been calibrated and therefore may not provide accurate results, trends from serious incidents leading to harm and staffing. All risks were current and regularly monitored with up to date actions and progress clearly detailed.
- The trustwide risk management arrangements were being reviewed with the recent appointment of the director of governance and risk along with the Board Assurance Framework (BAF) so it was not yet clear how the risk register for maternity would feed into the board assurance process due to the infancy of the new governance structure.
- The service held monthly governance meetings where quality issues such as complaints, incidents and audits were discussed. Staff were able to identify incidents and how they were shared with others during team meetings.

- The service had one main action plan, which combined the identified concerns from a CQC inspection in 2012 and Keogh review of 2014 and a review by the Royal College of Obstetricians and Gynaecologists. This action plan had been agreed through the local commissioning group and was routinely monitored at the directorate governance meeting to ensure continual progress is made.
- The senior team within maternity and gynaecology review reported incidents daily and themes were collected and presented at the service governance meeting. An example of an improvement leading on from this review is the appointment of a lead midwife for perinatal mental health and CTG training.
- All trusts are required, when they undertake a termination, to submit a form to the Department of Health, which is known as a HSA4 notification form. The report we examined demonstrated that for all the surgical and medical terminations between 01 April to the 30 September 2015 the service submitted 391 forms, which matched the total number of procedures undertaken. This meant that the service routinely reported all terminations to the Department of Health in accordance with the Abortion Act 1967.

Leadership of service

- The leadership of the service consisted of a clinical director, clinical lead, head of midwifery and associate director of operations. This followed the executive agreement to separate the role of the head of midwifery from the business role.
- The clinical lead, operational lead and head of midwifery were very respected amongst their teams and worked well together. Staff working within the units recognised who the leads for the service and clinical leads for specialties were.
- The leadership for gynaecology had recently changed with the responsibilities of gynaecology now with the acting head of midwifery and the clinical director. The gynaecological ward was locally well led by an experienced ward manager.
- Staff we spoke felt that the executive team were not all visible or accessible but staff felt well supported within the service and through their local leadership team.

Culture within the service

- The culture within maternity services was open and promoted supportive relationships between staff and patients. There was a willingness to learn from what worked well and what did not work well and a willingness to tackle concerns when raised.
- Staff informed us that they were 'passionate' and 'driven' to provide good care to patients but felt that this could not always be given due to the pressure of work, which was an issue recognised by the executive team that the pressures to deliver the care was high but staff were trying.
- We spoke with eight members of staff about the culture and they told us that they believed the staff worked well together as a team, the morale had improved over the previous six months and said they were proud to work for the trust.
- There was a whistleblowing policy for the trust. The trust board has recognised that it is still in the process of building trust with the staff to enable them to speak openly.
- The executive team encouraged staff to raise concerns through an open or anonymised route, but recognised there was still some way to go with this.

Public engagement

- The maternity services used a variety of communication methods on the trust website. The service also used social media to encourage involvement and feedback from women who used the services.
- The maternity services liaison committee (MSLC) was chaired by the clinical commissioning group (CCG). The maternity services liaison committee was a multidisciplinary meeting forum that included patient representation and worked to develop the service to meet the needs of women in the local area, which was good practice.
- A senior manager told us there was limited attendance from women who used the service. The midwives have proactively sought service users' opinions by holding an offsite coffee support morning to try and gain feedback where possible.
- Midwives were actively reaching out to pregnant women to promote the midwife led unit (Juno suite) through on-line information and social media. The website has a virtual tour of the delivery suite before its refurbishment.
- The "women's stories" monthly publication identified 96 compliments received over the last five months.

Maternity and gynaecology

Staff engagement

- The maternity and gynaecology leadership team encouraged innovation and in making changes. Staff told us they had been empowered to raise areas they wanted to identify as areas for improvement for shared learning amongst the teams and were encouraged to attend risk audit and governance meetings to participate in the improvement of service delivery.
- Staff development days include intrapartum care monthly forums, unit/ward meetings and case review meetings. Gynaecology staff spoke about the opportunity they had to work at a nearby trust to improve their knowledge and build on network opportunities.

Innovation, improvement and sustainability

- As an area of innovative practice the service introduced a hypnotherapy birthing service known as 'Hypnobirthing' which is a complete antenatal programme focussing on a combination of education, self-hypnosis & deep relaxation to help achieve a more comfortable birth. Hypnobirthing gives parents all the tools they need to minimise the fear-tension-pain cycle, resulting in shorter, more comfortable births.

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 emergency department. It has the capacity for ten patients, with eight beds and two side rooms and has one consulting room.; The ECU has the capacity for ten patients comprising of one six bedded bay and one four bedded bay. The children's ward has 24 beds across three four bedded bays and 10 side rooms; This includes two commissioned high dependency beds. The children's unit is located adjacent to the children's outpatients department. There is a level two neonatal unit for babies requiring short-term intensive care with 17 cots, inclusive of one cooling cot, four high dependency cots and 12 special care cots.

During the inspection, we visited the neonatal unit, the CAU, the ECU, the children's ward, theatres and recovery, intensive therapy unit (ITU), emergency department and the children's outpatients department.

We spoke with 16 children and their parents or guardians, 29 nursing staff, 13 medical staff, three play therapists, one health visitor, and four administrative and managerial staff. We reviewed 39 sets of medical records and information requested by us and provided from the trust.

The inspection encompassed the complete service including the transition arrangements for children transferring into adult services and the provision of care for children with long term conditions such as diabetes, epilepsy and asthma.

Services for children and young people

Summary of findings

Children's and young people's services at this trust were rated as good overall with safety being rated as requires improvement. High numbers of medication errors, inconsistency in hand hygiene compliance, the understaffing of qualified nurses and allocation of children to adult wards without appropriate risk assessment and outside trust policy meant that safety required improvement. Information links between the trust and other providers that shared care for some patients was not robust and readmission rates for some patients with long term conditions were high. Three staff members indicated that the reputation of the trust was not reflective of the good care that takes place in children's and young people's services. This indicated a disconnect between children's and young people's services and the rest of the trust which could make sharing of learning and communications less effective.

Children's and young people's services had a good incident reporting system that was understood by staff and there was evidence of scrutiny and learning from incidents and risks. Medicines and controlled drugs were stored safely. Data showed that staff completed their mandatory training and clinical competencies were regularly checked and updated, medical staffing levels were adequate to provide safe care and there was a robust integrated care pathway for children in place. Clinical audit was conducted, reported and learnt from and was co-ordinated by a lead physician. Caring was good with overwhelming positive feedback from patients and carers and positive interactions seen. Children's individual needs were met with good play provision and bespoke facilities such as a sensory room. Referral to treatment times was consistently within the 18-week target and there was an embedded respect for the matron. Leadership of children's and young people's services was good. Staff were engaged and informed, for example, staff received debriefing after unexpected events.

Are services for children and young people safe?

Requires improvement

Children's and young people's services at this trust were rated as requires improvement for safety because:

- There had been nine incidents of children being admitted to adult wards against trust policy under the care of staff who were not all compliant with safeguarding children's training and immediate life support training, and without appropriate risk assessments being completed.
- There was inconsistent provision of the appropriate level of safeguarding training for staff working within the service because not all healthcare professionals had received level 3 training.
- Compliance with hand hygiene levels were not consistently met
- Over a quarter of reported incidents between June 2015 to August 2015 were medication prescribing and administration errors.
- Nursing staffing was consistently below the required establishment and there was inconsistency in staff awareness regarding major incident processes.

However we also found:

- Staff were aware of how to report and escalate incidents and there were structured monthly governance meetings and risk management weekly meetings with the trust's risk management team and divisional leaders to identify learnings.
- There was a provision for the care of young women and girls who had endured female genital mutilation (FGM).
- Daily check lists for equipment, resources, and drugs including controlled drugs took place, ensuring that any issues were identified quickly.
- Staff were aware of who the safeguarding children's champion was, as well as the named nurse for safeguarding children.

Incidents

- No never-events were reported within the 12 months prior to April 2015.

- No serious incidents were reported from July 2014 to June 2015. Since July 2015, five serious incidents had been reported, one in July 2015 and four in August 2015.
- The latest serious incident was still in the investigation stage at the time of our inspection. The four remaining serious incidents related to the transfer of care to another provider, an unexpected admission to the neonatal unit, inappropriate prescribing of a drug, and the absconding of a patient from the ward. All four incidents had reports completed that highlighted learning and changes to be made to decrease the risk of these events reoccurring, including the provision of bespoke training for vulnerable adolescents, increased prescribing support for junior doctors, added teaching for senior house officers joining the children's and young people's services rotation, and the revision of processes for transfer of care to teams in other trusts.
- Staff were aware of how to report and escalate incidents. There was an awareness of incident themes amongst staff, and staff from all areas referred to medication incidents being highlighted at service level. This indicates that communication and learning was taking place. There was a folder seen in the staff room of the children's unit that contained all relevant incidents and complaints with outcomes for learning. Relevant documents had a signing sheet for staff to sign to say that they had read the document.
- The investigation of incidents took place in a timely manner. There were 98 patient related incidents for the period February 2015 to May 2015 with 9% or nine out of these 98 not having been actioned yet. A monthly governance meeting was held for children's and young people's services, to discuss incidents, with representation from medical, nursing, audit and risk management staff and the clinical lead. There was evidence in the minutes that incident themes and actions were discussed alongside associated action logs and plans for the dissemination of any relevant learning.
- The recorded incident data included the details of each incident, the date, the location, the level of harm and all associated actions. Seven incidents were checked at random to ensure they had been correctly classified and all were correct according to the Serious Incident Framework published by NHS England.
- There was a policy and process in place for ensuring duty of candour. Under duty of candour, the trust has the responsibility to ensure any incident resulting in moderate or severe harm ought to be communicated to parents of children. All four of the completed reports for the serious incidents between July and August 2015 noted communications with the parents of the children involved. Information posters were on display throughout the children service regarding duty of candour responsibilities.
- Data from the mortality and morbidity report, which measures numbers of deaths and the causes of deaths, for the period September 2014 to August 2015 showed eight child deaths, four of which were expected deaths with two occurring at home. Of the remaining four deaths in the hospital, two were awaiting post mortem reports and two were confirmed to be due to sudden infant death syndrome. This meant that it was unlikely that there were any trends of disease causing deaths in children in the trust.

Cleanliness, infection control and hygiene

- There were strict processes in place to prevent the potential spread of methicillin resistant staphylococcus aureus (MRSA). Testing for MRSA was standard, if a child had previously tested as positive; they were nursed in a side room until two negative results had been obtained. Improvements to infection prevention and control had taken place across children's services. An environmental cleaning audit for the period December 2014 to May 2015 showed one area of noncompliance in the children's and young people's outpatients department in January 2015 but this had improved and was compliant after this date.
- Monthly infection prevention and control (IPAC) audits took place in the children's unit, the results of which were submitted to the IPAC team who would feedback results and identify themes. The audit included factors such as hand hygiene; standard precautions; care of peripheral vascular device insertion and continuing care; patient equipment; and environment. The February 2015 audit of the children's assessment unit and the children's elective care unit showed that compliance was not achieved in the following areas: hand hygiene; standard precautions; and patient equipment.
- An action plan was in place to enable the areas audited to reach full compliance and improve patient safety although there was limited data at the time of inspection to assess the impact of this. The only data we

were provided was on hand hygiene, which showed that between June and August 2015 hand hygiene compliance had improved with the service achieving 99%-100%.

- A monthly infection prevention and control 'safety cross' was on display in the neonatal unit. This cross demonstrated how many days the unit had been free of infection outbreaks such as methicillin-resistant staphylococcus aureus (MRSA) and clostridium difficile (c diff) that month, in this case every day had been free of these infections.
- Both the neonatal unit and the children's unit contained equipment that had dated green 'I am clean' stickers once they had been cleaned, this meant that it was clear as to when equipment was last cleaned.
- Staff in all areas adhered to trust policy for "bare below the elbows" and washed their hands between contacts with patients to reduce the risk of infection Personal protective equipment (PPE) such as aprons and gloves were available. Staff in the neonatal unit were observed to wash hands and wear the appropriate PPE prior to commencing a feed

Environment and equipment

- There were three resuscitation trolleys located within the children's unit, one in the children's outpatients department, one on the children's ward and one located between the elective care unit and the children's assessment unit. Staff checked the trolleys daily and signed and dated a checklist, which was kept in a folder on the trolleys. The drawers of the trolleys were locked and secured by plastic tags that were identifiable by serial numbers and these were replaced and recorded daily as items in drawers were checked. Items with 31 days or less until their expiry date were noted on the checklist daily until stock was available to replace them. All items that we checked were in date. The resuscitation trolley on the children's ward was co-located with a defibrillator that was also checked daily, confirmed with signatures and dates. This defibrillator was the only one in the children's unit, meaning that staff on CAU and ECU would have to access the children's ward for the defibrillator should they require it on their units. Whilst this had never been an issue a risk assessment was not available in respect of this.
- Intraosseous vascular access devices were accessible on the three resuscitation trolleys. All registered nurses had been trained in the use of the device and had annual updates provided by the practice development nurse within the paediatric immediate life support training update.
- There was an equipment log on the neonatal unit (NNU) demonstrating what equipment was on the unit and when it was last safety checked by an engineer. The equipment log for the children's unit, inclusive of the ECU, CAU and children's ward, was requested; however, this was not submitted to us. Play equipment in the playrooms was visibly clean, although not all equipment was working. For example, a games console in the outpatients department waiting area was not working when a child attempted to use it.
- Entrance to the neonatal unit (NNU) and the children's unit was secured by buzzer entry. This meant that staff controlled the access to these units, which increased patient safety and reduced any security or abduction risk.
- There was direct access between the adult's outpatients department and the children's outpatients department. This presented a security risk to the children attending the outpatients department; the access door between the departments being locked at all times mitigated this risk. The department had nine consulting rooms and one treatment room.
- Faulty equipment was managed appropriately on the NNU. The contact numbers for the company responsible for the maintenance of equipment were printed out for ease of access. Two incubators that would not calibrate were discussed at handover in the equipment review. These two incubators were capable of delivering ambient oxygen and were calibrated on every shift. On one recent shift, both refused to calibrate in air. These incubators were taken out of service for babies who needed or might need ambient oxygen and warning stickers were applied to them stating that the incubators were to be used as "hot boxes" only. Equipment was ordered for the two oxygen analysers to replace the faulty ones so that the incubators could be used again.
- Certain essential equipment, such as the blood gas machine on the NNU, was under lease. There were processes in place to ensure regular calibration and maintenance of these items. Staff were aware of contact details for the company that provided a call out system to ensure the equipment was available at all times.

- There were two resuscitaires on the NNU for the performing of emergency clinical interventions on babies; one was used as a cooling cot and the other for the performing of procedures or interventions where appropriate access cannot be gained when the baby is in an incubator. The resuscitaires were calibrated and maintained by the same contracted company attending the unit weekly, ensuring that prompt action was taken in the event of a fault occurring.
- We randomly selected 25 different items of consumable stock, such as syringes, on the NNU, for integrity, sterilisation and expiry date, all of which were in date which meant that stock was rotated adequately and fit for purpose
- Saturations monitors, apnoea monitors and breast pumps on the NNU that were available had no known expected date of service and no consistency in the recording of last service date. This meant that there was no assurance that equipment used was safe and fit for purpose.
- There was a daily environmental checklist on the neonatal unit that checked issues such as equipment, drugs, and staffing levels. All entries were signed and dated.
- Two sets of height and weight measurement equipment and three temperature machines were all in date for service and maintenance. Three sets of suction equipment out of ten in the children's ward side rooms were tested and worked appropriately, indicating the suction equipment was fit for purpose.

Medicines

- A quarter of all incidents between June 2015 and August 2015 and had been reported as medication related incidents. Due to this high number, medication errors were noted as a risk and put on the risk register. The practice development nurse was developing additional training to reduce the rate of medication administration errors. This was a recent mitigation and a reduction had been seen in the numbers of incidents in the month of May 2015, which was the most current information.
- There was a dedicated desk on the children's ward that was away from the nurses' station for doctors to use whilst writing prescriptions. This desk had a sign requesting not to be disturbed. This reduced the risk of medication prescribing errors.
- The neonatal unit (NNU) had a 'medicines omitted cross' on the notice board. This displayed monthly data for the number of days each month that the unit had been free from omitting medicines inappropriately. Data for the month of August on display showed that there had been no medication errors on the unit.
- On the NNU, nurses wore red tabards whilst undertaking drugs rounds which indicated to other staff not to disturb them, this reduced the risk of medication administration errors occurring.
- The controlled drugs register and the total parenteral nutrition register for the NNU were checked, signed and dated daily.
- Consultants were in the process of educating junior doctors on safe prescribing after drug errors had become a risk on the children's and young people's services risk register. There was a children's British National Formulary guide on the intranet for the safe prescribing of a specific broad-spectrum antibiotic.

Records

- The majority of nursing care plans and patient notes were appropriately completed. Out of 39 sets of patient notes paediatric early warning scores, dietetic input, growth charts, pressure ulcer risk assessments, medication charts, intra-venous care records, medical care records, immunization charts, and parent contact logs were complete. The only omission being a child's height not recorded in one set.

One parent described an episode of their child becoming agitated under sedation prior to anaesthetic. There was a detailed account of this recorded in the medical notes.

- Documentation audits undertaken on the children's ward showed that children's heights were not always recorded in the children's malnutrition screening tool (CHIMP). Recent audits showed an improvement after staff had been made aware and asked to improve.
- Nine children had been admitted to adult wards in the 12 months prior to the inspection, in all nine cases no risk assessments had been completed, meaning that risks of children receiving inappropriate care for their needs were less likely to be identified.
- Daily checklists were completed on the NNU with daily actions logged. A sister told us that when issues arising from this checklist needed to be escalated they informed the bleep holder who was a senior nurse for children and young people's services.

- There was a policy in place for the transition of care from children's to adult's services. This policy was in place and set out the processes and responsibilities for care transition.

Safeguarding

- The safeguarding policy included guidance to staff regarding escalation and contact protocols when children did not attend a planned appointment in case the reason might be a safeguarding issue.
- There was a named safeguarding children's nurse for the trust. The nurse was part of a network group and received monthly support and supervision from other safeguarding colleagues and the lead clinician for safeguarding children. A trajectory of upcoming training and development had just commenced roll out across the trust.
- A review of safeguarding children training levels was being undertaken at the time of inspection that would be used to inform a revised training schedule for staff groups to ensure all staff had the appropriate level of training. For example, healthcare assistants and play therapists on the children's unit received level two training with level three updates and the plan was to increase training to level three. Administrative staff on the children's unit received level one training; the plan was to increase this to level two. Sourcing of level four safeguarding children training was in the process at the time of inspection.
- The named nurse for safeguarding children was supportive and present on the children's unit. The nurse delivered safeguarding children supervision to children's nurses, dieticians, allied health professionals, and specialist nurses in children's and young people's services.
- It was mandatory that all staff receive safeguarding training. There were three levels of training dependent on the level of contact staff had with children in their job role; Level one training was appropriate for facilities staff, administrative and non-clinical staff. Level two training for clinical staff that had some contact with children. Level three training was required for staff specifically working within the children's and young people's clinical areas.
- A safeguarding champion nurse on the children's ward had received level three safeguarding children's training. The safeguarding champion told us that they were well supported by the named nurse and all referrals to social care were reported onto the incident reporting system.
- Safeguarding children training was delivered by either ELearning or face-to-face sessions. A snapshot of training data for September 2015 showed: registered nursing staff compliance at 94% medical staff compliance 97% , administrative and clerical staff compliance 88% ,additional clinical services staff compliance 100% and additional professional scientific and technical staff compliance 67%. This information shows that not all staff groups reached the trust's compliance target of 95% for safeguarding children training and therefore some staff groups may not recognise nor know how to escalate safeguarding concerns.
- There were blue safeguarding folders at the nurses' stations on the children's unit, with details on how to progress a safeguarding concern and contact details for the safeguarding lead nurses. These also included recommendations from serious case reviews for information to educate staff and share learning.
- Staff were aware of their responsibilities and could provide examples of when safeguarding alerts had been raised. One play therapist told us how they had dealt with a child protection case
- There was a daily non-acute safeguarding clinic, led by a Community Paediatrician, held in children's OPD. Children were booked into this clinic following referral from social care or safeguarding team.
- The urology specialist nurse was booked on to a study day on female genital mutilation (FGM) in November 2015 with the aim of highlighting awareness of the issue to all staff.

Mandatory training

- All nursing staff on the children's unit and neonatal unit had individual files held in the staffroom that document all of the training, both mandatory and non-mandatory, that they have undertaken, inclusive of all competencies gained. Staff updated their own files and the practice development nurse as well as the sister monitored these. The ward manager of the neonatal unit had a live view of staff's mandatory training compliance, which was 96% at the time of inspection.

- The practice development nurse provided an annual paediatric immediate life support study day for all children's unit staff, inclusive of update training on the intraosseous drill; this ensured that all staff were trained in paediatric and newborn life support. Mandatory training compliance rates for paediatric basic, advanced life support, and newborn life support were 100% for those in additional clinical services, 98% for medical and dental staff and 97% for nursing, and midwifery registered staff. Staff had an awareness of learning disabilities and autism with all nurses in children's and young people's services being 100% compliance with the learning disability and autism level two mandatory training.

Assessing and responding to patient risk

- The paediatric early warning scoring system was used to ensure appropriate awareness and escalation of the deteriorating condition of a child. A score of four required an urgent referral to a more senior colleague who would assess and if appropriate would trigger the 'fast bleep' for an urgent assessment by medical staff. Those attending a fast bleep included junior and middle grade medical staff, the consultant (if prior to 22:00pm) and the children's critical care coordinator or senior nurse. The aim would be to stabilise the child and continue care in an appropriate setting. This could be the high dependency bay on the children's ward, or in the case of a child being intubated, the designated children's and young people's side room in the adult's intensive therapy unit where a children's nurse and a member of the children's and young people's medical staff would provide care. Ventilators on the intensive therapy unit were sufficiently flexible to support tiny tidal volumes and lower pressures and flow.
- In the 12 months prior to the inspection, nine children had been admitted to adult wards. In all nine of these admissions, no risk assessments had been completed. These children had been admitted to critical care, surgical assessment unit and Stanway ward. Critical care staff were 63% compliant with safeguarding children training and 44% compliant with paediatric immediate life support training. Staff on the surgical assessment unit were 100% compliant with safeguarding children training and staff on Stanway ward were 80% compliant with safeguarding children training. No data was submitted for paediatric immediate life support training on surgical assessment unit and Stanway ward despite a request. This meant that we were not assured that potential risks to the children's safety and consistency of care had been identified or considered.
- There was a discharge pathway for children being transferred from theatres back to the ward with a handover checklist. A recovery nurse and a carry kit containing age appropriate sized suction equipment and an oxygen supply accompanied children back to the ward.

There was dedicated space in theatre recovery for sick children requiring stabilisation before transfer from theatres to paediatric intensive care unit (PICU), a carry kit consisting of resuscitation equipment and a ventilator was available for all transfers.

Nursing staffing

- The nursing workforce was flexible and able to work across different areas of children's and young people's services to support areas of pressure. For example, staffing was not at establishment for one shift on the neonatal unit. The action noted that staff were called on from the children's unit to mitigate the risk this presented. As these staff were substantive staff members, their competencies were available on the children's unit for ease of access.
- Daily nurse staffing requirements and actual numbers were on display across all of the children's areas. Staffing on the children's ward was below establishment. At the time of inspection, acuity checks showed that the required nursing requirement and skill mix was seven qualified nurses and one healthcare assistant in the daytime and six qualified nurses and one healthcare assistant at night time. The ward was running with either five qualified nurses and two healthcare assistants or six qualified nurses and one healthcare assistant at the time of our inspection. Information from staffing rotas from May 2015–September 2015 demonstrated the nursing staff to consistently be one qualified member short for each shift. The rotas were produced by an electronic system that did not indicate numbers of bank nurses used.
- There were 22 whole time equivalent nurses still to be recruited. This was on the risk register, with a bay on the children's ward being closed until there are enough nurses to be able to open the bay and care for those patients safely.

- There was a 2.3% sickness rate in nursing, meaning that staff shortages were not impacting on the sickness rate.
- Bank staff were used in the children's unit. These were substantive staff from the children's service, which meant that they were familiar with the children's areas and their clinical competencies were assured. Competency files were accessible on the unit.
- Staffing levels were monitored by the reviewing of patient dependency and acuity reviews were completed between one and four times a day depending on the patients on the unit. This review was based on the Paediatric Assessment and Dependency Audit and the Royal College of Nursing Staffing Guidance.
- A dependency level tool from the British Association of Perinatal Medicine was utilised in the NNU. This tool graded the needs of babies into intensive care, high dependency, and special care. Staffing levels were then arranged dependent on these acuity levels. Babies in intensive care require one to one support, babies in high dependency require one nurse to every two babies and special care babies require one nurse to every four babies in line with national guidance. There were no temporary agency staff used in neonatal unit or CAU. The off duty rota on the neonatal unit confirmed the establishment numbers citied.
- Handovers demonstrated continuity of care for individual babies and included general topics such as safeguarding concerns, medication issues and pending admissions and discharges.
- An audit of the respiratory service completed between January 2015 and May 2015 revealed that the specialist asthma nurse was only reviewing 60% of all asthmatic children admitted to the trust. This had resulted in a business case to employ two additional asthma nurses and one allergies nurse, recruitment had not commenced at the time of the inspection. There was an out of hours bleep holder who was a senior nurse that provided cover and oversight of arising issues such as clinical incidents.

Medical staffing

- There were 11 consultants covering children's and neonatal services with one post currently under recruitment. This meant there was consultant cover on site for children's and young people's services between the hours of 09:00am and 22:00pm.
- There was only one vacancy for a middle grade doctor, which was expected to be filled by September 2015, otherwise medical staffing was at full complement. The highest percentage of locum use for inpatient children's and young people's services was 16% for the month of February 2015 with data showing less than half of this usage in the three months following, therefore, the use of locums was not excessive.
- There were three handovers each day at 09:00am, 16:30pm and 21:00pm that were all consultant led and all doctors were expected to attend. The afternoon and evening handovers included the doctors from the neonatal team. Weekend handovers were held twice daily with a smaller review mid-afternoon. Electronic board and anonymised paper print outs were used as tools to discuss patient cases. Safeguarding issues were discussed at the handover. The doctor's handover room was centrally located between the children's ward, children's OPD, CAU and ECU. This meant that doctors could respond quickly to any child requiring urgent medical care during the time of handover, as they were located close to the clinical areas.
- During the inspection, handover was observed and found to be disjointed and inconsistent. The 09:00 handover was consultant led but junior doctor driven and took the form of a formal teaching session. The handover was systematic, structured and included senior nurse input with detailed patient discussion. At the 16.30pm handover, there were some late attenders and neonatal staff tended to do their own. The care of each patient was discussed, including expected activity from antenatal and delivery units; however, the handover was informal and lacked structure. No learning opportunities were provided
- A 0.4 whole time equivalent (WTE) consultant, three WTE specialist nurses, one WTE dietician, 0.1 WTE psychologists and 0.3 WTE administrative support staffed the children's and young people's diabetes service (CYPDS). An external peer review of the service rated it as compliant for both hospital measures for CYPDS and CYPDS multidisciplinary team, indicating the team set up and numbers were suitable.
- Junior medical staff received one day of trust induction and two to three days of local induction with the following areas covered: resuscitation; safeguarding; drug prescribing; and pathways. Appraisals of junior staff were provided by the deanery. The appraisal rate for more senior medical staff members was 100%. Each junior staff member had a named educational and clinical supervision support.

Services for children and young people

Major incident awareness and training

- The major incident policy was accessible to all staff on the intranet however, knowledge was variable. Out of six staff interviewed three staff had a good understanding of the policy and process whilst three had little or no awareness. This meant that there was inconsistency across children's and young people's services staff of what actions to take in the event of a major incident.
- There was a clear process in place to deal with major incidents in the neonatal unit Staff provided the example of a power outage in the unit in 2010 where all electrical equipment became non-functional. An evacuation took place, incubators were brought in from other trusts, and babies requiring ventilation support were bagged until equipment support was received from other units. The incident resulted in a review of the policy and the neonatal unit being rewired.

Are services for children and young people effective?

Good

Children's and young people's services at this trust were effective because:

- There was evidence of multidisciplinary team working, a robust urology service and improvements in the epilepsy and respiratory nursing levels.
- The neonatal unit were compliant with national guidelines including the BLISS charter and the UNICEF Baby Friendly accreditation schemes.
- There was clinical audit activity that tracked recommendations and progress and had oversight from the trust wide audit group.

However some improvements were required because:

- The asthma nurse was only reviewing 60% of asthmatic children admitted to the trust and there was no epilepsy nurse cover at weekends.
- The information link between this trust and other hospitals was not robust.

Evidence-based care and treatment

- An audit report showed that 17 clinical audits had been undertaken between April 2014 and September 2015. Associated recommendations were in place with progress against these recommendations recorded. These audits included national audits such as the Epilepsy 12 national audit, the National Neonatal Audit Programme, a children's and young people's asthma audit that compared data to the trust's performance in the British Thoracic Society National Paediatric Asthma Audit, a national paediatric diabetes audit and the Patient and Parent Reported Experience Measures for diabetes.
- There was a rolling audit performance report that stated outcomes of audits completed, recommendations and progress against those recommendations.
- The trust had a nominated clinical lead for audits within the children's and young people's services. There was a monthly audit meeting to discuss audit performance and recommendations. The audit meeting reported into the wider governance meeting and trust wide quarterly audit meetings. Attendance at the audit meeting was encouraged amongst the junior medical staff but there was no representation from the nursing team, indicating that learning was not being shared across all clinical staff groups.
- The children's and neonatal units participate in the You Are Welcome, UNICEF UK Baby Friendly Initiative Standards and BLISS baby charter accreditation schemes. This meant that the trust measure themselves against standards to ensure good quality of service suitability for young people, breastfeeding of babies and care of the pre-term infant and their families.
- There was a transition service in place for children moving into adult services as they got older. Two pieces of national guidance (the Royal College of Nursing Guidance named Lost in Transition and the Royal College of Physicians of Edinburgh document named Think Transition) had informed the ethos for this service. National Institute for Health and Care Excellence (NICE) guidance on transition was due to be released in February 2016 and the transition nurse was proactively working on compliance to this in advance.
- Guidelines and protocols were up to date. We reviewed three sets of guidelines for asthma, sickle cell anaemia and febrile neutropenia, which were all within date.
- A comprehensive children's and young people's diabetes action plan had been produced. The following key areas were focused on: glycated haemoglobin (HbA1C) levels and machine; psychology access; insulin pump service; blood ketone monitoring for inpatients; dietician time; accessibility of a web-based diabetes

management service; patient, medical and ward staff education; diabetes related incidents; diabetes team training; national audit participation; out of hours provision; transition to adult care; and research participation. Each key area had aims, actions and target dates set with progress entered on to the plan.

Pain relief

- Pain assessment and pain relief provision were well managed in the children's and neonatal units. There was a pain management assessment tool used on the neonatal unit that was displayed for ease and speed of pain assessment. If a baby required pain relief this was included in the infant's integrated care pathway focus charts.
- There were nurse prescribers on the CAU and ECU but not on the children's ward who could prescribe pain relief in the absence of a doctor. This meant that children could receive pain relief promptly even when a doctor was not immediately available.
- There was a patient group directive in place, which means that certain medications can be provided without a doctor's prescription, for the provision of oral paracetamol and ibuprofen and pain assessment was repeated post administration to check the efficacy of the treatment.
- Nurses gave advice to parents regarding the dosing of over-the-counter pain relief at home. There was a stock of over-the-counter pain relief on the unit for use when required for example late evening discharge, to ensure the patients had a supply overnight.
- A pictorial pain assessment tool was used on the children's unit to determine levels of pain in children. This meant that children could demonstrate themselves what their pain levels were.
- Children received pain control in a timely manner. The parents of one child, admitted as an emergency, told us that their child had received prompt pain relief. Another set of parents, whose child had a long term illness, stated that the staff on the children's unit always showed awareness of their child's pain experience and respond with pain relief as required.

Nutrition and hydration

- A choice of meals was available and patients completed two menus choices a day. In addition to set meals, snacks were provided at 3:00 pm. and fruit was always available on the unit.
- The catering department work with dieticians and nurses to ensure appropriate provision of food for children with special requirements. For example high calorie, low bolus meals were seen for patients requiring high calories but could not tolerate much bolus. 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 and pharmaceutical input into the neonatal and children's ward rounds to ensure that children's nutrition and hydration were appropriately assessed and managed by medical and nursing staff.

Patient outcomes

- A paediatric asthma audit was undertaken in May 2015 with benchmarks set by the British Thoracic Society standards. Findings were compared with the trust's and the national data from 2013 British Thoracic Society National Paediatric Asthma Audit. Findings showed that the local asthma integrated care pathway was followed in 46% of patients, 64% of patients were given a personalised action plan, inhaler technique was checked in 60% of patients, 18% of patients were discharged under the care of a respiratory physician, and 39% of patients were advised to see their general practitioner within 48 hours of discharge from hospital, compared to 8.3% of patients in 2013 and the national average of 19.8%. Recommendations from the audit were to promote the use of the local asthma integrated care pathway for all asthmatic patients, and to increase the provision of a specialist asthma nurse to promote the correct management of asthma. These results were above the England average.
- The national neonatal audit programme was undertaken in April 2015. Results were yet to be finalised, however anticipated recommendations were to consider removal of long lines after seven days unless other access issues were identified, to put new arrangements in place for retinopathy of prematurity screening, and to continue training all staff in the promotion of breast-feeding.
- The national paediatric diabetes audit had not been finalised for this year. Recommendations from the previous year were focused around the reduction of glycated haemoglobin (HbA1C). Actions had been put in

place that focused on educating patients on HbA1C and complications, the commencement of HbA1C clinics, and the offering of bolus advisor meters to patients. Each action had a set target date and the new HbA1C clinics had commenced.

- On review we found that the recommendations made were being implemented by the trust and these changes were in the process of becoming embedded within the service.
- The trust was not achieving all National Institute for Health and Care Excellence (NICE) guidelines regarding care of epileptic patients. NICE guidelines state that a patient needs to be seen within two weeks of their first seizure, however the service was currently seeing patients within four weeks of their first seizure The outcome of the last Epilepsy 12 audit resulted in an increase in EEG's at this trust, the appointment of a second epilepsy nurse and extra clinic time for the consultant. This has prompted an audit due to start in 2016 against the NICE guidelines for epilepsy to assess performance against the whole guideline.
- Local monthly audits were undertaken across the service. On the children's assessment unit (CAU) these included integrated care pathway for surgery, hand hygiene and accessing central lines and cannulation.
- On the children's ward, there was a monthly audit of call bells, a fortnightly audit of the surgical pathways and weekly audits of documentation. Staff received feedback at team meetings. The trust's policy for the intensive care unit provides clear guidance for inter-hospital transfer of children and young people. There was production of a monthly quality scorecard for the children's service that gave an overview of performance against a range of standard such as the production of electronic discharge summaries, hand hygiene, and the completion of clinical screening tools.
- Readmission rates for epilepsy averaged at 10.3% for the year and for diabetes rates averaged at 8.3% for diabetes mellitus with complications and 19% for diabetes mellitus without complications. To address high readmission rates for diabetes, the diabetes team had added an extra clinic to the service from April 2015. Data was not yet available to see if this measure was reducing readmission rates.
- Data provided by the trust showed that readmission rates for asthma had averaged at 7.4% for the period covering December 2014 to May 2015. An additional part time asthma nurse was due to be employed and a business case had been completed for the addition of another specialist nurse for asthma and allergies.

Competent staff

- Medical staff appraisal rates were 100%. A snap shot of appraisal rates for the months of April, May, June and July 2015 showed the average appraisal rate for nursing and support staff was 75%. The trust's study leave policy stated that non-medical staff could request funding and leave for study after discussion and approval at appraisal. However, as not all nursing and support staff were being appraised in a timely manner, not all staff could request funding and leave for study.
- The practice development nurse had set competencies for nurses to provide care for high dependency patients. Nurses without the appropriate competencies could provide care under the condition that they were working alongside a nurse who had the appropriate competencies. Two staff members a year were sent on a training course to provide competencies for providing care in the high dependency bay.
- Clinical supervision was unstructured and varied. Two staff stated that they had received clinical supervision although they were unsure how regularly this took place. However, two different nurses referred to receiving debriefing sessions from the matron when difficult cases had been handled on the unit. This indicated that although staff were informed, they did not receive consistent and regular clinical supervision.
- The trust was preparing its nurses for upcoming revalidation by providing three protected study days per year. There was a dedicated practice development nurse to support all nursing staff in preparation for this.
- Student nurses received an orientation to the children's assessment unit, elective care unit, children's ward, and neonatal units on their first day, and were allocated a mentor to work alongside. Records of the orientation session were in place.
- Of 23 nurses on the children's assessment unit, 87% were registered children's nurses or registered nurses in the child branch. Of nine staff on the elective care unit, 100% were registered children's nurses. Of 32 nurses on the children's ward, 78% were registered children's nurses. The neonatal unit had 83% of their nurses qualified in their speciality, which was above the national recommendation of 70%. Information provided

by the trust states that the neonatal unit had 59% of nurses certified and 41% as registered nurses of their 34 nursing staff members, showing inconsistency between corporate and ward level data.
- There were three diabetes specialist nurses, one urology specialist nurse, one asthma specialist nurse, two epilepsy specialist nurses, three oncologyspecialist nurses, one continence specialist nurse and one transition specialist nurse for children and young people at this trust.

Multidisciplinary working

- The clinical nurse specialists were based in the multidisciplinary team office. This facilitated multidisciplinary conversations in an informal setting that supported care provision.
- The patient liaison health visitor worked closely with the neonatal staff, community health visitors, social care and parents to reduce the incidence of post-natal depression and increase the uptake of breastfeeding in vulnerable families.
- There was no hospital social worker for children meaning there was limited family and child support in the community for those with needs that are more complex.
- There was a dedicated specialist nurse for transition for children transferring into adult services. This nurse saw all patients from the age of 14 years who needed their care transferring to adult services. The nurse would work through the transition process with each child and facilitate joint transition clinics with the adult services consultants across specialities inclusive of diabetes and epilepsy. The transition service covered inpatients, outpatients, children's and young people's community services and specialist and mainstream schools. There was a policy in place and a specific transition plan, consent and referral process for children going through transition as well as a transition passport created for children to possess themselves. This document tracked their progress through transition to adult services.
- Links to other hospitals providing specialist care were in place. For example, there were established outreach clinics and links with other providers for the epilepsy service, children with respiratory illnesses and for children with complex needs. One parent told us that their child's care plan was provided in liaison with another trust and always worked well.

Seven-day services

- Children's and young people's consultants were available on site between 09:00am and 22:00pm daily, with an on call rota for out of hours.
- There was no on-call service from the consultants for diabetes specifically; however, the trust did participate in the on-call system of the East Anglia Network for families and children with diabetes at home. This meant that families of children with an urgent diabetes need could contact the diabetes consultant on call for the region via the trust switchboard.
- The children's unit has physiotherapy support between 8am and 8pm, Monday to Friday, but no support at the weekends, meaning that children may not always have physiotherapy support at the time that they need it.
- The children's ward had six play therapists employed to meet the needs of patients, working between 08:30am and 16:30pm, Monday to Fridays, with some weekend work dependant on the need for this service. The play therapists had raised funds at different events to provide equipment in the playrooms on the ward.

Access to information

- Information about children being seen in accident and emergency was available to staff on the children's assessment unit by means of an electronic system. Information included name, age, hospital and NHS numbers, waiting time in A&E and the reason for attendance. The same electronic 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 due to be received on the unit in advance.
- An electronic system was in place that enabled users to see blood test results and clinical correspondence. Local general practitioners in the surrounding area had access to this system, which enabled timely access of information between both primary and secondary care.
- One parent told us that their child attends a specialist hospital elsewhere as well as this trust. They told us that information between the two hospitals was not shared very well.
- The neonatal unit staff had access to an electronic system that is used in the community and primary care. This system allowed neonatal staff to identify some

issues in advance such as mothers and families with mental health or substance misuse issues. This enabled the unit to adequately prepare appropriate care and support for families of babies admitted to the unit.

Consent

- Staff told us that consent and parental responsibility were checked on arrival to the elective care unit. A student nurse demonstrated a good understanding of parental responsibility.
- Staff stated that the play therapists worked closely with staff and children in gaining informed consent for treatment.
- There were robust tracks in place to ensure that consent was understood and agreed upon throughout the period of children transitioning into adult services. Age appropriate resources were given to ensure that the sharing of information was consented to in an informed way. Consent for information sharing was revisited every year of the child's transition plan, i.e. at ages 14, 15 and 16.

Are services for children and young people caring?

Good

Children's and young people's services at this trust were rated as good for caring because:

- There was overwhelming positive feedback from patients and carers and parents stated they felt listened to.
- Data from the friends and family test showed that most parents would recommend the hospital to their friends and family.
- Parents felt informed and updated on the treatment of their children.
- Children with long-term illness were nominated a link nurse for support.
- The neonatal unit had designated bereavement links with a local hospice which provided support for bereaved families.

Compassionate care

- The friends and family test results were positive. There was an average response rate of 32% for children's and young people's services, with an average score of 97% of respondents that would recommend the service to their friends and family.
- Some areas of the CQC Children's patient survey undertaken in July 2014, published in July 2015, indicated areas around pain relief, food and information giving to be poorer than experienced at other trusts, although this was not reflected in the people we spoke with on our inspection. The trust scored 8.3/10 from parents and carers regarding the confidence and trust they had in the staff treating their child. This was worse than other trust's scores. Parents and carers scored the trust 7.6/10 when asked if they felt that staff did all they could to ease their child's pain, this score was about the same as other trusts. The trust scored 7/10 from parents and carers stating that they had been given information about what would happen after their child was discharged from hospital. This was worse than other trusts.
- Parents felt informed and updated on the treatment of their children. One parent with a child in the elective care unit stated, "Everyone has been so nice, said thank you, I've met loads of staff. They even came to see me to explain what was happening. I can't fault anything". Another parent of a child on the neonatal unit stated, "The team have been brilliant, we're very happy with everything that's happened".
- One parent of a child with a long-term illness said that that they received a phone call from their child's consultant with blood results on the same day they were taken. This provided them with reassurance that they needed.
- Staff communicated directly with the children. Two set of parents stated that their child had their treatment explained to them rather than staff speaking directly to the parents. This meant that the child was kept at the centre of what was happening and involved in their own right.
- Staff communicated effectively with children using age appropriate language and with dignity and respect. One nurse on the neonatal unit was feeding a distressed baby, using soft, quiet and calming tones when communicating to ease the baby's distress.

Understanding and involvement of patients and those close to them

Services for children and young people

- Parents were involved in their child's care. Six parents spontaneously stated that they felt listened to and well informed regarding their child's care.
- Children were involved in, and understood their own care. The parents of a child that was having surgery stated that staff had explained the surgery to the child with the use of pictorial aids that were age appropriate. There was a pre-admission service for children booked to be admitted to the children's unit. Children and their families were invited to attend the unit, have a tour and meet the nurses and play therapists. A photo book describing the child's journey through the unit was used for information as well as a doll to demonstrate intravenous cannulation
- One parent stated that one of their children was provided with specialist support for behavioural needs that had arisen from the family dynamic of having their sister in and out of hospital with complex needs. This meant that there was additional support and care available for the family as a unit, which in turn would support the child receiving hospital treatment.

Emotional support

- Staff were aware of the emotional requirements of smaller children who may not be able to express themselves as clearly as older children. A mood assessment tool was used to enable staff to ascertain how smaller children were feeling.

One parent explained that their young child became agitated under sedation prior to receiving their anaesthetic for surgery, which had been upsetting. They were taken to a private quiet room where a member of staff had provided reassurance and comfort.

- An external charity had funded the provision of clown doctors on the children's ward. These were support staff who dressed up as clowns pretending to be doctors, with the aim of uplifting the mood of children by laughter and entertainment.
- Children with long-term illness were nominated a link nurse for support. One parent stated that their child's link nurse was "always one phone call away" and had arranged open access back into the hospital for their child when required.
- The neonatal unit had designated bereavement links with a local hospice. For babies that pass away on the neonatal unit, the cool cot was used to help maintain the baby's body on the unit so that the family could visit the baby in this setting rather than the mortuary. Memory boxes were given to parents who had lost their babies on the neonatal unit.

Are services for children and young people responsive?

Good

Children and young people's services were rated as good for being responsive because:

- The service had begun to respond to capacity concerns. Staffing levels on the children's assessment unit had been reviewed and a bay of four beds had been closed on the children's ward so that safe staffing levels could be achieved.
- The integrated care pathways 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.
- There was a robust and supportive transition service for children transferring into adult care.
- There was a dedicated epilepsy consultant who held two clinics every week, supported by two epilepsy nurses.
- The neonatal (NNU) had a family room available as recommended by both parents of premature babies' project: your needs (POPPY) and the baby life support systems (BLISS) Charter that sets out standards for babies born too soon, too small and too sick, and their families

However there were some areas that could be improved because:

- There was no dedicated learning disabilities nurse within the children's and young people's services. This meant that patients with learning disabilities might not have their needs fully understood and met.

Service planning and delivery to meet the needs of local people

- Care was not always delivered in an age appropriate way. The cut off age for patients attending children's and young people's services was 16 years, unless they

were undergoing transition arrangements into adult care. In the previous 12 months to the inspection, nine children had been admitted to adult wards, not including those on maternity wards, with no formal risk assessments completed.

- There was a dedicated epilepsy consultant who held two clinics every week, supported by two epilepsy nurses. The epilepsy pathway was in the process of being finalised. General practitioners refer patients with a possible or definite diagnosis of epilepsy straight to the service. Epilepsy patients undergo electroencephalogram (EEG) and magnetic resonance imaging with anaesthesia if appropriate, and there was open access available for epilepsy patients if appropriate.
- There was a comprehensive respiratory service provided with a lead respiratory consultant supported by one full time senior nurse. The caseload was approximately 70% allergy cases and 30% asthma cases. There were 11 allergy clinics, two asthma clinics, two cystic fibrosis clinics, one general respiratory and five general acute consultant clinics each month. There were also nurse-led allergy and asthma clinics and weekly asthma clinics held by a middle grade doctor. Once fully recruited, the respiratory team aimed to provide telephone follow up appointments for all asthmatic patients attending accident and emergency within 72 hours. Recruitment of two additional nurses was not complete at the time of inspection.
- Children's and young people's asthma clinics were held three times a month in local tertiary centre for those families that had difficulty accessing the clinic in the trust itself.
- This trust had the only children's urology service in the whole of Essex, which had been in place for two years and was expanding with a newly employed senior urology nurse. Clinics offered include constipation, soiling, and night time wetting.
- 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.

The neonatal unit had a community outreach team providing support at home for neonatal babies. This service was provided in line with national neonatal service specification published by NHS England. There was also a children's and young people's community outreach team whose service specification was under review to separate it from the more general specification of the trust.

- The local Child and Adolescent Mental Health Service (CAMHS) was accessible for patients admitted to the unit with mental health problems and also provided a seven day crisis team. The team received referrals from the children's unit by telephone or email. One example was given of that service not providing effective care, however the matron had provided a debrief to staff for future learning.
- The trust was proactive in managing service demand from the community and primary care. Free study days had been offered by the trust to local general practitioners, school nurses and special educational needs coordinators on epilepsy, urology and diabetes care, to improve knowledge and care in the community and primary care before secondary care was required.

Access and flow

- Between April and August 2015, the service had been consistent in achieving the referral to treatment time (RTT) target of 18 weeks. The target had been achieved in 99% of cases for children requiring treatment that did not necessitate a hospital admission, and for children still waiting to commence treatment. One parent who had a child on the elective care unit (ECU) stated that their child waited nine working days from referral for day surgery to the day of admission.
- Throughput, meaning the number of admissions and transfers into a unit, occupancy rates, and the number of outpatient clinics were not having a negative impact on RTT waits for patients. This indicates that children's and young people's service's capacity and demand was appropriately managed. For the period April 2015 to August 2015 the throughput of the neonatal unit was 208, the children's ward was 1258, and the children's assessment unit was 2,110. Throughput data was requested for the children's elective care unit but was not received. The average occupancy rates from April 2015 to June 2015 were 57% for the children's ward and 21% for the children's assessment unit. Occupancy data was requested for the children's elective unit and the neonatal unit but was not received. There were approximately 3,500-4,000 admissions to the CAU in the

past year, and during the inspection week there were 105 children's and young people's outpatient clinics taking place throughout the trust and its associated locations.

- There was a policy and process in place that gave specific guidance on the processes that should be followed in the event on a child not attending a planned appointment. This guidance covered who needed to be informed and how to escalate the issue appropriately. The guidance was linked to the safeguarding children and young people policy.
- The children's acute transfer service facilitated the transfer of any children requiring hospitalisation in a specialist children's unit In the case of small babies; the acute neonatal transfer service would facilitate transfer. Length of stay on the children's assessment unit averaged at approximately three hours, with a maximum stay of four to five hours. This meant that children were usually transferred to an appropriate bed on the children's ward in a timely manner.
- There was a process in place for any children needing to stay in the children's assessment unit in the event of a bed not being available on the children's ward; a child would remain on the children's assessment unit until a bed became available although there had been no recent examples of this occurring.
- Babies requiring admission from delivery suite to the neonatal unit were transferred quickly. The neonatal unit is located next to the delivery suite and was easily accessible through one set of doors for the transferring of babies from the delivery unit to the neonatal unit.
- A patient liaison health visitor, who covered issues such as post-natal depression and breastfeeding, facilitated discharge home from the neonatal unit for vulnerable families.
- For the period March 2015 to May 2015, electronic children's and young people's discharge summaries produced within 24 hours of discharge in 92% of cases on average. This issue was discussed at the monthly paediatric governance meetings with associated actions. The issue was ongoing and had not been resolved at the time of the inspection.
- Open access to the children's unit was given to children with reoccurring or long term conditions to avoid delays in treatment by accessing children's and young people's services directly from home, although this had a direct impact on readmission rates.
- The children's assessment unit received children directly from general practitioner referral, accident and emergency transfer, the under one's pathway and children in the community given open access. This meant that those providing care across a variety of settings had awareness and access to the children's unit.

Meeting people's individual needs

- There was no dedicated learning disabilities nurse within the children's and young people's services. This meant that patients with learning disabilities might not have their needs fully understood and met. The trust mitigated this risk in several ways, for example, all nurses in the children's unit were up to date with the learning disability and autism level two mandatory training and senior members of the nursing staff received level three training. Staff on the children's ward opened up a closed bay so that a child with learning disabilities could pace to prevent anxiety building up. This demonstrated staff awareness of learning disabilities patients.
- A sensory room was on the children's ward for use by patients with special needs. The trust had a policy for assessing and meeting additional support needs. This was a trust-wide document that stated it applied to children as well as adults but that care provision set out in the document did not require amendment for children. There was also the provision of a 'My Hospital Passport' for patients with additional needs that could be adapted for both adults and children.
- Needs of adolescents were accommodated on the children's ward. A separate room was arranged for adolescent patients that had age appropriate decoration. The room had a games console; a drinks and snacks machine and had posters on the walls advising adolescents about issues such as online safety, bullying and alcohol.
- There was a playroom accessible for children admitted to the children's assessment unit and the elective care unit that contained many interactive play items such as games consoles, books, and train sets. One child said that they had not been bored whilst in hospital because they could play in this room.
- The neonatal (NNU) had a family room available as recommended by both parents of premature babies' project: your needs (POPPY) and the baby life support systems (BLISS) Charter that sets out standards for

babies born too soon, too small and too sick, and their families. There are also three mother and baby rooms on the unit where babies and mothers can sleep in the same room in preparation for discharge home. The children's ward had a parents lounge for parents and carers to relax.

- There were playrooms accessible to both the ECU and CAU, and the children's ward too. An outdoor play area was also available that was accessible from the children's ward.
- 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. There was also a transition board on display that asked the reader 'age 13+? Read this" and gave information about the provision of transition arrangements into adult care.
- Children's needs in the community after discharge were considered to enable continuity of care. All children admitted under one year of age had their health visitors informed of their admission so that appropriate community support could be provided on discharge.
- There was provision of parent beds on the children's assessment unit in the event of a transfer to the children's ward being delayed. This meant that children could remain with their parents at all times, although there had been no recent cases of delays causing this arrangement to be used.
- Individual needs of patients were understood and accommodated. One parent of a long-term patient told us that a phlebotomist was chosen by their child's consultant to take blood at appointments because they knew the child was difficult to get a blood sample from. This reduced the risk of pain and upset to the child as the phlebotomist was chosen due to being highly skilled.
- Staff on the neonatal unit provided education to vulnerable families to enable them to care for their babies appropriately upon discharge. Staff had taught a deaf mother to recognise facial cues of her baby for particular needs. Staff had also taught a mother with learning disabilities to administer her baby's medications using the assistance of clock pictures to reduce confusion over reading the time on different types of clocks at home.

Learning from complaints and concerns

- In the past year, children's and young people's services had received a total of 33 complaints and 2,645 compliments from patients and their families.
- Staff were aware of the complaints process and could explain that complaints were attempted to be resolved informally whilst children and parents were still on the children's unit if appropriate.
- Patient advice and liaison leaflets (PALS) containing information on how to raise a formal complaint, were given when informal complaints were made. If a resolution could not be reached, the patient or parent was advised to contact the PALS service to escalate their complaint appropriately.
- The neonatal unit had a 'you said we did' board on display, informing parents of how their opinions had helped to shape care provision on the unit. There was also a 'complaints cross' on display to illustrate how many days the unit had been complaint free that month. For the month of September 2015 no complaints had been raised.
- There had been several feedback reviews of children's meals completed throughout 2014. This had resulted in new menus offering more choice, with patient feedback gained a month after the roll out of the new menus to ensure the changes were what patients wanted.
- In the adolescent's sitting room, the play specialists had a 'Tell us what you think' board where patients could put their thoughts and suggestions. The play specialist advised that these suggestions were discussed with the ward sister for possible implementation. Lack of accessible Wi-Fi had been a recent complaint, as Wi-Fi provision was not consistent across children's and young people's services.

Are services for children and young people well-led?

Good

Children's and young people's services at this trust were rated as good for well-led because:

- There was a vision and strategy for the service for the next three years and clinical quality was managed well, with clear escalation of assurance and concerns from ward to board level.

- Local leadership teams were highlighted by staff as approachable and supportive.
- Communication and multidisciplinary working between medical and nursing staff was effective.
- Interactions and working relationships between nursing and medical staff was good. Nurses felt that medical staff were approachable and supportive.
- Staff stated they would be able to raise a concern without fear of reprisal.

However there were some areas that could be improved because:

- There was a sense of separation between children's and young people's services and other services within the trust. This view was based on how they believed the service to be performing and how it was viewed, with an indication that some staff were keen that this service was not associated with other services. This indicated a disconnected culture to the rest of the trust that could have a negative impact on shared learning and support.

Vision and strategy for this service

- There was a defined strategy in place for children's and young people's services for the next three years. This strategy focused on providing safe services and harm free care; personalised patient centred care; providing services for deaf/blind, learning disability and cognitively impaired patients; carers support; workforce development; education and training; innovation; responding to competition; changing expectations; supporting capacity in primary care; care provided closer to primary care in the community; integration; sustainability; and standards compliance. However, within this strategy there was no information regarding expected dates of completion, other than the three year projection. There was no process for tracking of progress so it could not be easily determined whether this strategy was achievable or not.
- Senior nursing staff working in specific roles, such as clinical specialist nurses, were aware of the vision and strategy for their own specialisms. There was inconsistency of staff awareness of the values of the trust. Two senior nurses described the trust's vision differently, both of which were not in line the with trust's actual vision.

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 round meetings as well as weekly safeguarding and ward and patient safety meetings. These all reported into respective monthly meetings. Clinical governance issues for assurance and escalation were then reported into the monthly children's and divisional clinical governance meetings and then on to the board.
- Minutes demonstrated that there was appropriate oversight and scrutiny of the risk register at the services monthly clinical governance meetings between February and May 2015. This included risks being discussed for escalation to the divisional meeting.
- A dedicated risk management team that monitored all reported incidents and risks daily held weekly risk management meetings. Emerging themes around risks and incidents would be discussed and passed on to all relevant teams to mitigate.
- Senior nursing staff were aware of their own local risks. Two nursing sisters on the children's unit identified the three main risks for the service as nursing staffing, high dependency staffing and medicines related incidents. There was a clinical governance folder in the staff room of the children's unit that had all learning from incidents and complaints and all risk information. Staff were required to sign and date on a monthly basis to confirm they had read it.
- Mitigation of risks was taking place in children's and young people's services. There was a drug error risk on the children's unit risk register. The practice education facilitator was putting together a package to train newly qualified staff on appropriate single sign off for the preparation and administration of medicines. This was not yet rolled out at the time of inspection.
- Staff on the children's ward acknowledged that the staffing of the high dependency bay was a risk and was on their risk register. This was being mitigated by the development and rolling out of specific high dependency competencies by the practice development nurse. Three major acuity reviews had occurred between December 2013 and December 2014 and results had been submitted to the executive team for consideration of increased staffing. This led to funding for an additional 13 whole time equivalent nurses from October 2015, recruitment to which was underway.

Leadership of service

- Communication within the service was good. There was a monthly newsletter produced for children and women's services staff from the associate director of operations. This newsletter gave information regarding management focuses, upcoming events, and updates on known issues such as staffing levels, recruitment and patient advice and liaison feedback. Staff from children's assessment unit, the elective care unit, the children's ward and the neonatal unit received cascaded information from the executive on a weekly basis by the service manager.
- Staff stated that the matron had a positive leadership style and was respected amongst the team. One senior nurse told us that the senior management team was supportive. There was a strong link between the division and the board resulting in the board being supportive of the uplifting of nursing establishment.
- There was a weekly open forum with the divisional leadership that enabled issues to be raised and resolved quickly without the need for formal escalation.
- The clinical director for the women and children's division was also a member of the board, which meant that the divisions concerns could be raised directly with the board.

Culture within the service

- Interactions and working relationships between nursing and medical staff was good. Nurses felt that medical staff were approachable and supportive.
- Staff stated they would be able to raise a concern without fear of reprisal.
- Three staff members indicated that there was a sense of separation between children's and young people's services and other services within the trust. This view was based on how they believed the service to be performing and how it was viewed, with an indication that some staff were keen that this service was not associated with other services. This indicated a disconnected culture to the rest of the trust that could have a negative impact on shared learning and support.

Staff engagement

- Staff were encouraged to professionally develop. One healthcare assistant stated that there was a pathway for career progression to nurse training and another registered nurse aimed to specialise in children's oncology nursing and felt confident that the trust would support them to do so.
- Overseas nurses were supported to develop at this trust. The trust was working with a local university to support overseas nurses with additional qualifications so that they could progress in their careers.
- One student nurse stated that they wanted to work at this trust when they had completed their studies and qualified, due to the support received whilst on placement.

Innovation, improvement and sustainability

- The trust had a plan to recruit an additional transition nurse for children transferring into adults services after the need was recognised in a local audit.
- There was a diabetes action plan in place for development of the service between 2015 and 2016. The plan included several aspects for development including education and training and audit and research. A business case had just been approved for the development of an insulin-pump service.

End of life care

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

Information about the service

End of life care and palliative care services at Colchester General Hospital are provided across all wards and departments. Since our last comprehensive inspection some oncology services previously provided at Essex County Hospital had been moved to the main Colchester General Hospital site. The hospital does not have a dedicated palliative care ward, care to patient who were at the end of their lives was provided throughout the hospital.

The specialist palliative care team who support ward staff to deliver care to patients' at the end of their life care are available seven days a week between the hours of 09:00 and 17:00. Out of hours advice was provided by single point a telephone advice service based at the nearby Hospice. The specialist palliative care team is comprised of 5.6 WTE clinical nurse specialists, including the team leader. Two consultants who together make up 1.0 WTE and a part time administrator. End of life care in the trust is also supported by 1.0 WTE End of Life Care Facilitator.

We visited a variety of wards at Colchester General Hospital including the stroke unit, cardiac wards, hospital mortuary, the porters lodge and the hospital chapel. We spoke to 41 members of staff including nurses, doctors, health care assistants, and mortuary and chaplaincy staff. We spoke to nine patients who were at the end of their life and eight patients' relatives.

There were 1477 in-hospital deaths in the year from January 2014 to December 2014. We reviewed the medical records of patients at the end of life and observed the care provided by medical and nursing staff on the wards. We spoke with patients receiving end of life care and their relatives. We received comments from our public listening event and from people who contacted us separately to tell us about their experiences.

We last inspected end of life care services at Colchester General Hospital in April 2014 and we rated end of life care as requires improvement at that inspection.

End of life care

Summary of findings

We have rated end of life care as inadequate overall with all five domains being rated as inadequate. The service was not safe because there was a lack of recognition, when assessing patients that patients were at the end of their life. We observed several examples of patients who should have been receiving dedicated end of life care who were not because staff had not identified that they were at the end of their life. Due to the lack of identification of patients at the end of their life the standard procedures for end of life care plans were not given priority or utilised when needed and opportunities to prevent or minimise harm are missed.

Equipment required for the use of providing care to patients at the end of their life was not serviced or maintained and therefore were not assured they were safe to use. End of life care training was not provided as a mandatory training subject and there was no formal records available which recorded if patients were trained on end of life care and the individual care record for the last days of life.

We have rated end of life care services as inadequate for effectiveness because people are at risk of not receiving effective care or treatment. The trust does not have a policy in place for end of life care, their action plans and strategies made no reference to end of life care. The trust had removed the Liverpool Care Pathway and replaced it with an 'individual care record for the last days of life', however not all staff were aware of this record, not all staff had been trained to use it and in one instance a member of medical staff told us that they refused to use the new record. This meant that patients were not receiving appropriate care in line with current evidence-based guidance and best practice.

There was a lack of consistency in how people's mental capacity is assessed and not all decision-making is informed or in line with guidance and legislation when a do not attempt cardiopulmonary resuscitation order (DNACPR) is completed. In four 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.

We rated end of life care services as inadequate for caring because there were times where patients and relatives did not feel well supported or cared for. We spoke with nine relatives and eight patients at the end of their life and whilst some praised the care received several concerns were raised about the way patients were treated including examples of delays in receiving pain relief, and a lack of information provided at the end of the patient's life about what to expect. Five concerns were raised with us before, during and after the inspection about how bad news was broken to patients and families with examples provided which people informed us was not caring, empathetic or compassionate.

We rated end of life care services as inadequate for responsiveness because services do not always meet people's needs. The hospital was not recording a patient's preferred place of death, or recording the breakdown of referrals to determine what referrals were received relating to cancer and which were related to other conditions. Fast track was acknowledged by the trust to not always be rapid or fast with some cases taking up to 21 days to get a person discharged. The teams recognised they needed to improve communication and working relationships with other stakeholders to help improve this experience for patients.

The needs of the local population are not fully identified or understood or taken into account when planning services because the town of Colchester is forecasted to have the highest growth in population per hectare over the next decade, however Colchester General Hospital does not yet have a clear approach to planning, delivering and monitoring end of life care. There were no plans regarding the fridge capacity in the mortuary for the deceased to take account of population expansion.

We rated Leadership for end of life care was inadequate because the trust does not have a fully developed end of life care strategy that included prioritised, time bound actions with appropriately allocated leads. Issues around end of life care have been brought to the attention of the trust through previous inspections in May, November and December 2014 and in July 2015. However little progress has been made to improve the

End of life care

provision for end of life care. There was a lack of local leadership in relation to end of life care. The role of the lead palliative care nurse was not clear to us during the inspection and the end of life care facilitator had been seconded to another role which left the team with reduced staffing, no leadership and no direction which impacted on the provision of the service.

Are end of life care services safe?

Inadequate

We found that end of life care services were not safe and we rated them inadequate because:

- There was a lack of recognition, when assessing patients that patients were at the end of their life. We observed several examples of patients who should have been receiving dedicated end of life care who were not because staff had not identified that they were at the end of their life.
- Due to the lack of identification of patients at the end of their life the standard procedures for end of life care plans were not given priority or utilised when needed and opportunities to prevent or minimise harm are missed.
- Equipment required for the use of providing care to patients at the end of their life was not serviced or maintained and therefore were not assured they were safe to use.
- There were high levels of incidents being reported which related to end of life care, whilst not reported and categorised as end of life the incidents occurred to patients receiving end of life care.
- There was a lack of learning from incidents relating to end of life care and regular incidents reoccurred and there is no evidence of action being taken to improve safety associated with incidents for end of life care.
- 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 and the individual care record for the last days of life.
- It was identified after the inspection by the trust that there had been a lack of follow up on training and staff on Mersea ward never received training.
- Staff on all the wards we visited were able to describe an appropriate process for escalating and recording safeguarding concerns and could identify the lead nurse for safeguarding. However with the incidents of poor care identified with staff not recognising patients' who are at the end of their life which potentially, in some

circumstances, could be considered a form of neglect and we are not yet assured that the procedures for the identification of safeguarding in poor care were not yet embedded in every day practice.

Incidents

- Staff had access to use an online incident reporting system and informed us that they knew what needed to be reported as an incident. We spoke with 15 staff and all of those 13 were able to explain how an incident was identified, investigated and how learning would be shared.
- We examined the incident records for the trust which showed that the service had reported three and five incidents which related to end of life care. These included incidents such as: accidental damage to a deceased patient's body in the mortuary and a patient who was discharged with incorrect pain relief.
- The trust does not have a consistent method of recording end of life incidents. We were given two sets of data and we were not assured that the trust systematically captures end of life incidents, identifies trends and takes action to remedy shortfalls in end of life care.
- The service had no never events reported for patients' receiving end of life care. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- Staff were able to describe learning from general incidents to us but not specifically end of life care. There was a lack of learning from incidents which related to patients at the end of their life because reoccurring incidents such as discharge arrangements and pain relief at the end of their life are consistently reported.
- On the 18th September during our inspection on the Emergency Assessment Unit between 10:00 and 11:00 we saw in a patient's notes the doctor requested at 07:00 that an incident form was completed because a patient receiving end of life care on the ward was missing their medicines administration record. We asked the ward manager to see if this incident form was completed and we asked the trust to provide a copy of the incident report however there was no evidence that this incident had been reported in line with the trust's incident reporting policy.
- We spoke with 15 members of staff about the requirements of the Duty of Candour regulations. Of those we spoke with 13 were aware of the duty of candour requirements and all of these staff were aware of the trust incident reporting requirements and reporting procedure.
- We spoke with 6 doctors during the inspection and of those one doctor on West Bergholt ward and one on emergency assessment unit to whom we spoke did not know the duty of candour requirements.
- A member of the portering team informed us that the porters do not have computer access so they do not have access to the online incident reporting system. This meant that they had to ask their manager or a member of ward staff who can access the electronic system.

Environment and equipment

- The hospital had 230 'T34 McKinley' syringe drivers available to provide anticipatory medicines to patients at the end of their life. These items had been purchased by the trust over the last eight years.
- An internal document viewed showed that these items do not have a current service or maintenance plan in place. We asked if these items were serviced or received maintenance during this time, we were informed that some had, however no records of the servicing and maintenance of these syringe drivers were available. Therefore we were not assured that these items have been serviced, maintained or that they are safe to use.
- 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. The fridges are alarmed and monitored by the switchboard 24 hours a day and we saw evidence these are maintained annually.
- The team regularly monitored the temperature of the fridges. Faults on the fridges were alerted through the hospital switchboard to the team who were available 24 hours a day to respond to any problems.
- We saw evidence that additional maintenance was carried out when the switchboard received an alert. There had been 12 alert calls for fridge breakdowns and temperature concerns between 14 October 2014 and 22 July 2015.
- Policies specific to the mortuary included admission of the deceased and which provided clear guidance on management of infectious patients. Mortuary staff were able to describe how deceased patients should be stored in line with this policy.

End of life care

- We saw that the post mortem room had been upgraded to provide a modern post mortem environment, had four post mortem tables and fixtures and fittings could be easily cleaned to minimise risk of infection through cross contamination.

Medicines

- We asked the trust about their policies for managing end of life including anticipatory medicines. The trust told us they use the economy wide anticipatory prescribing guidelines and flow chart. We saw that the individualised care record for the trust referenced the anticipatory prescribing guidelines and accompanying flow chart for use.
- The trust provided copies of the economy wide anticipatory prescribing guidelines, flow chart and the individualised care record template. The guidelines explain the types of medicines that can be prescribed to relieve end of life symptoms including pain, agitation, nausea, breathlessness or respiratory secretions and where to seek additional help from.
- We asked nine staff members if they were aware of any policies to support them caring for end of life patients. These staff told us they believed there were policies on the intranet, but none of them had checked or could identify a particular policy that they had used to support them caring for patients' receiving end of life care.
- We reviewed the medicines administration records of 9 patients who were receiving anticipatory medicines and found that they had been appropriately prescribed and administered.

Records

- We examined the records of 48 patients during the course of our inspection. Records were difficult to navigate and it was unclear without referring to the handover sheets which patients were to receive end of life care and who was not.
- Patient notes were difficult to navigate, for example one patient's records on Mersea were inconsistently named and the patient's age was recorded as both 52 and 56. On Tiptree we identified the records of other patients within the record for a dying patient who had not been placed on the trust end of life care plan.
- 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 and notes left on tables with patient identifiable information on display.
- We reviewed the documentation for certification after a patient died and observed a doctor completing a certificate in the mortuary. A medical certificate of cause of death (MCCD) enables the deceased's family to register the death. We found the certificates had been issued within 14 days of death and burial or cremation forms had been signed in accordance with the Births and Deaths Registration Act 1953

Safeguarding

- Staff on all the wards we visited were able to describe an appropriate process for escalating and recording safeguarding concerns and could identify the lead nurse for safeguarding. Two staff described how they had escalated a safeguarding concern in relation to physical abuse.
- With the incidents of poor care identified with staff not recognising patients' who are at the end of their life which potentially, in some circumstances, could be considered a form of neglect. Following the inspection we raised a safeguard alert in respect of a patient who died who was not considered by the trust to be at the end of their life. Therefore we are not yet assured that the procedures for the identification of safeguarding in poor care were not yet embedded in every day practice.
- Mandatory training information provided by the trust showed that all mortuary staff had been trained in child protection level 1. The trust was not able to provide evidence that mortuary staff had been trained in adult safeguarding.
- Mandatory training information showed that 75% of porters had been training in child protection level 1 and 100% in adult safeguarding level 1.
- Mandatory training information provided by the trust showed that of the 6.6 WTE (nursing and medical) specialist palliative care staff all been trained in child protection at level 1; five had also been trained in child protection at level 2 and that all had been trained in adult safeguarding level 2.

Mandatory training

- End of life care training which includes identification for patients at the end of their life, advanced care planning, when to implement end of life care pathways, anticipatory medicines and do not attempt cardio pulmonary resuscitation orders (DNACPR) is not currently provided as mandatory training subject to staff who work at Colchester General Hospital.

End of life care

- The specialist palliative care team undertake training, when required, for staff on wards when requested. Staff of different grades with whom we spoke on wards told us they had between 20 minutes and one day end of life training, however we could find no evidence or training records that showed which staff had received what training.
- We asked 37 staff about end of life care training over the 14 wards and departments we visited and 14 said they had received no training on end of life care; two medical staff told us they had received a 20 minute session as part of induction; six nursing staff told us they had received a one day training session.
- Five ward managers told us it was difficult to release staff for any training owing to staff shortages.
- Mandatory training information provided by the trust showed that mortuary staff were up to date with mandatory training including health and safety, fire safety, hand washing, information governance and moving and handling.
- There had been vacancies in the specialist palliative care team throughout the year and the rate for other training varied between 88% for hand washing; 37.5% for learning disability Levels 1 to 3; 25% for record keeping and 77% and 100% for health and safety training.
- The specialist palliative care team told us they provided training for other teams within the trust. We saw evidence of scheduled dates for this training throughout the year. There was no identification of which staff will do this training or whether any priority was given to identification of staff most in need of end of life training.

Assessing and responding to patient risk

- The trust used a version of the National Early Warning Score system also known as NEWS. We saw evidence of 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 in the NHS.
- Patients' at the end of their life were not always being identified in a timely way which meant that there was a lack of clarity with regards to the ceiling of care to be provided, including treatment for patients who have high early warning scores, was not being appropriately assessed.
- We identified, in the records of one patient who was at the end of their life on Peldon ward, that they had an increasingly high warning score which was not followed up and there was no clear plan or ceiling of care for treatment in place. We spoke with a staff member on the ward about this, however there was no rationale provided for why this patient had not received appropriate treatment.
- We identified five patients during the course of our inspection who should have been on end of life care plans, however the staff had not recognised that these patients were at the end of their life.
- The lack of recognition of patients at the end of their life meant that in two cases treatment had been provided which was not appropriate. For example, one patient was given a prophylactic injection to prevent blood clots when they were receiving anticipatory medicine at the end of their life.
- Another end of life patient had been given contrast medication; contrast medication improves the diagnostic accuracy of the MRI scan. We were not assured that the trust is protecting end of life patients from unnecessary or inappropriate treatment through timely identification of patient's at the end stage of life
- We asked one consultant why a patient on Langham ward was not on the individual care record for the last days of life when they should have been. The consultant was challenging towards the inspection team and said they did not intend to use the trust individualised care record because they did not want to use it.

Nursing staffing

- The mortuary manager told us they have a full team consisting of 3.0 WTE technicians and 1.9 WTE bereavement officers.
- The specialist palliative care team comprised of one band 7 end of life care facilitator and 5.6 WTE clinical nurse specialists. The specialist palliative care team have had vacancies and absence due to sickness, secondments and maternity leave over the previous 12 months.
- The Band 7 end of life care facilitator had recently been seconded to a ward to act as a ward manager which meant that the staffing for palliative care had reduced further.

End of life care

- Since January 2015 the specialist palliative care team had accepted 1060 referrals which, with the staffing numbers available, mean that the capacity of the team to deliver the service was challenged and could impact on patient care.
- We spoke with the trust executive team and specialist palliative care team about staffing levels and they were planning, since our inspection, to write a business case to request additional funding for nursing support. They also informed us that they had recently appointed a new nurse who will join the team in three months.

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 1.0 WTE covering approximately 596 in-patient beds at Colchester General Hospital. Therefore the staffing provision was not in line with recommended guidelines.
- We spoke with the trust executive team and specialist palliative care team about medical staffing levels and they were planning, since our inspection, to write a business case from a collective network perspective to increase medical staffing to become more in line with the recommendations from the association.
- Access to out of hours was provided twenty four hours per day by consultant staff from the group of local hospices.
- Two ward managers told us that the specialist palliative care team visit the ward upon request but don't routinely participate in handovers. The specialist palliative care team told us they attend wards upon request but don't have capacity to participate in all the handovers.

Major incident awareness and training

- The mortuary were aware of the trusts major incident plan and informed us that they had good links within the trust and received regular communication from the Emergency planning office.
- 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.
- Staff were appraised of the risks of patients with high risk conditions or diseases from outside of the UK and had provisions and equipment to safely manage high risk infectious cases if required.
- The mortuary team took part in the internal major incident exercise which was held in June 2015.

Are end of life care services effective?

Inadequate

We have rated end of life care services as inadequate for effectiveness because:

- The trust had removed the Liverpool Care Pathway and replaced it with an 'individual care record for the last days of life', however not all staff were aware of this record, not all staff had been trained to use it and in one instance a member of medical staff told us that they refused to use the new record.
- Due to this lack of awareness of end of life in the trust during the inspection we identified 12 patients close to end of life, none of whom were on the 'individual care record for the last days of life' (ICR). This meant that patients were not receiving appropriate care in line with current evidence-based guidance and best practice.
- The trust scored much worse than the national average in the national care of the dying with poor results for end of life training, board level representation and development of relevant policies and protocols to support patients' families and staff making decisions about end of life care.
- We were not assured that staff providing end of life care were appropriately supervised or trained as records of appraisals, revalidation and training were not all available.
- Training records for staff throughout the trust, who use syringe drivers which provides pain relief to patients, were incomplete, out of date and we are not assured that all staff required to use syringe drivers were trained or competent to use them.
- There was a lack of consistency in how people's mental capacity is assessed and not all decision-making is informed or in line with guidance and legislation when a do not attempt cardiopulmonary resuscitation order (DNACPR) is completed.

End of life care

- We found that 61% of DNAPCR's checked were completed in line with Resuscitation Council guidelines, however we observed many examples where decisions not to resuscitate were made without appropriate mental capacity assessments being in place.
- In four 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.

However we also found:

- The specialist palliative care team and discharge team worked well with ward teams and local services including the hospice. However further work to improve multi-disciplinary from a system wide end of life care point was required.

Evidence-based care and treatment

- There was a lack of understanding by staff at all levels, including the executive level, within the trust about the stages of end of end of life care and when certain plans were required. This included the need for advanced care planning following a terminal diagnosis to the care required in the final hours and days of life.
- The trust has procedure for the recognition of the deteriorating patient which references Royal College of Physicians acute and NICE guidelines. The procedure was last reviewed in November 2013, which was prior to the withdrawal of the Liverpool care pathway.
- This policy cross references the do not attempt cardio pulmonary resuscitation (DNACPR) policy dated May 2015. Neither of these policies made reference to the 'individual care record for the last days of life' (ICR) for the last days of a patient's life.
- Whilst the do not attempt cardio pulmonary resuscitation (DNACPR) policy dated May 2015 had been recently reviewed it had not taken into account the need to review the fact that the East of England form for do not attempt cardio pulmonary resuscitation (DNACPR) was revised in April 2014. The forms currently used by the trust remain valid, however there was no evidence to support that the trust was planning to transition over to the updated form.
- We spoke to 42 members of staff, six staff told us that the Liverpool Care Pathway (LCP) had been replaced by the new 'individual care record for the last days of life'. This is the trust care plan and record keeping forms for patients identified as end of life.
- However we found that this was not being used throughout the trust and staff were not all aware of its existence and those who knew of it were inconsistently using it.
- The 'individual care record for the last days of life' recognises the 5 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.
- We found that the trust end of life individualised care record was not being used consistently where patients were identified as end of life to ensure they receive evidence based end of life care.
- We asked one consultant on Langham ward who was treating a patient who was at the end of their life, but was not on the 'individual care record for the last days of life' (ICR). They were very challenging towards our team and informed us that they had no intention of using the 'individual care record for the last days of life' (ICR). We raised our concerns regarding this consultant to the Medical Director for the trust.
- The trust currently does not have a clinical dashboard for end of life care. The trust told us this is on the trust action plan to develop, however there was no evidence of this on the trust's action plan.
- Birch ward undertook an audit on death on the ward for the month of May 2015. The results of this audit stated 'All patients had DNAR forms completed with documented escalation plans', '17 out of the 19 patients (89%) had palliative care review, or least identified as approaching end of life with anticipatory medicines prescribed'.
- Of the two patients who died without palliative care input the results stated, 'Both patients were seen on daily basis and reviewed regularly by the consultant in charge.' The conclusion was that the deaths were unavoidable and there was no trend.
- Whilst it was good practice to reflect on when events occurred and that might appear to be unusual. However, the audit parameters were not stated, the data reported lacked robustness and the evidence provided did not support the conclusions.

Pain relief

End of life care

- We spoke to nine patients and five relatives of patients. Three of the patients and one relative told us pain relief was offered often, two patients told us about delayed administration of pain relief and the rest did not comment.
- One patient on Layer Marney and relatives of one on Mersea ward told us about delayed pain relief. In both cases we drew this to the attention to staff on the wards who took immediate action to ensure patients received appropriate pain relief.
- Three patients or relatives told us of delays in pain relief being given across Langham, Layer Marney and Mersea wards.

Nutrition and hydration

- The national care of the dying audit results for nutrition and hydration showed that the trust received a score of 54% against a national average of 41%. This meant that the trust performs better for nutrition and similar to average for hydration.
- We saw evidence of a mouth tray in use for one end of life patient on Mersea ward. Mouth trays are used to assist end of life patients with mild hydration and is good practice.
- Due to the lack of awareness of medical staff on end of life care requirements since the removal of the Liverpool Care Pathway, and through the limited training provision, that medical staff were aware of the General Medical Council (GMC) requirements for nutrition and hydration at the end of a person's life; this includes the option of clinically assisted feeding.

Patient outcomes

- The national care of the dying audit data (2013/14) for the trust shows that the trust did not achieve four out of seven key performance indicators including: care of the dying continuing education, trust board representation, clinical provision/protocols promoting patient privacy, dignity and respect, up to and including after the death of the patient and formal feedback processes regarding bereaved relatives/friends views of care delivery.
- The trust scored 35% against the national average of 44% in the national care of the dying audit in response to the question about review of care after death.
- We asked the trust about monitoring of patient outcomes and the trust provided information about an outcome monitoring approach called Outcome Assessment and Complexity Collaborative adopted by the local hospice. The trust told us that two members of the specialist palliative care team had been trained in the Outcome Assessment and Complexity Collaborative approach and would be rolling this out to the hospice as part of the end of life project group meetings. This approach was not identified on the cancer action plan or the end of life 5-year strategic vision.
- There were notable poor outcomes identified during the inspection for patients who were or should have been receiving end of life care. We identified 12 patients close to end of life, none of whom were on the 'individual care record for the last days of life' (ICR).
- For example one patient on Peldon ward requiring end of life care had a feeding tube inserted for nutritional reasons even though death was expected to occur soon and a symptom of dying is difficulty swallowing. This patient became agitated and removed the feeding tube and subsequently aspirated increasing their risk of choking; a staff member observed the patient's oxygen level was compromised and commenced treatment.
- A second patient on Langham ward was recorded as being for end of life care and was receiving pain relief through a syringe driver and was being nursed in a side room because they were defined as being at the end of their life. However the patient was not on an 'individual care record for the last days of life' (ICR) which is the document the trust informed us was for those patients who are assessed to be in the last few days of life.
- We asked the management team, local and executive level, about this patient who assured us that the patient was not in the last days or hours and therefore did not require the record to be completed.
- We identified a third patient on Mersea ward who was dying and staff had not identified this. We escalated this patient to the person in charge and we were informed that no requests had been made for the family to come in despite that being their wish. We requested that they review the patient and their decision to call the family before it was too late. We asked if this patient was on the 'individual care record for the last days of life' because they were in a side room and in receipt of anticipatory medicines used at the end of a patient's life, we were informed that this patient was not on the 'individual care record for the last days of life'.
- We escalated the care of this patient to the executive team, along with others, and they reviewed the care with the teams and responded to us by saying that they

felt this patient was not at the end of their life and the care provided was appropriate. The patient died the following morning, therefore the trust had failed to recognise that this patient was dying.

- A fourth patient on Peldon ward who had been identified as end of did not have their regular medicines discontinued including, iron and an injection to prevent blood clots forming in line with the trust individualised care record. We were concerned that end of life care was not correctly implemented resulting in unnecessary intervention for this patient who died during the period of our inspection.
- Patients close to end of life normally have their usual medications withdrawn if it is not contributing to their symptom control, to prevent interventions which would not improve a patient's condition and or which might contribute to discomfort at end of life. Of the 9 patient records we examined for patients who were at the end of their life, and receiving anticipatory medicine, we identified that three of these patients had not been identified by the trust as at end of life and had not been placed on the end of life care plan.
- It was evident that there was a lack of knowledge in the trust about the stages of care at the end of a patient's life, including the advanced care planning stage when a terminal diagnosis is given, to the end of life care plan in the last days and hours and when do not attempt cardio pulmonary resuscitation (DNACPR) is required. This lack of knowledge and understanding about end of life care places patients at risk of receiving inappropriate or unsafe care and in the five cases above those patients did experience inappropriate care.

Competent staff

- We requested to see evidence that appraisals and revalidation for the nursing and support staff in specialist palliative care were being undertaken, however we were not provided with this information.
- Appraisal and revalidation had been undertaken for both medical staff working in the service.
- Trust staff had not been formally trained to use the 'individual care record for the last days of life' (ICR) and it was inconsistently used for end of life patients. We found no evidence which supported that staff were competent in using the end of life care plan available.
- We spoke with the trust Executive team and palliative care lead about the programme to roll out training on the 'individual care record for the last days of life' (ICR) and they explained that this was undertaken in all areas, with the exception of Mersea ward, one year ago however there had been a lack of follow up training. They informed us that not providing the training on Mersea Ward was an oversight.
- The trust has 230 T34 McKinley syringe drivers in use for the use anticipatory medicines at the end of a patients' life. We asked to see training records and competency records for the staff using these machines. The trust provided a sample of information relating to syringe driver training that took place between May 2007 and May 2014 for staff on Birch, Dedham and West Bergholt wards.
- Training information on these items was incomplete, out of date and we are not assured that all staff required to use syringe drivers were trained or competent to use them.
- This information showed that 66% of staff on West Bergholt (an oncology specialty ward), 100% of staff on Birch and 89% of staff on Dedham ward had been trained to use McKinley syringe drivers by February 2012. The end of life care facilitator had not been trained.
- The trust also provided copies of the template competency assessment for healthcare assistants and registered nurses. No evidence was provided that these have been undertaken for ward managers.
- The trust information did not provide assurance that ward based end of life champions have been competency assessed, or that ward based staff know from whom to seek support at ward level or when none of the specialist palliative care team are available.

Multidisciplinary working

- We found that the specialist palliative care team worked well with some wards including West Bergholt, D'Arcy, Easthorpe and the stroke ward. The manager on D'Arcy ward spoke with great respect about the dedication of the palliative care consultants.
- Ten ward managers told us the specialist palliative care team will attend the ward when referrals were made formally and less formally for advice and support when requested to do so. We found the specialist palliative care team do not routinely visit the wards and they don't participate in handovers.

End of life care

- The rapid discharge team told us they attend handovers if a referral was made. We observed a handover on Peldon ward, and a member of the rapid discharge team was present.
- The specialist palliative care team participate in local, economy wide work, to improve end of life care and have established working links with the local hospice and with other NHS trusts in the area.
- The North East Essex Clinical Commissioning Group has an end of life care strategy for 2013-2017 and the purpose of this was to join care at the end of life to make it integrated between home, primary care and hospital care. The trust is not an active member in participating in this strategy because attendance at meetings has been poor.

Seven-day services

- The specialist palliative care team provide support Monday to Sunday between 09:00 and 17:00. We were told that out of hours advice is available through 'Single Point' a telephone advice service run by the local hospice.
- The mortuary told us they provide a service normally between 08:30 and 15:30 Monday to Friday and have 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

- The trust uses the local 'My Care Choices' register. This was combined with the daily referrals to specialist palliative care team in the hospital. The 'My Care Choices' register is a collaborative secure online portal run by the hospice. Information can be accessed and updated by the hospital, the hospice and patients' participating GP's about patients for who end of life care advanced decisions and preferences have been identified and recorded.
- Staff had access to patient records on the wards and also to the online systems for pharmacy, radiology and pathologies if required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- 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 65 do not attempt cardio pulmonary resuscitation (DNACPR). Of the 65 do not attempt cardio pulmonary resuscitation (DNACPR) records reviewed, 40 (61%) were completed in line with Resuscitation Council UK guidelines.
- Of those not accurately completed 21 did not have clearly documented end of life discussions of the decisions with the patients. The reasons stated on the forms for not having those required conversations included reasons such as, 'frailty', the patient was 'unwell', the patient was 'elderly', the patient was 'drowsy'.
- Of those not completed in line with guidelines 32 did not have a discussion documented with their families, reasons provided included 'family not present' however in these cases no follow up attempts had been made to speak with the families.
- In 31 cases the patient had a do not attempt cardiopulmonary resuscitation order (DNACPR) in place when the patient did not have capacity. Of those cases 23 (74%) did not have a mental capacity assessment undertaken which should have been completed in the patient's best interest.
- In 10 cases the patient had a do not attempt cardiopulmonary resuscitation order (DNACPR) in place without their knowledge. The reasons given for four of these included the patient's 'frailty' or that they were 'unwell'.
- The Court of Appeal in England ruled on 17th June 2014 that doctors now have a legal duty to consult with and inform patients if they want to place a do not attempt cardiopulmonary resuscitation order (DNACPR) on medical notes. There were no recorded efforts made to ensure that the patient was made aware of this decision and in those cases we escalated our concerns about these cases to the senior staff on the wards to ensure that the order was reviewed and the decision discussed with the patient.
- We saw good examples of appropriately completed do not attempt cardio pulmonary resuscitation (DNACPR) and 'individual care record for the last days of life' (ICR) documentation for two patients on the stroke ward including discussion with the patient and relatives and appropriately completed mental capacity assessments.

End of life care

- The trust do not attempt cardio pulmonary resuscitation (DNACPR) policy required clinicians to take account of a patient's capacity to consent or to refuse treatment including do not attempt cardio pulmonary resuscitation (DNACPR).
- The trust carried out a do not attempt cardio pulmonary resuscitation (DNACPR) audit in November 2014 a key finding of which was the poor identification and recording of patients' capacity to consent.
- The results of this audit showed 40% of patients with a do not attempt cardio pulmonary resuscitation (DNACPR) in place either had a formal assessment of their mental capacity and 32% of patients had been involved in the decision making process.
- We were not assured that the Mental Capacity Act and deprivation of liberty safeguards are always implemented for people who had do not attempt cardio pulmonary resuscitation (DNACPR) documentation.

Are end of life care services caring?

Inadequate

We rated end of life care services as inadequate for caring because:

- There were times where patients and relatives did not feel well supported or cared for. We spoke with nine relatives and eight patients at the end of their life and whilst some praised the care received several concerns were raised about the way patients were treated including examples of delays in receiving pain relief, and a lack of information provided at the end of the patient's life about what to expect.
- Five concerns were raised with us before, during and after the inspection about how bad news was broken to patients and families with examples provided which people informed us was not caring, empathetic or compassionate.
- We observed that in the majority of cases patients' at the end of their life had their privacy and dignity respected with care provided in side rooms where possible. However we observed during handovers on wards that people's privacy was not respected because of the level of personal information shared and the staff spoke about the patients and not to them.
- The majority of relatives we spoke with felt that they were informed about the care and what to expect, however were provided with some examples of where staff could improve this. Relatives said that staff did not always explain things clearly or give them time to respond.

However we also found:

- Information on end of life and what to expect was available for patients and relatives throughout the ward, through the specialist palliative care team and through the bereavement and chaplaincy teams. Emotional support though counselling services were available to both patients and their relatives.

Compassionate care

- We spoke with nine patients and eight relatives about the end of life care they or their relative received on the wards. Two patients and one relative told us that that staff took a long time to answer the call bells, and there were delays in pain relief being given and staff attitude was dismissive towards patients' needs.
- Relatives of a patient on Mersea ward told us how their terminally unwell relative had been "dragged out of bed and made to wash and walk back to bed". They said "no one knew she was palliative". This patient's relatives told us they had not received any information about the symptoms of end of life and that they felt communication between staff and the patient was poor.
- Five concerns were raised with us before, during and after the inspection about how bad news was broken to patients and families. These related to care in accident and emergency, emergency assessment unit and on inpatients areas such as Mersea and gastroenterology wards.
- Relatives of patients who had received bad news felt that the news was not broken in a way which was empathetic, caring or compassionate. Examples were provided to us of how, "doctors did not stay to answer questions", "they just blurted it out like they did not care, like it was a job to them", "there was no care there, no compassion, I didn't think they were human".
- In one case the patient asked for all treatment options to be given, but their relative told us that they were spoken by three doctors in a row about how they did not want doctors "jumping up and down on their chest" as it "would not be the right thing to do". The relative told us they felt pressured and said they wanted

treatment and resuscitation. A resuscitation order was placed on the patient's records despite the discussion, which was not in line with guidance, and the relative informed us of the distress this had caused to them.
- We saw that end of life patients were cared for by ward staff in side rooms to protect the privacy and dignity of the dying patient and their families.
- Ward rounds which occurred during handovers were not undertaken in a way which protected the privacy and emotional needs of the patient. Staff stood in the bay and spoke about each patient in the bay without addressing the patient directly. We observed an example of a patient who staff said was dying, along with other person elements about their care in front of the whole bay. We asked the person in charge about this who informed us that it was common practice to handover in that way.
- Relatives of a patient on Mersea ward told us "staff are nice but have to be asked to do anything" and "they are not geared up to provide basic nursing care. No one knew she was palliative".
- The relative of patient at the end of their life being cared for on Easthorpe ward told us there is excellent continuity, nurses and clinical staff all introduce themselves at the start of each shift and provide refreshments.
- We spoke to relatives of an end of life patient in the emergency assessment unit. They told "The staff are great. He's not been left for long at any time. "
- The NMC Code of practice says nurses "must recognise and respond compassionately to the needs of those who are in their last few days and hours of life." (NMC, 2015). We found that staff were not consistently identifying end of life patients in a timely way.
- For example on Langham ward on 17 September we asked and were told that there was one patient at the end of their on the ward that day, however we identified a further two end of life patients. One of these patients had been seen three times by the specialist palliative care team over a period of eight days, who each time had suggested the patient be moved onto the end of life pathway and individualised care record. This was not done which meant that the staff were not fulfilling their duties to provide the care needed at the end of a patient's life.

Understanding and involvement of patients and those close to them

- Three relatives raised concerns with us about a lack of information being provided to them about care, what to expect and discharge planning.
- Relatives of a patient at the end of their life on Langham ward told us they were not sure who was in charge of their relative's care and that they would like information about what to expect. They had spoken with the specialist palliative care team and the ward but did not feel their questions were answered or that they were being included in their relatives care.
- We observed a patient in Mersea ward who was at the very end of their life and the staff had not informed the family. It was the patient's and families wish to be present when this person died, however staff did not recognise that this patient was dying and had not called the family. We spoke with the staff to ensure that the family were called to be with the patient as soon as possible.
- Staff on Mersea ward told us they make a referral to the specialist palliative care team to visit when patients or relatives ask for more information about dying.
- Relatives of a patient at the end of their life on Langham ward told us they were happy with the care for their relative told us they would like more information and would appreciate a single point of contact.
- Relatives of an end of life patient in the emergency assessment unit told us sharing of information to plan their relative's discharge could be better.
- CQC had received 10 enquiries about caring at the end of life care prior to the inspection and in response to this we undertook a bespoke analysis of all the complaints received by the trust between September 2014 and August 2015. We identified that because the trust does not categorise end of life complaints separately from ward based complaints that opportunities to improve the care of patients at the end of their life from feedback from patients and relatives were missed.

Emotional support

- The chaplaincy provides a seven day service is available 24 hours per day to provide emotional support to patients and their families. Wards had signs displayed on the wards with methods to contact the teams at any time of the day.
- The Chaplains told us they had 55 volunteers of varying denominations who can provide emotional support across the trust.

End of life care

- The mortuary bereavement service is by appointment in half hour slots and staff would try to accommodate requests for particular times. They ensure that people can take the time they need and don't rush people so that they can 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 can provide them with support.
- We were given information that showed counselling services are available from Macmillan cancer support upon referral for oncology patients. We were also given information about referral to a hospice bereavement counselling service.
- As part of the palliative care teams assessment of patient needs, patients who are at the end of their life can be referred for psychological support and provided with support for anxiety or depression if this was identified through the assessment as needed.
- The intensive care unit (ICU) does not have a dedicated leaflet for bereavement, we were informed that each relative of a person who dies on the unit was sent a personal letter of condolence and offered support in the letter from the team.
- Through the hospice the trust can refer families and relatives for external bereavement support through trained counsellors after their relative had died. This service was offered through the hospice and supports all ages including a specialist support service for children.

Are end of life care services responsive?

Inadequate

We rated end of life care services as inadequate for responsiveness because

- The hospital was not recording a patient's preferred place of death or auditing or following up to determine if they were being responsive to a patients needs to get them to their preferred place of death or not.
- There were no link nurses on the wards for end of life care.
- Fast track was acknowledged by the trust to not always be rapid or fast with some cases taking up to 21 days to get a person discharged.
- The fridge capacity in the mortuary for the deceased had not been upgraded to increase capacity in the last five years to take account of population expansion, there were no confirmed plans in place to increase capacity which could place the service at risk of not being able to maintain access and flow.
- The trust does not categorise end of life complaints separately from ward based complaints. There was a notable theme of end of life care through complaints raised by patients and relatives however no formal plans address these themes had been agreed.
- Care and support responding to the needs of relatives of those at the end of their lives was poor.

Service planning and delivery to meet the needs of local people

- The specialist palliative care team participated in the North East Essex locality outcome measures work stream. We saw minutes for the end of life project group meetings held in January, February and March 2015. These minutes showed a member of the specialist palliative care team represented the trust in February and March. This work is led by the hospice and Colchester General Hospital does not yet have a clear approach to planning, delivering and monitoring end of life care.
- According to the office for national statistics, Colchester's population grew by 12.8% between 2001 and 2012. The whole population of Colchester is expected to grow by a further 15.7% by 2021 with Colchester being forecasted to have the highest growth in population per hectare over the next decade. The number of people aged over 65 years is projected to increase by 37.6% between 2012-2032.
- There were no plans regarding the fridge capacity in the mortuary for the deceased to take account of population expansion in the Colchester area. The service had submitted plans to increase capacity however no plans have been approved by the trust.

Meeting people's individual needs

- There were 1477 in-hospital deaths in the year from January 2014 to December 2014. They informed us that

since January 2015 the specialist palliative care team had received 1060 referrals. Of the referrals received the service were able to visit and assess 983 (93%) of these patients.

- The service was not recording the breakdown of referrals to determine what referrals were received relating to cancer and which were related to other conditions such as heart failure.
- The hospital, at the time of the inspection, was not recording a patient's preferred place of death or auditing or following up to determine if they were being responsive to a patients needs to get them to their preferred place of death or not. The trust executive team recognised, during a meeting, that this was an area which they needed to improve.
- Relatives of patients on Mersea ward told us some staff let them stay with their relative who was end of life and others did not. This meant that there was not always a consistent approach to providing information to families who wish to stay with their relatives at the end of their life.
- The relative of an end of life patient in the emergency assessment unit and a patient on Mersea ward told us the nurses take a long time to answer the call bell. We did not observe delays during our observations. Call bell response times were not routinely recorded or audited by the trust.
- The specialist palliative care team told us there were end of life champions on the wards. The trust provided information named 'palliative care ward leaders' that highlighted 11 staff were end of life champions. Of these, nine were healthcare assistants and two were allied healthcare professionals.
- We spoke with staff on wards about the provision of end of life care and training, the trust was in the process of introducing ward champions for end of life care. We spoke with two members of staff on different wards about their role as ward champions who informed us that the role was a supportive role.
- We asked staff on 14 wards about end of life champions and six could name who their champion was. However the names ward staff told us for three of these differed from the information provided by the trust.
- Layer Marney, Easthorpe, Emergency Assessment Unit, Mersea and Dedham wards did not have a named end of life care champion.
- There were no link nurses (a registered nurse with specialist training in end of life care) on the wards for end of life care. We spoke with the trust and specialist palliative care team who informed us that it was in their future plans to introduce link nurses; however this had not happened at the time of our inspection.
- A variety of leaflets were available on the wards including information about coping with dying, chaplaincy and spiritual care and what to do following a bereavement. However some of these leaflets were outdated and had not been reviewed for some time. For example the format of the leaflets did not make use of symbols commonly in use elsewhere to depict death and dying for example a butterfly symbol.
- We saw that the leaflets stated on the back to ask for alternative formats if required. We did not see any leaflets in alternatives formats on the wards.
- We saw that the bereavement suite had a leaflet prepared by the hospice and the 'what do I do now' booklet contained helpful and practical advice about registering a relative's death and planning a funeral.

Access and flow

- The specialist discharge team told us they worked closely with the specialist palliative care team to discharge people to their preferred place of dying quickly. Staff on Darcy ward told us that fast track doesn't always happen before end of life patients become too frail to be discharged
- We saw data for the first six months of 2015 that showed the discharge team had been asked to fast track 108 patients. This data showed that 81% of these patients had been fast tracked to their preferred place of care, 19% of patients died in hospital before they could be discharged. None of these patients had chosen the hospital as a preferred place of dying.
- The specialist discharge team told us that more recently patients were not discharged as quickly and that funding had increasingly been the reason for delayed discharge. We saw evidence that between April and October 2014 no fast track referrals had been rejected by the CCG and that between November 2014 and April 2015, 26 had been rejected.
- We identified that an end of life patient on Langham ward had repeatedly requested to go home between the end of August and 15 September 2015, the first date of the inspection. There was no clearly documented rationale for the patient not being discharged home as this was their preferred place of death. We spoke to nursing and medical staff about this patient. Staff could

not provide a rationale for why this patient was not being discharged. Despite requesting to be discharged over a period of 20 days, this patient remained on the ward and died during the course of our inspection.

- Ward staff told us the specialist palliative care team will attend the ward if requested. The specialist palliative care team do not visit wards unless requested to do so. We asked senior palliative care team members if they proactively visit wards. They told us they had vacancies throughout the year and did not have capacity to attend ward handovers.
- The trust told us they had does have strong links with the hospice. Rapid discharge information showed that one patient was discharged to the hospice as a preference between January and June 2015.
- 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.
- There were occasions where the deceased patients were having to go through multiple moves due to insufficient capacity within the mortuary facilities.
- 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 a recognition that the facilities required expansion.
- On call arrangements were in place to manage the flow within the mortuary, and we were informed of an example where the on call person came in over a weekend to organise storage as the service had reached full capacity and bodies were waiting on the wards. They told us that they can usually manage though it is getting increasingly more challenging, particularly during public holidays such as Easter and Christmas.
- Translation services were available 24 hours per day through a telephone service.
- We spoke with staff throughout the medical and surgical wards and all were knowledgeable about learning disabilities and what do if a patient admitted has a known learning disability. Each area had a link staff member to seek guidance and support from, there was also a named specialist nurse for learning disabilities.
- There was a specialist named nurse for dementia. Staff on the wards had received training in dementia and understood how to make a patient's experience of hospital better for patients living with dementia better.

Learning from complaints and concerns

- CQC had received many enquiries about Colchester hospital prior to and during the inspection, ten of these related to end of life care and eight were specifically complaints regarding how their complaint to the trust regarding end of life care was handled.
- In response to this we undertook a bespoke analysis of all the complaints received by the trust between September 2014 and August 2015. We identified that the trust had received 54 complaints relating to end of life care during this period. However the trust does not categorise end of life complaints separately from ward based complaints.
- The people who raised these concerns to us felt their concerns were not handled appropriately, that their questions were not answered or that they were not treated with compassion.
- For example one patient's family complained about the patient being placed on the Liverpool Care Pathway on Layer Marney ward. We asked the associate director of nursing about this and she told us there had been a misunderstanding, the patient had not been placed on the Liverpool Care Pathway and that correspondence with this family was ongoing.
- In another complaint a patient on Langham ward had been told of his end of life status without appropriate family or nursing support present. The associate director of nursing told us the trust had accepted that the service had made errors on this patient's care.
- Complaints are investigated, but the outcome of complaints about end of life care are not shared with the end of life steering group. We were not assured that the trust processes for learning from complaints are appropriately cascaded so that learning from complaints takes place.
- We spoke to associate director of nursing about complaints. We were told there had been a significant backlog of complaints particularly in medical wards and a trend of poor communication in end of life care had been identified which they needed to investigate further.

End of life care

Are end of life care services well-led?

Inadequate

We rated the leadership for end of life care as inadequate because:

- The trust does not have a coherent end of life care strategy that included prioritised, time bound actions with appropriately allocated leads.
- The trust action plan for improving end of life care was included within the trust cancer action plan and was not seen as a standalone subject which required a strategic view on all inpatient care, not just cancer.
- The needs of the local population are not fully identified or understood or taken into account when planning services because the town of Colchester is forecasted to have the highest growth in population per hectare over the next decade, however Colchester General Hospital does not yet have a clear approach to planning, delivering and monitoring end of life care.
- The trust had a risk register, which acknowledges concerns around end of life care, however all items were listed as ongoing and there had been no progress recorded on reducing the risk.
- Concerns around end of life care have been brought to the attention of the trust through previous inspections in May and December 2014 and July 2015, however we found that end of life care had not improved, and had deteriorated since our last comprehensive inspection of End of Life Care in May 2014.
- The service was not recording the breakdown of referrals to determine what referrals were received relating to cancer and which were related to other conditions such as heart failure.
- There was no effective board or executive leadership and there had been multiple changes in divisional, executive and non-executive level management which had resulted in instability of the service.
- There was a lack of local leadership in relation to end of life care due to a lack of clarity on the role of the lead nursing staff and also with a senior member of the team being seconded to another role which left the team with reduced staffing, no leadership and no direction which impacted on the provision of the service.

Vision and strategy for this service

- The trust does not have a policy in place for end of life care. When we asked the trust about this we were informed that it was an item for completion on their action plan, however work on this had not yet commenced.
- The trust provided us with their action plan which did not make reference to development of an end of life policy or protocol.
- The trust does not have a fully developed end of life care strategy that included prioritised, time bound actions with appropriately allocated leads. When we asked the trust about this they acknowledged that there was no strategy at present for end of life care and this was something they needed to work on.
- The trust five year strategic vision document did not include development of more inclusive end of life care, the need for a policy or strategy on end of life care.

Governance, risk management and quality measurement

- The trust action plan for the national care of the dying audit is included within the trust cancer action plan and was not seen as a standalone subject which required a strategic view on all inpatient care, not just cancer.
- The cancer action plan, which includes the provision of end of life care, showed that all but two of the 52 end of life action points are categorised as ongoing although most of the action points had not been achieved.
- The inclusion of end of life in the cancer action plan did not demonstrate that the trust saw end of life care as an important function on its own. Approximately one quarter of all deaths reported in hospital relate to cancer, which meant that the trust had not focused on the end of life care agenda.
- For example the plan cites that all patients who are end of life will undergo a mental capacity assessment when completing a do not attempt cardio pulmonary resuscitation (DNACPR) decision to be a mandatory training subject for staff at the trust. We identified through the inspection that this training had not been undertaken and patients remained at risk through not having their needs assessed in line with national guidance.
- The trust risk register recorded end of life care as an area of concern specifically relating to delayed discharge to preferred place of death; poor communication around

cardio pulmonary resuscitation (DNACPR); education around end of life care; secondment of the end of life facilitator to another role and lack of oversight of end of life complaints by the end of life steering group.
- All items were listed as ongoing however there had been no progress monitoring on reducing this risk. The trust had identified four separate individuals responsible for these risks all of whom are operational managers and sit within the cancer services directorate. We did not see evidence that risk register items specific to end of life care were being monitored or that they had improved since the risks were added.

Leadership of service

- One week prior to the inspection the trust advised CQC that the board lead currently the director of nursing would change to the medical director on 01 October 2015.
- Prior to May 2015 there was no appointed non-executive director lead for end of life care. At the time of the inspection we were informed that the Chair of the trust was taking the non-executive lead role for end of life care.
- End of life care was raised as an area of concern during the previous inspections in May, November and December 2014 and in July 2015 however little progress has been made to improve the provision for end of life care.
- The importance of end of life care were not included in the leadership roles of associated directors and clinical and divisional directors in each core service. .
- There was a lack of local leadership in relation to end of life care. The role of the lead palliative care nurse was not clear to us during the inspection and the end of life care facilitator had been seconded to another role which left the team with reduced staffing, no leadership and no direction which impacted on the provision of the service.
- The specialist palliative care team told us they had found the board were more recently engaged in highlighting end of life care. They told us that the director of nursing leads and the trust chairman supports the palliative and end of life meetings.
- We saw minutes of these meetings for January, March, July and August of this year; neither the chairman nor the Director of Nursing were at the January or March meeting. The chairman attended the meetings in July and August. The lack of executive presence does not assure us that end of life care was being given sufficient priority and this was having a significant impact on the care patients received.

Culture within the service

- We found that the specialist palliative care team work well with ward staff when requests for support were made. The team worked particularly well with oncology wards.
- The specialist palliative care team were aware of the challenges to implementation of good end of life care including providing sufficient end of life training to support staff at all levels and resistance by some groups of staff or ward areas. They told us they believed the trust board was now engaged with their work.
- The culture of end of life care on the wards and in clinical care was limited with staff not recognising a patient at the end of their life at the earliest opportunity and therefore not offering them the care they may have required.
- The culture of not considering end of life care in the best interests of the patients, including the need to commence end of life care in the advanced planning stage prior to the end of life was poor. The trust was not providing the recommended current care which meets the needs of patients.

Public engagement

- The specialist palliative care team told us about 'Dying matters' week in May 2015 when they had stands throughout the trust to raise awareness of end of life care.
- The trust does not make use of social media to engage people in end of life care.
- The service and the trust does not undertake any audits, any feedback questionnaires or any surveys of the public relating to care at the end of life or bereavement and therefore have limited information to evidence how they engage the public on matters of end of life care.

Staff engagement

- We found that individual staff with whom we spoke to across the trust wanted to provide good end of life care. Staff on Birch ward were justifiably proud of the end of life work and had been recognised by the trust through a 'team of the month' award for end of life care earlier this year 2015.

End of life care

- The hospital undertook a survey called 'End of Life Care Staff Satisfaction Survey' however due to low numbers being returned the trust is reviewing its processes for getting staff feedback on end of life care provision.
- The trust has a specialist palliative care team who work well within the oncology department and respond to request for support throughout the trust. However, there had been staffing shortages within the specialist palliative care team and a lack of board level engagement with the specialist palliative care team and end of life care.

Innovation, improvement and sustainability

- We were informed of discussions which were taking place to jointly fund posts for nursing staff between the hospice and the hospital with a rotation between hospice and acute care which the trust hoped would benefit end of life care in the future.

Outpatients and diagnostic imaging

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

Information about the service

We observed care and treatment. We reviewed information provided by the trust.

Outpatient services at Colchester General Hospital are provided in main outpatients and from the Gainsborough Unit. Outpatient appointments are provided to assess, treat, monitor and follow up patients referred to the services.

Colchester General Hospital provides clinics for a range of specialties, including orthopaedics, urology, diabetes, respiratory, gastroenterology, cardiology, ear nose and throat (ENT), haematology, neurology, dermatology, rheumatology, therapy services, podiatry and paediatrics. Between January 2014 and December 2014 Colchester General Hospital had a total of 388,966 outpatient appointments booked. Twenty three percent (89,462 appointments) of the total were first appointments and 48% (186,704 appointments) were follow up appointments.

Colchester Hospital University NHS Foundation Trust radiology provides services including x-ray, computerised tomography (CT), magnetic resonance imaging (MRI), interventional radiology, ultrasound, breast screening, angioplasty and cardiology scans. Services are delivered by a multi-disciplinary team. CT scans use x-rays to produce cross sectional and 3D images of the body. MRI scans also produce cross sectional and 3D images of the body, using magnetic energy as opposed to x-rays.

During our inspection of outpatient services we spoke with patients and staff members. Staff we spoke with included radiologists, imaging assistants, senior radiology service managers, lead radiographers, medical, nursing, allied health professional, administrative and clerical, reception and patient appointment booking staff.

Outpatients and diagnostic imaging

Summary of findings

This service was inadequate overall. We rated safety, responsiveness and leadership of the service as inadequate, we do not rate effectiveness of outpatients currently and we rated care provided by staff as good.

Safety was inadequate because people using the service were at high risk of avoidable harm. During our inspection we identified a significant number of patients for whom the outcome of their outpatient appointment was not recorded correctly on the patient portal or they were overdue for a new or review appointment. There are currently 370,791 open referrals on the Portal system and there was a risk of patient being 'lost' in the system. An 'open referral' means referrals should be addressed on a speciality or sub-speciality basis to minimise out-patient waits and to ensure that the delivery of the 18 week referral to treatment time is not compromised. Where the outcome of appointments was not recorded, patients were at risk of appropriate and timely action not being taken regarding the care and treatment they needed. As of January 2016 the trust confirmed that they had commenced the validation of the open referrals on their system to assess if there had been any adverse impact of this issue on patients, and ensure patients receive appropriate treatment.

We were not assured staff had fully completed or recorded concerns related to the age, servicing and maintenance requirements for some equipment. We found gaps in the recording of staff checks and found staff had not always followed the trust required schedules of resuscitation equipment and trolley checks.

Not all staff in outpatients and diagnostic imaging had completed mandatory training. There was a potential risk because any staff member could create a set of temporary notes for outpatients, which meant patients may have multiple and duplicated medical records.

Staff had access to trust policies and procedures however we found not all staff were always following the access and booking policy. Clinical staff in outpatients and diagnostic imaging were not always aware of consent considerations, to ensure patients gave appropriate consent for their care.

Most clinical and administrative and clerical staff in outpatients and diagnostic imaging told us they had appraisals with their line managers. However no administrative and clerical staff in outpatients had had an appraisal between April 2013 and May 2015.

The trust had implemented a new clinical portal to replace its patient administration system (PAS) in November 2014. The trust acknowledged there was a large scale backlog of historical data inaccuracies and open referrals on the portal, which remained nearly a year after the new portal had been implemented.

Staff in the Gainsborough Unit, therapies and diagnostic radiology teams worked with a multidisciplinary approach which was well managed.

Patients who used the service at Colchester General Hospital told us they had been treated with compassion and respect. Diagnostic imaging and radiology staff at Colchester General Hospitals had a caring approach and attitude towards patients for whom they provided treatment. Patients in Gainsborough Unit told us they appreciated and valued the help and support of volunteers who were based in the unit.

The trust worked with local commissioners to provide outpatient and diagnostic imaging services for local people at Colchester General Hospital. However, we noted that local commissioners did not have full confidence in the management of outpatients' appointments and were not using electronic referrals to the trust. All outpatient referrals were made by using a paper based referral system.

The trust did not referral to treatment time data from November 2014 due to the implementation of a new patient records system called the portal. The service did not always meet patients' needs. The time waited by patients from referral to treatment was worse than the England average and below the expected standard. When attending clinics, some patients experienced delays for their appointments. Staff told us they only had access to interpretation services via telephone. Staff were not able to access and book interpreters for face to face interpretation services for patients whose first language was not English.

Outpatients and diagnostic imaging

We found a disconnect between the trust and divisional senior management teams and operational staff in outpatients and diagnostic imaging services.

We did not find a clear and embedded clinical governance structure, processes and management in place across all outpatients' services at Colchester General Hospital. We found outpatients' services across all of Colchester General Hospital were disconnected and there was a lack of overall governance and management.

Are outpatient and diagnostic imaging services safe?

Inadequate

The safety of this service was inadequate because:

- People using the service were at high risk of avoidable harm. During our inspection we identified a significant number of patients for whom the outcome of their outpatient appointment was not recorded correctly on the patient portal or they were overdue for a new or review appointment.
- The trust was not aware of these patients and the number lost at the time of the inspection and provided us with a comprehensive overview two weeks post inspection.
- At the time of the inspection there were 370,791 open referrals on the Portal system and there was a risk of patient being 'lost' in the system.
- There was a lack of process for risk assessing patients within the 370,791 referrals, or how best to approach this at the time of and following the inspection.
- We were particularly concerned about the provision of dermatology services. We spoke with the community provider who was contracted to provide this service and they were unaware of a risk assessment process for dermatology community outpatients or if a process existed for dermatology partial booking patients.
- Where the outcome of appointments was not recorded, patients were at risk of appropriate and timely action not being taken regarding the care and treatment they needed.
- There was a potential risk because any staff member could create a set of temporary notes for outpatients, which meant patients may have multiple and duplicated medical records.
- We were not assured outpatients' staff received information; feedback and learning in a consistent and timely way after incidents were reported, including never events and serious incidents. Diagnostic imaging staff did receive learning from incidents.
- We were not assured staff had fully completed or recorded concerns related to the age, servicing and maintenance requirements for some equipment.
- We found gaps in the checking of resuscitation equipment and trolleys.

Outpatients and diagnostic imaging

- Mandatory training compliance for outpatients and diagnostics were below the trusts compliance target.
- Staff had access to trust policies and procedures however we found not all staff were always following the access and booking policy. Clinical staff in outpatients and diagnostic imaging were not always aware of consent considerations, to ensure patients gave appropriate consent for their care.

However we also found:

- The trust had a proactive pathway and timely outpatients process in place for patients who needed new appointments as part of their cancer care and treatment.
- As of January 2016 the trust confirmed that they had commenced the validation of the open referrals on their system to assess if there had been any adverse impact of this issue on patients, and ensure patients receive appropriate treatment.
- The diagnostic radiology department had major incident plans and protocols in place.
- Diagnostic radiology staff at Colchester General Hospital reported any notifiable radiation incidents to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspectorate at the Care Quality Commission and the Health and Safety Executive as appropriate.

Incidents

- The outpatients and diagnostic imaging services at Colchester General Hospital used the trust incident reporting system to report incidents, including near miss incidents. The incident reporting system was well established. Most staff in we spoke with in outpatients and diagnostic imaging were aware of the trust incident reporting system. Staff told us they had received training to report incidents and reported incidents using the trust wide system.
- Diagnostic radiology staff at Colchester General Hospital reported any notifiable radiation incidents to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspectorate at the Care Quality Commission and the Health and Safety Executive as appropriate. All diagnostic radiology staff knew how to report incidents and what the reportable threshold was for radiation incident reporting.
- We saw minutes from a radiology governance meeting which showed staff had discussed recently reported incidents. The minutes had been sent to all diagnostic staff members so they were aware of discussions related to incidents.
- The clinical lead for diagnostic imaging told us they were able to change the ratings for reported incidents, by upgrading or downgrading these, if changes were required. The clinical lead told us any changes were discussed at radiology clinical governance meetings.
- Between May 2014 and April 2015, outpatients reported two never events and between outpatients and diagnostics there had been seven serious incidents. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. The two never events were due to wrong site surgery and surgical error.
- The serious incidents included two incidents of delayed diagnosis, one incident of wrong site surgery, one transfusion incident and a radiology/scanning incident. The other two serious incidents had been categorised as 'other' and 'remaining.'
- We asked staff about individual serious incidents and never events which had been reported but not all the staff we spoke with were aware of these incidents or the lessons learnt following the investigation of these incidents. We were not assured all staff were fully updated following reports of never events or serious incidents, or that learning from incidents had been systematically shared with staff.
- Colchester General Hospital had a 'Being Open' policy in place which provided information for staff in relation to Duty of Candour requirements. We found not all staff in outpatients had a complete understanding of the requirements to inform patients under Duty of Candour when harm had been caused.
- However, we found most staff in diagnostic radiology at Colchester General Hospital knew about Duty of Candour requirements and were encouraged to be open with patients regarding incidents.

Cleanliness, infection control and hygiene

- Main outpatient, Gainsborough Unit and diagnostic radiology clinics, treatment and waiting areas were visibly clean. Staff effectively managed, prevented and reduced the risk of infection.

Outpatients and diagnostic imaging

- We saw staff followed trust policies on infection control and hygiene in the clinics and treatment areas we visited at Colchester General Hospital. We observed staff using appropriate hand washing techniques and personal protective equipment, which included aprons and gloves as required.
- Hand alcohol gel dispensers were available in outpatient, Gainsborough Unit and diagnostic radiology clinics, treatment and patient waiting areas.
- Most nursing and allied health professional (AHP) staff in many clinics and diagnostic radiology services at Colchester General Hospital had completed hand washing training. The required trust mandatory training rate was 100% for hand washing. This was not always met however training completion rates were still high.
- Radiology staff had attendance at hand washing training of between 80% and 100%. Nursing staff in dermatology had a training attendance rate of 100% for hand washing but the rate for administrative and clerical staff from dermatology was 0%. Administrative and clerical staff in main outpatients had 100% hand washing attendance rate but the rates for nursing staff were 82% and for additional clinical services staff were 77%. AHP staff in physiotherapy outpatients had attendance rates of 86% for hand washing training.
- We saw equipment which had been cleaned was labelled with 'I am clean' stickers.
- Staff completed cleanliness audits for clinic and treatment area environments and equipment.
- However, we noted the interventional radiology room was currently on the trust risk register because it did not have a dirty utility or scrub room. This may present risks that the management, prevention and control of infection in this room were not adequately or appropriately managed.

Environment and equipment

- We saw staff had regularly completed audits to check equipment availability and expiry dates. However, we were not assured staff had fully completed or recorded concerns related to the age, servicing and maintenance requirements for some equipment. For example, we saw equipment lists in main outpatients but we did not see that the department had a replacement programme in place for equipment which was nearing or had exceeded their usage expiry dates.
- We also found in main outpatients a resuscitation trolley and the equipment on the trolley was not always routinely checked. We found gaps in the recording of checks and found staff had not always followed the trust required schedules of resuscitation equipment and trolley checks.
- We found equipment checking records in diagnostic imaging also had gaps where staff had not followed the trust required checking schedules.
- During our inspection diagnostic imaging staff told us x-ray machines had malfunctioned and other equipment, such as a contrast pump and portable x-ray machines, were outside their service dates.
- In main outpatients we found a defibrillator which was due to be checked in 2013 but there was no evidence on the defibrillator that a check test had been completed.
- However, we found cardiorespiratory outpatients staff had completed equipment checks and echo machines had been replaced as required.
- At Colchester General Hospital in diagnostic radiology we saw equipment specific protocols were available. Staff had access to these on the trust internal computer systems.

Medicines

- Medicines in the main outpatients were stored securely. We found temperature readings for drugs fridges were taken according to required schedules.
- Staff were aware of trust policies and procedures in relation to the administration, management, storage and disposal of medicines.

Records

- Staff in some clinics told us patients' medical records were not always available when they attended outpatient appointments. There were no audits or numbers available about how often notes were not available in clinic, though we were informed that it was frequent.
- We found staff were able to create a set of temporary patient notes if this was the case. However, the system for creating temporary notes was not managed which meant patient notes could and had been duplicated. Staff told us any staff member could create a set of temporary notes for patients. This was a potential risk because patients may have multiple and duplicated medical records.

Outpatients and diagnostic imaging

- We found staff in Gainsborough Unit were using day case records for patients rather than trust outpatient specific patient records. This meant Gainsborough Unit staff were not using trust standard documentation for their patient records.
- In urology clinics we found patient records had not always been completed in line with requirements on the records for clinical information. We also noted some patient records in urology did not have dates recorded which meant patient records were incomplete.
- In diagnostic radiology at Colchester General Hospital patients' records were held securely on the radiology information system. Staff could access radiology records via the trust system to allow assessments to be undertaken and diagnoses to be made.

Safeguarding

- In radiology 90% of nursing staff in radiology had completed training in Child Protection Levels 1 and 2, however 0% had received training at level 3.
- In main outpatients, nursing staff had completed 90% for Child Protection Levels 1 and 2 and 0% for level 3. The trust required standard for completion of both Child Protection Levels 1 and 2 was 100%.
- This meant not all outpatients and diagnostic imaging staff had completed safeguarding children training in line with trust training requirements and may not have received all relevant information for safeguarding children and reporting potential concerns.
- Within outpatients 80% of staff had received safeguarding adults level 1, and in radiology 96% of staff had received safeguarding adults training at level 1.
- Staff had access to the trust safeguarding policy via the trust computer system. Staff we spoke with were aware of the procedures to follow should they need to report a safeguarding concern.
- We also found staff in Gainsborough Unit liaised well with safeguarding colleagues in the trust. Staff members were able to describe specific incidents and occasions when they had raised safeguarding concerns, especially for children. Staff also told us they had received feedback following safeguarding concerns they had reported.

Mandatory training

- Mandatory training modules which all outpatients and diagnostic imaging staff were required to complete included health and safety, conflict resolution and information governance training. The target percentages for all staff and teams for completion of mandatory training were 100%.
- Although most Colchester General Hospital staff and teams had completed mandatory training this had not always been in line with the trust target of 100%.
- We found there were notable variations and exceptions. For example in main outpatients figures provided by the trust showed 88% of nursing staff and 73% of additional clinical services staff had completed conflict resolution training.
- However, the administrative and clerical staff in main outpatients had 0% attendance rate for conflict resolution training. This meant administrative and clerical staff, who may be in direct patient contact at main outpatients reception, might not be adequately trained to deal with and manage conflict in their working environment.
- In Gainsborough Unit, only 67% of nursing staff had completed information governance training and 63% of nursing staff had completed manual handling training against trust requirements of 100% training completion.
- For radiology medical and dental staff, only 6% had completed adult basic life support, which was significantly lower than the trust requirement of 100%.
- Seventy five percent of nursing staff and 70% of additional clinical services staff in radiology had completed information governance training by e-learning. Completion rates for radiology staff in health and safety training ranged between 80% and 100%. The trust requirement for all training was 100%.

Assessing and responding to patient risk

- Prior to our inspection we had been alerted to potential concerns about backlogs in outpatient services, concerns were also raised by staff about backlogs in outpatients services. Also the trust were not able to assure us that the risk regarding backlogs were being identified an safely managed.
- During our inspection we identified a significant number of patients for whom the outcome of their outpatient appointment was not recorded correctly on the patient portal or they were overdue for a new or review appointment. Post inspection the trust informed us that the trust currently have 161,570 patients who are in the system and require review, and these patients are linked

to the 370,971 open referrals on the Portal system, which meant that there was a risk of patient being 'lost' in the system or one of their pathways being missed or not completed.

- This included 278 patients classified as high risk because they were partial booking patients where the date for follow up was not specified. All 278 patients were to be validated.
- A group of 236,685 patients were classified as high risk because their outpatients' appointments were recorded as 'unclassified.' However the trust had not specified the sample size to be validated for this group and high risk areas were still to be identified.
- There were 33,337 patients classed as moderate risk because they were awaiting follow up and test results; 15,253 patients were classed as moderate risk because they were awaiting follow up and data was missing and 19,297 patients classed as moderate risk because they were on the outpatients waiting list.
- For all three of these patient groups, classed as moderate risk, the trust intended to sample only 10% using the validation process. This was not a significant number of patients, in total 67,887, who had been classified at moderate risk and for whom the trust had not begun validation processes in October 2015 to check if patients had received appropriate and timely treatment. There were no assurances that the other 90% would be safe during this time.
- As of January 2016 the trust confirmed that they had commenced the validation of the open referrals on their system to assess if there had been any adverse impact of this issue on patients, and ensure patients receive appropriate treatment.
- However, we found the trust had a proactive pathway and timely outpatients process in place for patients who needed new appointments as part of their cancer care and treatment.
- Where the outcome of appointments was not recorded, patients were at risk of appropriate and timely action not being taken regarding the care and treatment they needed. Patients who were overdue for a review appointment were at risk of essential treatment being delayed and the adverse effect this could have on their health.
- At the time of the inspection the trust not aware of the scale, breadth and depth of the issues or the number of patient awaiting their appointments, this meant that there was no risk assessment process in place to assess the risk to those waiting for appointments who are delayed for significant amounts of time.
- After our inspection the trust confirmed data validation and management of clinical risk for outpatient open referrals and appointments had been added to the trust risk register as a high risk. The risk had been added on 21 September 2015, which was after our inspection and as a direct result of initial feedback provided to the trust by our inspection team.
- Following our inspection the trust provided more information in October 2015 about outpatients whose appointments were incorrectly recorded or who were overdue for an appointment, either a new or follow-up appointment.
- The trust confirmed they had begun a process to validate larger samples of the "open referrals" for those patients identified as either high risk or moderate risk, to establish a more accurate estimate of the level of risk.
- Colchester General Hospital holds contracts with external providers for some outpatient specialties and pathways, including dermatology. We spoke with managers from the external provider for dermatology regarding the clinical risk assessment process for outpatients waiting for new or follow-up appointments. They were unaware of a risk assessment process for dermatology community outpatients or if a process existed for dermatology partial booking patients. We were not assured dermatology outpatients were adequately or appropriately risk assessed and managed via the external provider, on behalf of the trust.
- We also found Gainsborough Unit nursing staff and consultants risk assessed and appropriately triaged outpatients who were treated in the unit.

- The trust had an appointed radiation protection advisor. The diagnostic radiology team at Colchester General Hospital was well supported by their medical physics team.
- We saw local rules and Employers Procedures under Schedule 1 of IR(ME)R, all of which were regularly reviewed and revised.
- National Diagnostic Reference Levels (DRL's) were displayed throughout the department and regular dose audits were carried out.

Nursing staffing

Outpatients and diagnostic imaging

- Nurse staffing levels and skill mix required were based on individual clinic lists at Colchester General Hospital.
- Staff told us there was minimal use of bank and agency nurse cover to fill shifts.

Medical staffing

- Medical staff were provided for clinics by relevant divisions in the trust.
- Staff we spoke with, including nursing and allied healthcare professional (AHP) staff told us they could seek advice from medical staff as and when required.

Other staffing

- We were told the interventional radiology team at Colchester General Hospital should have consisted of five whole time equivalent (WTE) staff but at the time of our inspection there were only three WTE staff.
- An ongoing recruitment programme was in place for additional staff for interventional radiology.
- The cardiorespiratory outpatients team told us an additional physiologist had been recruited to their department which had increased their team's capacity to provide treatment.

Major incident awareness and training

- The trust had a major incident plan in place which staff could access via the trust computer system.
- The diagnostic radiology department had major incident plans and protocols in place. Staff in diagnostic radiology at Colchester General Hospital confirmed major incident rehearsals were arranged in order to test and provide assurance the diagnostic radiology team would be prepared and able to respond if a major incident occurred.

Are outpatient and diagnostic imaging services effective?

We inspected but did not rate the effectiveness of this service for outpatients and diagnostic imaging because there was insufficient evidence to provide a judgment on rating.

The following areas that required improvement were identified

- Staff had access to trust policies and procedures however we found not all staff were always following the access and booking policy.
- Clinical staff in outpatients and diagnostic imaging were not always aware of consent considerations, to ensure patients gave appropriate consent for their care.
- Most clinical and administrative and clerical staff in outpatients and diagnostic imaging told us they had appraisals with their line managers. However no administrative and clerical staff in outpatients had had an appraisal between April 2013 and May 2015.
- The trust had implemented a new clinical portal to replace its patient administration system (PAS) in November 2014. The trust acknowledged there was a large scale backlog of historical data inaccuracies and open referrals on the portal, which remained nearly a year after the new portal had been implemented.

However we also found:

- Staff in the Gainsborough Unit, therapies and diagnostic radiology teams worked with a multidisciplinary approach which was well managed.

Evidence-based care and treatment

- Staff had access to trust policies and procedures. This included the access and booking policy, the cancer access policy and leave policy.
- Staff were aware of the policies however we found not all staff were always following the access and booking policy.
- We also found the cancer access policy was a replication of the access and booking policy, which did not contain any additional or specific information for patients on the cancer pathway.

Patient outcomes

- We asked staff in outpatients for evidence of audits completed in their departments however we did not receive this information from staff during our inspection.
- Outpatients staff told us they were aware an audit on clinic start and finish times was due to be completed.
- Diagnostic imaging staff had completed an audit on patients who were pregnant. The last audit had been undertaken in March 2013. This audit was due to have been completed again by March 2015, according to trust audit timescales. We found the department had not yet completed the March 2015 audit and it was overdue when we inspected in September 2015.

Outpatients and diagnostic imaging

Competent staff

- Outpatients staff in main outpatients and the Gainsborough Unit at Colchester General Hospital were clear about their roles and the work they completed.
- Outpatients staff told us the skill mix for individual clinics was reviewed and adjusted to meet the needs of patients attending the individual clinics. Nurses who worked in main outpatients told us they worked across all outpatient clinic specialties, which meant they had experience of a range of different outpatients' specialties.
- Most clinical and administrative and clerical staff in outpatients and diagnostic imaging told us they had appraisals with their line managers. For example, the average percentage for the majority of diagnostic imaging staff who had completed appraisals between April 2013 and May 2015 ranged from 68% to 100%. However healthcare scientists in the radiotherapy physics department had completed an average of only 10% of their appraisals in the same time period.
- Additional clinical services staff in Gainsborough Unit had completed 100% of their appraisals in the last two full years between April 2013 and May 2015. However, nursing staff in Gainsborough Unit had completed only 67% of their appraisals in the same time period.
- Outpatients' additional clinical services staff had an average completion rate of 72% between April 2013 and May 2015. Nursing staff in outpatients had completed their appraisals by an average of 77% between April 2013 and May 2015.
- However administrative and clerical staff in outpatients had an appraisal completion of 0% between April 2013 and May 2015. This was confirmed by the outpatients booking team, who told us they had not had appraisals with their manager.
- Diagnostic imaging staff told us there was a staff competency programme in place.
- Clinical staff who worked in Gainsborough Unit also told us they felt their competencies were appropriately assessed, monitored and were well managed.
- We found administrative and clerical staff worked well within their competencies and were able to carry out their roles as required.

Multidisciplinary working

- Diagnostic imaging and radiology staff at Colchester General Hospital told us there was a multidisciplinary team approach to their work, which they felt worked well. Radiographers in particular told us there was good team working for their staff group. However we were told by some staff the increased multidisciplinary team working had impacted on consultants' time and availabilities.
- Therapies staff worked across the trust worked together in a multidisciplinary approach. We also found there was a multidisciplinary approach embedded and delivered by staff in Gainsborough Unit.
- However we found the multidisciplinary team approach was not working effectively between the outpatients booking team and specialty service managers in regard to the outpatients booking, assessment and triage processes. The outpatients booking team confirmed they had escalated their concerns to senior managers in medicine division but had not yet received a response.

Seven-day services

- Outpatients at Colchester General did not provide seven day services at the time of our inspection. Senior divisional management team members told us work was ongoing to review the provision of outpatients' services on a seven day basis.
- Diagnostic radiology staff at Colchester General Hospital told us they were also reviewing and working to provide seven day working.

Access to information

- Staff in main outpatients and Gainsborough Unit at Colchester General had access to patients' records via the trust information systems. However some staff told us information was sometimes shared on paper based systems rather than via trust computerised systems. This might present risks to the trust that information was not always systematically and appropriately shared.
- The trust had implemented a new clinical portal to replace its patient administration system (PAS) in November 2014. Outpatients' records, including new and follow-up appointments, had been migrated from the previous PAS system to the new portal. The aim of the migration to the new portal was to allow the trust to progressively improve its information systems and the quality and accuracy of the data contained in them.
- The trust acknowledged there was a large scale backlog of historical data inaccuracies and open referrals on the portal, which remained nearly a year after the new portal had been implemented. On 28 September 2015,

after we had inspected and provided initial feedback to the trust, the trust's executive team was informed data validation work still needed to be completed in order to improve reporting from the portal and ensure appropriate clinical governance of outpatient referral pathways.
- Staff told us the implementation of the new portal had created delays and difficulties for staff using the system. Staff, including clinical and administrative and clerical staff, told us they had not all received training to use the new portal to record and update outpatient bookings. This meant staff might not be using the portal system accurately or appropriately to record and update outpatient appointments.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Clinical staff in outpatients and diagnostic imaging were not always aware of consent considerations, to ensure patients gave appropriate consent for their care.
- Most staff in outpatients and diagnostic imaging had completed Mental Capacity Act (MCA) training. However, 56% of nursing staff in main outpatients had completed level 1 MCA training and only 33% had completed level 2 MCA training.
- For Gainsborough Unit, 88% of nursing staff had completed level 1 but only 38% had completed level 2 MCA training. The trust target for completion for both levels 1 and 2 MCA training for all staff was 100%.
- The completion of Deprivation of Liberty Safeguards (DoLS) level 1 training in Gainsborough Unit was only 25% for additional clinical services staff and 50% for nursing staff.
- Gainsborough Unit nursing staff had completion rates of 38% and 0% respectively for DoLS level 2 and level 3 training. The trust target for completion of all levels of DoLS training was 100%.
- Only 40% of additional clinical services staff in main outpatients had completed DoLS level 1 training. For main outpatients nursing staff, 56% had completed both levels 1 and 2 of DoLS training.
- Allied healthcare professionals in diagnostic imaging and radiology had higher completion rates of DoLS training at levels 1 and 2; completion rates varied between 72% and 100%.

Are outpatient and diagnostic imaging services caring?

Good

The care provided to patients using this service was rated as good because:

- We spoke with patients in outpatients clinics, the majority of them told us clinics were busy and sometimes delayed but staff tried to assist them individually. Patients also told us staff were quick to help them and were friendly
- Patients in Gainsborough Unit told us they appreciated and valued the help and support of volunteers who were based in the unit.
- Patients were encouraged to provide feedback about their care and their experience in main outpatients, Gainsborough Unit and diagnostic imaging

However some improvements were required because:

- We observed that privacy and dignity was not always maintained for some patients in diagnostic radiology. We saw one patient who was transferred through the department on a trolley and who was not appropriately covered with a blanket.

Compassionate care

- Outpatients at Colchester General Hospital told us they had been treated with compassion and respect. Patients also told us staff were quick to help them and were friendly.
- We spoke with patients in outpatients clinics, the majority of them told us clinics were busy and sometimes delayed but staff tried to assist them individually.
- We saw many staff who spoke with patients respectfully, politely and in a caring way.
- Patients attending for appointments and treatment from plaster clinic staff told us they had been able to build up relationships with staff members over a long-term basis. Patients felt this was a positive experience for them.
- Outpatients in cardiorespiratory also gave us positive feedback about their care and treatment from staff in the department.

Outpatients and diagnostic imaging

- Diagnostic imaging and radiology staff at Colchester General Hospitals had a caring approach and attitude towards patients for whom they provided treatment.
- However we observed that privacy and dignity was not always maintained for some patients in diagnostic radiology. We saw one patient who was transferred through the department on a trolley and who was not appropriately covered with a blanket.

Understanding and involvement of patients and those close to them

- Patients told us they had been informed about their appointments and felt able to discuss their care.
- We saw patient feedback forms which were available for patients and those close to them to complete.
- Patients were encouraged to provide feedback about their care and their experience in main outpatients, Gainsborough Unit and diagnostic imaging.

Emotional support

- Nursing staff in outpatients' clinics helped to reassure and support patients who were waiting for their appointments or who had been seen.
- Patients in Gainsborough Unit told us they appreciated and valued the help and support of volunteers who were based in the unit.
- The trust chaplaincy service and chaplain were available for patients to access.

Are outpatient and diagnostic imaging services responsive?

Inadequate 

We rated the responsiveness of this service as inadequate because:

- There was a significant backlog of patients waiting for outpatient appointments. The trust was still working through the high risk cohort of 236,685 unclassified patients, the medium risk cohort of 33,337 patients and those awaiting follow up and test results.
- The longest wait for a routine appointment on the 18 week outpatient pathway was 116 weeks.
- local commissioners did not have full confidence in the management of outpatients' appointments and were not using electronic referrals to the trust. All outpatient referrals were made by using a paper based referral system.
- The trust did not formally submit RTT data since its move over to a new system called portal.
- Of the data reviewed referral to treatment was worse than the England average and below the expected standard.
- When attending clinics, some patients experienced delays for their appointments
- Staff were not able to access and book interpreters for face to face interpretation services for patients whose first language was not English.

However we also found:

- Following the inspection the trust informed us, in November 2015, that they had reduced this longest wait from 116 weeks to 60 weeks.
- Staff in main outpatients told us there were plans and processes in place to help meet the individual needs of patients living with dementia, learning disabilities or mental health conditions.
- Staff in main outpatients, Gainsborough Unit and diagnostic imaging at Colchester General Hospital tried to deal with and resolve patient complaints within their local services.

Service planning and delivery to meet the needs of local people

- The trust worked with local commissioners to provide outpatient and diagnostic imaging services for local people at Colchester General Hospital.
- For example, diagnostic radiology teams had established and implemented a protocol to identify cancer patients in conjunction with local commissioners and GPs.
- However, we noted that local commissioners did not have full confidence in the management of outpatients' appointments and were not using electronic referrals to the trust. All outpatient referrals were made by using a paper based referral system.
- The facilities and clinic premises in main outpatients and Gainsborough Unit were appropriate to deliver outpatient and diagnostic imaging procedures.

Outpatients and diagnostic imaging

- Car parking was available for outpatients at Colchester General who were attending for outpatients' appointments, treatment in the Gainsborough Unit or in the diagnostic imaging department.

Access and flow

- Data provided by the trust relating to patient waiting times from referral to treatment was for all patients across the trust. The trust did not submit data from November 2014 due to the implementation of a new patient records system called the portal.
- Operational standards are that 95% of non-admitted patients should start consultant-led treatment within 18 weeks of referral. Between April 2013 and November 2014 the trust fell below this standard from January 2014 onwards and remained below the England average from January 2014 to November 2014.
- Non-admitted referral rates in November 2014 were 92%. This was below the operational standard of 95%.
- Operational standards are 92% of patients on incomplete pathways should start consultant-led treatment within 18 weeks of referral. Between April 2013 and August 2014 the trust met this standard but was below the England average and did not meet this standard between September and November 2014.
- The percentage for urgent GP referrals within two weeks for patients who needed a first consultant appointment for all cancers was mostly met by the trust between April 2013 and September 2013. The 95% standard was not met between October 2013 and March 2015. There was a decrease to 90% in July 2014 and an even sharper decrease to less than 90% by March 2015.
- There was a significant backlog of patients waiting for outpatient appointments. The trust was still working through the high risk cohort of 236,685 unclassified patients, the medium risk cohort of 33,337 patients and those awaiting follow up and test results. The trust is unsure of the impact on the service at the time of the inspection.
- Following a review by the trust the longest wait for a routine appointment on the 18 week pathway was 116 weeks.
- Following the inspection the trust informed us, in November 2015, that they had reduced this longest wait from 116 weeks to 60 weeks.
- Diagnostic waiting times for the percentage of patients waiting more than six weeks consistently fell below the England average for the trust between July 2013 and December 2014. Between December 2014 and January 2015, the trust performed better than the England average. However the trust fell below the England average from January 2015 onwards.
- Between February 2015 and May 2015, an average of 12% of all scheduled sessions were cancelled. The two main clinic cancellation reasons were 'No Consultant' and 'Clinician on Holiday'. Together these accounted for 68% of all cancellations. The trust has now implemented an active workstream to resolve this.
- One patient in the outpatients' pain clinic told us their appointment had been cancelled four times in the last 12 months.
- The trust confirmed 13% of patients waited over 30 minutes to see a clinician.
- Less than 1% of patients were seen in outpatients without the full medical record being available.
- Between January 2014 and December 2014 the percentage rates for patients who did not attend their appointments was in line with the England average of 7%.

Meeting people's individual needs

- Staff in main outpatients told us there were plans and processes in place to help meet the individual needs of patients living with dementia, learning disabilities or mental health conditions.
- For example, nursing staff described how one patient's appointment times were carefully planned and arranged with them, to take into consideration the best times for the patient's appointments. This patient had an adapted appointment booking procedure in place which staff used to book all their outpatient appointments.
- We were told interpretation services were available as required for individual patient appointments, this was via a telephone interpretation line which staff could use during appointments. However staff told us they only had access to interpretation services via telephone. Staff were not able to access and book interpreters for face to face interpretation services for patients whose first language was not English. Scheduled appointments should have access to interpreters through effective planning, however we found that this was not the case.
- Chaperone services were available for patients if they wished to use this service during their appointments.
- The main outpatients waiting area at Colchester General Hospital had been refurbished. The waiting area was

spacious but the acoustics were poor. This meant patients were not always able to clearly hear staff calling out the names of patients for individual clinics. There was no other way for patients to know who had been called to attend their appointment, such as appointment boards or visual displays.

Learning from complaints and concerns

- Staff in main outpatients, Gainsborough Unit and diagnostic imaging at Colchester General Hospital told us they tried to deal with and resolve patient complaints at their local level initially.
- If patients wished to take their complaint or concern further, staff provided information on how to contact the trust Patient Advice and Liaison Service (PALS) or the complaints department.
- However some patients who had received treatment in the Gainsborough Unit told us staff from the unit had signposted them directly to PALS rather than complaints department, when the patient had wanted to make a complaint.
- We found information on contacting PALS and making formal complaints to the trust were available in main outpatients, Gainsborough Unit and diagnostic imaging.
- The trust shared information from complaints with all members of their Foundation Trust group.

Are outpatient and diagnostic imaging services well-led?

Inadequate

The leadership of this service was inadequate because:

- There was a disconnect between the trust and divisional senior management teams and operational staff in outpatients and diagnostic imaging services.
- There was a lack of a clear and embedded clinical governance structure, processes and management in place across all outpatients' services at Colchester General Hospital.
- Outpatients' services across all of Colchester General Hospital were disconnected and there was a lack of overall governance and management.
- The risks associated with the backlog of patients, the volume of patients potentially lost in the system, those at risk going beyond 52 weeks on the 18 week pathway and the risk of harm to those patients was not a known risk identified by the trust prior to the inspection.
- The local leadership and trust board had not made substantial progress to tackle and resolve these issues at a pace which was appropriate to meet the needs of outpatients.

However we also found:

- Cancer services were well managed locally.
- Staff knew about their service's and the trust's vision.
- Outpatients' staff, Gainsborough Unit and diagnostic imaging staff all told us they felt there was a good staff culture and teamwork between colleagues.
- Staff told us they worked hard to deliver care which met patients' needs but felt they were not always able to achieve this due to factors outside their control.

Vision and strategy for this service

- We found staff knew about their service's vision and strategy. They were also aware of the trust vision and described the 'At our best' trust vision to us.
- Main outpatients staff were aware of the trust's strategy for nursing.

Governance, risk management and quality measurement

- We did not find a clear and embedded clinical governance structure, processes and management in place across all outpatients' services at Colchester General Hospital. This meant the trust did not have full assurance that outpatients' referrals, bookings, assessments and reviews were being appropriately managed in a timely way. This was particularly evident for those patients on the dermatology outpatients' pathway, which the trust had contracted out to an external provider.
- An outpatients' risk register was in place but as not fully completed to appropriately identify and address identified risks. The trust updated its outpatients' risk register following our inspection.
- Staff told us they felt there was a lack of sustained, managed planning of clinics.

Outpatients and diagnostic imaging

- The contract to validate outpatient referral to treatment times (RTT) was due to end in 2015, which might adversely impact the trust's ability to accurately validate RTT information from the portal in a sustained, managed way.
- Main outpatients' services and outpatient services provided by Gainsborough Unit staff were not linked. We found no evidence that learning and best practice was shared between these two outpatient service areas.
- We found outpatients' services across all of Colchester General Hospital were disconnected and there was a lack of overall governance and management.

Leadership of service

- Staff in outpatients and diagnostic radiology at Colchester General told us their local managers were approachable and available to discuss concerns. They felt supported by their local managers.
- However, staff also told us they felt there was a disconnect between the trust and divisional senior management teams and operational staff. In particular, staff told us they felt service managers responsible for outpatients were not responsive or managing their services well.
- The outpatient services' structure had not been fully formalised or implemented. We found a lack of forward planning and appropriate pace to implement the changes.
- The outpatient matron's role was not visible within the trust senior management structure and staff told us they felt the trust had not been sufficiently sighted or focussed on this role.
- We found the senior sister for main outpatients led and managed the service well. However we did not find a robust management plan in place to mitigate against the senior sister being unavailable or away from Colchester General Hospital main outpatients.
- Orthotics and physiotherapy staff members shared the same manager however some physiotherapy staff felt they were less well supported by the manager.
- The partial booking team also expressed their concerns to us about the lack of engagement with their senior management team. Allied healthcare professionals told us they did not feel supported or appreciated within the trust senior management teams.
- Some members of the diagnostic radiology and interventional radiology teams told us they did not feel well supported by their service manager. We discussed and raised this with the trust during our inspection; the trust confirmed they were aware of this situation.
- Outpatients' staff told us the Chief Operating Officer, who was the trust executive member for outpatients, had been more visible in the service.
- Main outpatients staff at Colchester General Hospital told us the relocation of some outpatients services from Essex County Hospital to the Colchester General Hospital had been well planned and managed by the senior sister for outpatients.
- Cancer services for outpatients' services were well managed, as a discrete and separate service for patients on the cancer two week wait pathway. These patients were not managed together with the rest of outpatients' services at Colchester General Hospital.

Culture within the service

- Outpatients' staff, Gainsborough Unit and diagnostic imaging staff all told us they felt there was a good staff culture and teamwork between colleagues.
- Staff told us they worked hard to deliver care which met patients' needs but felt they were not always able to achieve this due to factors outside their control.

Public engagement

- Patients and those close to them were asked for feedback.
- The trust had a Foundation Trust group membership who were informed about developments in outpatients and diagnostic imaging.

Staff engagement

- Staff completed trust surveys regularly.
- Staff in outpatients and diagnostic imaging at Colchester General old us they were able to discuss suggestions for their team and services with their managers.

Innovation, improvement and sustainability

- Staff in the CT scanning team had begun a staff consultation process with trust senior management on 14 September 2015. Some staff members were anxious about the consultation and the potential impact of the consultation, especially for those roles which had been identified as 'at risk.'

Outpatients and diagnostic imaging

- The trust had begun to implement an outpatients' project plan to address issues in outpatients' services.

We found the trust board had not made substantial progress to tackle and resolve these issues at a pace which was appropriate to meet the needs of outpatients.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure that there is a suitable training provision in place to support staff to recognise and identify patients at the end of their life so that appropriate treatment can be provided.
- Ensure that staff receive training to use the dedicated end of life pathway so that patients can receive appropriate care at the end of their life care and treatment.
- Ensure that do not attempt cardiopulmonary resuscitation (DNACPR) decisions are undertaken in accordance with national guidance and best practice.
- Ensure that mental capacity assessment are undertaken in the patients best interest, prior to agreeing medical decisions regarding care or treatment.
- Ensure that staff are trained and assessed as competent to use equipment which is required for the provision of patient care.
- Ensure that there a policy, procedure and strategy for end of life care is developed.
- Ensure there is a robust incident and accident reporting system, including reporting of lessons learnt to all groups of staff.
- Take action to ensure patients receive appropriate and timely clinical review and that the system for escalation of a patients deteriorating condition is robust.
- Ensure that there are sufficient numbers of qualified, skilled and experienced nursing staff in all patient areas at all times.
- Complete a review of senior medical staffing and consultant support, especially within Orthopaedics, to ensure that there are sufficient numbers of qualified, skilled and experienced medical staff at all times, across all specialities.
- Ensure that there are sufficient numbers of suitably qualified medical staff, below consultant grade, on duty at all times.
- Ensure that medicines are stored in accordance with manufacturers and legislative guidance and that staff take appropriate actions when temperatures breaches occur.
- Ensure that patient's records are appropriately stored in accordance with legislation at all times.
- Ensure that policies and procedures are formalised and in place and that all staff have awareness and can access trust policies and procedures.
- Ensure that temporary and locum medical staff have access to the appropriate hospital systems to ensure continuity of patient care.
- Review admission times and fasting periods for patients awaiting surgery to ensure the nutritional and hydration needs of the patient are met.
- Ensure local audit and review of patient outcomes is consistent across all areas.
- Ensure that all staff have receive an appraisal and frequent supervision.
- Review handover arrangements and ward rounds to ensure that they are effective and include the multidisciplinary team to ensure holistic review of a patients care and treatment.
- Review the process for obtaining patient consent to surgery to ensure that patients have adequate time to consider informed consent.
- Review staff communication with patients and relatives to ensure that patients are treated with dignity and respect, to include maintenance of patient privacy during nursing handover.
- Review the arrangements for internal transfers of patient, including moves at night, to ensure this is kept to a minimum.

Outstanding practice and areas for improvement

- Ensure a robust system for risk assessment is in place and that the governance structure introduced is consistent across all areas to ensure safe care and treatment.
- Improve patient care to those on cancer pathways by reducing waiting times for treatment.
- Improve mandatory and statutory training rates.
- Ensure that patients are risk assessed and prioritised in outpatient pathways.
- Ensure that duty of candour is undertaken in all outpatient cases where significant delays have been identified and the patient was placed at risk of harm.
- Ensure that there is a robust safety oversight of dermatology service provision.
- Ensure that staff are enabled to freely speak up about concerns and provide feedback about services and care without fear of reprisal.
- Review the processes formotality and morbidity within the divisions to ensure that risks, trends and lessons are learned from patient deaths.

Action the hospital SHOULD take to improve

- Provide support to medical staff throughout the trust on breaking bad news to patients and their families.
- Review the handover procedures on wards so that patient privacy is respected.
- Review the fridge capacity within the mortuary and develop a future plan for the sustainability of service provision.
- Review working relationships and arrangements in place to support rapid and fast track discharges for patients at the end of their life.
- Undertake audits and monitor activity on preferred place of death to meet patients preferences.
- Reviewing the nursing, and medical and leadership establishments within end of life care.
- Improve governance arrangements by improving learning and the identification of trends from complaints and incidents.
- Review the arrangements and focus on end of life care to ensure that its given sufficient priority on the directorate, board and patient council agenda.
- Review the complaints process to ensure that lessons to be learnt are communicated to staff.
- Ensure there are sufficient therapy staff out of hours and at weekends to provide services and minimise delays to patient discharge.
- Review staff communication and engagement within the therapy services and theatre.
- Review the length of time patients are on trolleys within the emergency department, EAU, SAU and on Copford ward and ensure risks of harm to patients is minimised.
- Improve staff understanding to raise concerns and report incidents and near misses.
- Ensure the care and treatment of those patients identified as having a long term conditions reflects current evidence-based guidance, standards and best practice.
- Consider reviewing the policy for patient movement out of hours.
- Ensure there is a timely review of the provision of services within the endoscopy unit.
- Ensure the security of patient records to minimise the risk of access by an unauthorised person.
- The trust should ensure there is a consistent approach to patient handover within the division to ensure patient's privacy and dignity is maintained.
- Review the process for the creation of temporary records in outpatients.
- Review caring, culture and morale on the wards highlighted in the inspection report as requiring support to improve the attitude and care provided to patients.
- Review the staff morale and concerns highlighted by staff in outpatient booking centre, therapies, endoscopy and radiology to find a resolution which improves services.