

Colchester Hospital University NHS Foundation Trust

Quality Report


Colchester General Hospital
Turner Road
Colchester
Essex
CO4 5JL
Tel: 01206 747474
Website: www.colchesterhospital.nhs.uk

Date of inspection visit: 25-27 July 2017 and an
unannounced on 2 August 2017
Date of publication: 02/11/2017

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

Ratings

Overall rating for this trust

Requires improvement 

Are services at this trust safe?

Requires improvement 

Are services at this trust effective?

Good 

Are services at this trust caring?

Good 

Are services at this trust responsive?

Requires improvement 

Are services at this trust well-led?

Good 

Summary of findings

Letter from the Chief Inspector of Hospitals

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

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

Colchester Hospital University NHS Foundation Trust is comprised of two main hospital sites which are Colchester General hospital and Essex County Hospital. The Essex County Hospital is scheduled to close during 2018 and the only services currently provided on site are outpatient services and ophthalmic eye surgery under local anaesthesia. Colchester General hospital has 763 beds, spread across various core services, and provides district general hospital care to 370,000 in Colchester and the surrounding area of North East Essex and South Suffolk.

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

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

- Surgical Procedures
- Diagnostic and Screening

- Treatment of disease, disorder or injury

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

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

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

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

The team in place now worked together with more structured disciplines being embedded around executive

Summary of findings

and performance behaviours and responsibilities. Within the every patient, every day programme (EPED), the responsibility, accountability and ownership of service improvement had been given back to the local leaders. We saw many examples of local leaders and senior staff being highly motivated, engaged in seeking solutions to drive improvements locally.

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

Our key findings were as follows:

We saw several areas of outstanding practice including:

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

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

Importantly, the trust must:

- The trust must ensure that nursing and medical staff complete all safeguarding and mandatory training including basic life support.
- The trust must ensure that all equipment is maintained and fit for purpose.
- The trust must ensure that initial assessments within the emergency department are undertaken and documented to maintain an accurate clinical record based on clinical judgement, and that initial assessments in the emergency department are documented.
- The trust must ensure access to a designated mental health assessment room.

- The trust must take action to ensure that patients are clinically risk assessed as safe to wait for outpatient appointments.
- The trust must ensure that medical records contain completed risk assessments relevant to patient care
- Ensure that patient's records are appropriately stored in accordance with legislation at all times.
- The trust must ensure that staff administering contrast for diagnostic imaging investigations use a patient group direction or have it prescribed.
- Ensure that do not attempt cardiopulmonary resuscitation (DNACPR) decisions are undertaken in accordance with national guidance and best practice.
- The trust must ensure that the design and layout of the paediatric emergency department enables effective oversight of paediatric waiting areas to ensure patient safety.
- The trust must ensure that there is an effective governance and risk management framework in place to identify and assess all risks relevant to the emergency department.
- The trust must ensure that patient's dignity is protected in changing cubicles in In Beta X-ray.
- The Trust must ensure that the doors for Beta X-ray are fully fitted and a risk assessment is in place to ensure patients are not a risk of unnecessary exposure of ionising radiation.
- The trust must ensure there is an effective process in place for timely review of policies and procedures and that these comply with national guidance and best practice.

Action the hospital SHOULD take to improve

- The trust should improve its overall performance in the management of referral to treatment times.
- The trust should ensure that clinics are not cancelled without exploring every option in order to contribute to reduced waiting times.
- The trust should ensure the clinics start on time.
- The trust should ensure that all staff are aware of translation services for non-English speakers.

Summary of findings

- The trust should ensure that clinical audit is undertaken and where data is not submitted, that it is followed up.
- The trust should ensure that all staff have received an appraisal and frequent supervision.
- The trust should review admission times and fasting periods for patients awaiting surgery to meet the nutritional and hydration needs of the patient.
- The trust should ensure managers and senior staff have the relevant level of skill and experience to perform their roles.
- The trust should ensure that staffing levels reflect the needs of patients at all times.
- The trust should ensure that it reviews its existing staff practice in relation to MCA and DoLS specifically in relation to the cohorting of patients in supervised bays.
- The trust should ensure that domestic staff follow infection control procedures, wear correct uniform, identification and personal protective equipment at all times.
- The trust should improve its overall performance in the management of patient falls.
- Continue to work to improve delayed discharges and discharges that occur between the hours of 10pm and 7am.
- Continue to work to improve attendance and documentation of meeting minutes at mortality and morbidity meetings.
- To ensure that patients diaries are being completed in line with guidance, and that these diaries are used throughout the patient journey.
- To improve the recording of actions following governance meetings and ensure that these are followed up and that evidence of learning or changes in practice are recorded.
- Ensure there are appropriate formal systems to share actions and learning from incidents consistently among all staff in the service.
- Update the policy for safeguarding children in line with best practice and national guidance, for example to ensure all child protection cases are overseen by a paediatrician.

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

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

Background to Colchester Hospital University NHS Foundation Trust

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

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

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

Population served

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

Health and deprivation

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

Our inspection team

Our inspection team was led by:

Chair: Dr Sean O'Kelly.

Head of Hospital Inspections: Fiona Allinson, Care Quality Commission

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

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

How we carried out this inspection

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

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

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

Before visiting, we reviewed a range of information we held, and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG); NHS Improvement, Health Education England (HEE); General Medical Council (GMC) and the local Healthwatch.

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

Summary of findings

assistants, pharmacy technicians, and pharmacists. We held a number of focus group sessions, across all staff grades, spoke with staff individually as requested and held 'drop in' sessions.

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

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

What people who use the trust's services say

The trust's Friends and Family Test performance (% recommended) was consistently better than the England average between April 2016 and March 2017. The patient survey, 31 May 2017, showed that Colchester Hospital University NHS Foundation Trust was the most improved trust in special measures.

On inspection we found that patients were generally positive about their treatment at Colchester General Hospital. They found that staff were responsive to their individual needs.

Facts and data about this trust

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

Number of beds

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

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

Clinical Commissioning Group

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

Staff

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

- 507 Medical (against an establishment of 531)
- 1573 Nursing, midwifery and AHP (against an establishment of 1684)
- 2020 Other (against an establishment of 2132)

Budget and spending

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

Activity and patient throughput

Between February 2016 and January 2017:

- 87,639 A&E attendances
- 90,792 Inpatient admissions
- 661,444 Outpatient appointments


Summary of findings

• 3,574 births

• 1,675 deaths

Summary of findings

Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>We rated safe as requires improvement because:</p> <ul style="list-style-type: none">• Whilst planned staffing was attained on most ward areas there were staffing vacancies which led to high agency usage and therefore potential inconsistencies in care provided.• There was limited oversight of the paediatric waiting room area from the paediatric emergency department.• Data supplied by the trust showed that in April 2017, the percentage of patients receiving the Sepsis six care bundle within one hour was 50.7%, which is below the trust target of 100%. In May 2017, compliance rose slightly to 51.9% and increased again in June 2017 to 60.7%.• Medicines administration and storage required improvement in the children's and young people's service.• The trust did not have a standardised formal process or policy to risk assess patients who were awaiting follow-up appointments that were delayed. This was raised at the previous inspection but had not been fully addressed. <p>However:</p> <ul style="list-style-type: none">• The trusts incident reporting and learning lessons following these had improved across most services.• Maintenance of equipment was also seen to have improved across most of the wards.• The duty of candour was being carried out and most staff were aware of the implications of the legislation. The chief executive and the managing director frequently spoke with patients and their families who felt that they were experiencing poor care. <p>Duty of Candour</p> <ul style="list-style-type: none">• Throughout the trust, staff were aware of the duty of candour regulations. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.• The Trusts policy 'Procedure for the Reporting and Management of Incidents and Serious Incidents requiring Investigation' clearly referenced the duty of candour and when it should be used. Staff had access to this policy on the intranet.	<p>Requires improvement </p>

Summary of findings

- Staff were able to provide examples of when duty of candour had even applied, and we observed this recorded in patients notes throughout the core services. The chief executive and the managing director frequently spoke with patients and their families who felt that they were experiencing poor care.

Safeguarding

- There had been significant concern in relation to safeguarding at previous inspections. In spring 2016 the trust produced an action plan in respect of our concerns. When the new management team took responsibility for the trust all action plans were reviewed and a programme of Every Patient Every Day implemented. One of the core work streams from this initiative was quality and governance, which encompasses patient safety. At this inspection we saw that the actions from this work stream were beginning to have demonstrable outcomes for patients. However there was ongoing work to enhance and embed the actions taken from this group.
- The executive lead for Safeguarding is the Director of Nursing, supported by head of safeguarding (adult Lead), named nurse for children safeguarding and named midwife for safeguarding. Trust safeguarding meetings took place quarterly.
- Not all departments had an established named safeguarding lead, for example in the emergency department, which was in the process of being allocated at the time of inspection. Clinical pressures also affected the ability of the senior nurse from the emergency department attending safeguarding meetings. This was mitigated in part by an established system of access to a paediatric 'consultant of the week' and registrar on call to respond to any concerns over safeguarding.
- The trust's target for mandatory training in adults and child safeguarding training was 95%. In April 2017 medical and dental staff at Colchester General Hospital did not achieve the target for any of the safeguarding training, the lowest compliance score was 53% for safeguarding children update level 3.
- Nursing and midwifery staff, for the same period, achieved the 95% target for all but three safeguarding courses. The three courses where the target was not achieved were: safeguarding children core level 3 (87%), safeguarding children update level 3 (69%) and safeguarding looked after children (84%).
- Further work was required to ensure policies and procedures followed national best guidance. There was an up-to-date policy for safeguarding children, which included guidance for those under 16 years of age and identified high risk areas such as female genital mutilation (FGM) and child sexual

Summary of findings

exploitation. However, the policy was not in line with best practice in all areas. For example, it stated that consent was required before medical examinations for child protection can be undertaken, which not the position for cases is falling under section 47 of the Children Act 1989.

- At the previous inspection, there was a concern that there was no abduction policy available for staff. Since then, the Infant Abduction Policy (from Maternity Services or Neonatal Unit) version one was ratified in October 2015 and reviewed. A practice drill had also been conducted in November 2016, to embed staff knowledge and awareness.
- Staff we spoke with in children's outpatients said that where there had been two missed appointments, they would raise it with the consultant to be aware of any potential safeguarding concerns and make further enquiries as they saw fit. This was good practice; and a section on missed appointment was included in the Safeguarding children, young people and the unborn policy, (16) 180, October 2016.

Equipment and Environment

- There had been a substantial improvement in the way in which equipment throughout the trust was safety tested, serviced and maintained. There had been a clear action plan put into place following our previous inspection, which included the recruitment of a dedicated medical equipment coordinator and a risk based approach in maintaining equipment. However some equipment in the outpatients department still required on-going maintenance.
- There were sufficient syringe drivers available from the hospital equipment library and these were calibrated and serviced through a regular contract. We reviewed a selection of syringe drivers and the planned preventive maintenance (PPM) schedule which were all tested and in date. This addressed the concerns raised at the last inspection where there were no systems and process in place to ensure equipment required for the use of providing safe care to patients at the end of their life were being serviced or maintained.
- The emergency department did not have a dedicated mental health assessment room. The department was in the process of re-design at the time of our inspection, with the aim to have a dedicated mental health room by October 2017. However mental health patients were accommodated in an isolation room adjacent to the majors' area in the emergency department. This room had one point of access and exit, no panic buttons and lacked direct oversight from staff. There were

Summary of findings

ligature points on the door handle. There were no formal risk assessments in place to show that patients would be assessed on an individual basis if they were appropriate to be admitted into this area.

Incidents

- At previous inspections we had raised significant concerns around the grading of incidents at the trust. The trust had reviewed its governance processes and developed management committees for key areas, including a patient safety group. The group reviews incidents reported and once investigated allocates an appropriate grading for the incident.
- Between June 2016 and May 2017, the trust reported two incidents which were classified as never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There were 8141 incidents reported to the National Report and Learning Service (NRLS) between March 2016 and March 2017. NRLS incidents were reported at a rate of 7.6 per 100 admissions, lower than the England average of 8.9 per 100 admissions.
- In accordance with the Serious Incident Framework 2015, the trust reported 97 serious incidents (SIs) which met the reporting criteria set by NHS England between June 2016 and May 2017; of these, the most common type of incident reported was Treatment delay meeting SI criteria (20%).

Staffing

- Staff recruitment and retention was recorded on the corporate risk register. As at April 2017, the trust employed 4100.59 whole time equivalent (WTE) staff out of an establishment of 4347.82 whole time equivalent staff. This meant the overall gap between planned staff WTE and actual staff WTE worked (including bank and agency) at the trust was 6%.
- In January 2017, the proportion of consultant and junior (foundation year 1-2) staff reported to be working at the trust were about the same as the England average.
- Nursing staff vacancies was around 6% across the trust. Agency and bank staff were used to back fill these posts. We found that there was an established process for induction of agency nurses across the trust, which included specific medicine management checks.

Summary of findings

- The trust had a formal induction programme, which was compulsory for all new members of staff. Staff confirmed that if they were moved to different ward area, due to staffing levels, they received an induction to the new ward.

Are services at this trust effective?

We rated effective as Good because:

- Specialties provided care and treatment in line with guidelines from the National Institute for Health and Care Excellence (NICE) and Royal College guidelines. Local policies were written in line with these guidelines.
- Local guidance had been introduced including several standards to enable further improvement following national audits.
- Identification of sepsis and management of the deteriorating patient was focused on as a work stream incorporated in the Every Patient Every Day programme.
- Interactions observed between members of the multidisciplinary team were noted to be positive and clearly showed mutual respect for each other's roles.
- The trust participated in a national audit relating to palliative and End of Life Care (EoLC) services and carried out its own audits and re-audits to test action plans for improvement including the Last Days of Life Audit which measures compliance with the care provision for the last days of life at the trust.

However:

- We were not reassured that staff followed the trust policy on Mental Capacity Act (MCA) or Deprivation of Liberty Safeguards (DoLS) and found instances where staff did not reassess the capacity of patients when their condition deteriorated. We highlighted this to the staff and action was taken immediately.
- Not all policies and procedures had been updated. We found some guidance out of date and significantly overdue for review. Some audits reflected that further work was required to meet national standards. The trust was aware, and work was ongoing to address this.
- As of April 2017, not all staff at the trust received an annual appraisal. Appraisal rates were generally below the trusts target.

Evidence based care and treatment

Good



Summary of findings

- Specialties provided care and treatment in line with guidelines from the National Institute for Health and Care Excellence (NICE) and Royal College guidelines. Local policies were written in line with these guidelines. Policies and procedures were easily accessible for staff via the trust intranet.
- There were a number of specific patient pathways to standardise care given for certain conditions. Examples included management of sepsis, acute kidney injury and adult head injury pathway.
- At our last inspection in September 2015, we did not see care pathways in place for the management of those patients with long-term conditions for example Parkinson's or patient living with dementia. However, the trust had made significant improvements in this area and had dedicated care pathways for patients living with both dementia and Parkinson's disease.
- Staff were aware of evidence-based guidance and best practice across all areas at the Trust and teams, such as the specialist palliative care team, were utilising these to develop services. For example the individual care record for the last days of life' (ICRLDL) incorporated the five priorities set out by the Leadership Alliance 2014 for the Care of Dying People and this was being used across the trust in all adult wards.
- Each speciality had an audit plan which included identified starts dates, dates of proposed completion and the responsible member of staff for both local and national audits.
- The East of England Critical Care Network peer review carried out in February 2017, showed that the critical care service was meeting the seven East of England evidence based principles for critical care, known as the "magnificent seven".
- In urgent and emergency care we found that medical records did not contain a formal risk assessment or scoring system to identify high-risk patients with mental health conditions. This was not in line with the Royal College of Emergency Medicine standards.
- Not all policies and procedures had been updated. We found some guidance out of date and significantly overdue for review. The trust was aware, and work was ongoing to address this.

Patient outcomes

- The trust has one active mortality outlier alert, as of June 2017, for the following indicator: Intestinal obstruction without hernia (Dr Foster, Apr 16). Action plans have been submitted by the Trust which indicates improvement. Data provided indicated the percentage of patients reviewed by a consultant within 14 hours had increased to 75% in May 2016 compared to annual data for 2013-2014 (45%) and 2014-2015 (54%). Results from the

Summary of findings

second NELA report published in July 2016 showed significant improvements with the Trust being above the national average for 9/14 standards relating to the management of emergency laparotomies.

- Local guidance had been introduced including several standards to enable further improvement. The small bowel obstruction pathway was implemented from the start of November 2016 and participation in the national small bowel obstruction audit (NASBO) from January 2017 to allow peer benchmarking.
- The trust results in a number of cardiac audits was better than the England average. These included the heart failure audit and the non-ST- elevation infarction (nSTEMI) audit.
- Between January 2016 and December 2016, patients at the trust had a higher than expected risk of readmission for non-elective surgery admissions when compared to the England average.
- The trust 2016, hip fracture audit showed an overall improvement from 2015. However, the proportion of patients having surgery on the day of or day after admission was 67.5%, which does not meet the national standard of 85% and was worse than the 2015 figure.
- Within carotid endarterectomy, the trust median time from symptom to surgery was 17 days, worse than the national standard of 14 days. Delayed surgery is
- The trust participated in a national audit relating to palliative and EoLC services and carried out its own audits and re-audits to test action plans for improvement including the Last Days of Life Audit which measures compliance with the care provision for the last days of life at the trust.
- Identification of sepsis and management of the deteriorating patient was focused on as a work streams for the Every Patient Every Day programme. Key outputs to improve patient outcomes included clear protocols for identification and treatment of sepsis (sepsis care bundle) in the emergency department and all inpatient areas. A Trust wide protocol for use of NEWS and escalation process, a sepsis and deteriorating patient group to co-ordinate actions across the trust as recommended nationally, a sepsis nurse specialist to co-ordinate training, audit care and share best practice, and hence monitor efficacy of escalation processes.
- The trust developed a Watchpoint system in 2016 which tracks sick patients requiring senior review out of hours to the on call medical and senior nursing teams. In addition the trust was exploring the implementation of an electronic vital signs monitoring system and scoping the need for high dependency

Summary of findings

and step down beds for deteriorating patients and those that have received critical care but require a period of rehabilitation before being stable enough to be cared for in the ward environment.

Multidisciplinary working

- There was good evidence of multidisciplinary team (MDT) working in all surgical areas to help maximise patient outcomes.
- The discharge team worked closely with other health care professionals, for example community physiotherapists. This was to meet the patient's discharge support needs prior to their discharge home or to another healthcare provider.
- Therapy staff we spoke with stated that they felt part of a strong multidisciplinary team (MDT) and their views and opinions were valued by staff across various professional teams. All staff described teams working well together and sharing best practice to improve patient outcomes.
- Interactions observed between members of the MDT were noted to be positive and clearly showed mutual respect for each other's roles.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Patient care records allowed staff to record patient's capacity and consent in one place within the document. Throughout our inspection, we noted that staff did not use the trusts MCA paperwork from its MCA policy when supporting decision making regarding a patients capacity.
- In the medical wards, Birch and Peldon, we found that records showed no MCA had been completed for patients despite an obvious change in their condition. The trust addressed this immediately. However this was a theme that ran through all core services reports
- 26% of do not attempt cardio pulmonary resuscitation (DNACPR) records reviewed during the inspection were not accurately completed, with a lack of documented discussions of the decisions with patients noted. Of those not completed in line with guidelines, in three cases the patient had a DNACPR order in place when the patient did not have capacity and there was no evidence of a mental capacity assessment undertaken.
- The trust reported that as of April 2017 Mental Capacity Act (MCA) Level 1 training has been completed by 97% of staff. MCA training level 2 had been completed by 96% and, Level 3 training was completed by 83% of staff, below the 95% target.

Summary of findings

- Deprivation of Liberty Safeguards (DoLS) Level 1 training has been completed by 96% of staff. DoLS training level 2 has been completed by 95% of staff, and level 3 by 85%. The trust set a target of 95%.

Are services at this trust caring?

We rated caring as Good because:

- We observed staff caring for patients in a kind and compassionate manner.
- Staff took steps to ensure that the dignity and privacy of patients was respected.
- The trust's Friends and Family Test performance (% recommended) was consistently better than the England average between April 2016 and March 2017.
- We saw and heard examples of where staff had gone the extra mile to ensure that patients received care which was individualised to them. Examples of this include a book signing for a child and a number of marriages for patients at the end of their lives.
- The chief executive wrote letters to all families of patients who had died in the hospital expressing their condolences.
- Patients had access to psychological support, and could be sign posted to specialist counselling services where appropriate.

However:

- We heard from a few patients that they had had a poor experience in which the attitude of staff was not what they would have expected. However these were isolated cases.

Compassionate care

- The trust's Friends and Family Test performance (% recommended) was consistently better than the England average between April 2016 and March 2017.
- In the Cancer Patient Experience Survey 2015 the trust was in the top 20% of trusts for four of the 34 questions, in the middle 60% for 28 questions and in the bottom 20% for two questions.
- The trust performed about the same as the England average in the Patient-Led Assessments of the Care Environment (PLACE) 2016 for assessments in relation to food, privacy/dignity/wellbeing and facilities.
- Staff respected and recognised patients' individual needs and choices at all times. Staff displayed kind and gentle behaviour, offering reassurance and positive support to patients who were often uncomfortable and needing reassurance.

Good



Summary of findings

- We saw examples of where staff had ‘gone the extra mile’ to make patients’ experiences easier. For example, there had been a nine-year-old oncology patient on the ward who said they wanted to be a writer when they were older. Staff arranged a ‘book signing’ day where medical and nursing staff in the unit took photos with the child and received ‘signed copies’ of a story book the child had made.
- The chaplaincy provided examples of marriage blessings that had taken place at the hospital for patients who had a limited life expectancy. The chaplaincy, SPCT and ward staff had organised three weddings in the last six months to fulfil the wishes of dying patients. One of these weddings was organised within five hours, by contacting the Chelmsford registry office, who granted a special licence for the marriage to take place.
- The chief executive wrote letters to all families of patients who had died in the hospital expressing their condolences.

Understanding and involvement of patients and those close to them

- In the CQC Inpatient Survey 2015, the trust performed about the same as other trusts for all the 12 questions.
- Family members we spoke with told us they felt involved in the care delivered.
- Family or carers could stay with patients who were cared for in a side room and visiting times were flexible. This was to promote the patients welfare for example, a confused patient or a patient not having appetite following treatment or to support a patient who may be at the end of their life.
- The hospitals Parkinson’s disease nurse service sent a questionnaire to patient’s home address to complete and return back using a freepost service. Patients said they were given the opportunity to be involved in the decisions made in regards to their care plan and having their input listened to and incorporated into their plan. The majority of patients were satisfied with the level of support the Parkinson’s disease nurse service offers (94%).

Emotional support

- Colchester Hospital University NHS Foundation Trust employs 2.84 whole time equivalent (WTE) trust chaplains. In addition, approximately 40-trained multi-faith volunteers attend the trust one morning or afternoon a week. Services are provided in

Summary of findings

Colchester General Hospital to meet the spiritual needs of patients and staff. Staff contacted the Trust chaplains via switchboard and a 24/7 on-call rota was in place for urgent referrals.

- The clinical nurse specialists (CNS) from the specialist palliative care team (SPCT) spent time with patients and their families to provide reassurance and support and answer any difficult questions that they may have in relation to the treatment being received.
- The bereavement team understood the importance of emotional support. The mortuary bereavement service was by appointment in half hour slots and staff would try to accommodate requests for particular times. We heard of examples of how the mortuary and bereavement team ensured that people could take the time they needed and didn't rush people so that they could say goodbye to their relatives and ask any questions they may have of the bereavement team.
- There were effective processes in place to provide emotional support to women who terminate pregnancies or miscarry babies with access to specialist support services available.
- We met with two volunteers on the stroke unit, a previous patient and his wife. They often came to the stroke unit to offer advice and guidance to patients and families dealing with the aftermath of a stroke.
- Patients in the Elective Care Centre and Elmstead ward gave specific praise for the emotional support they had received from staff prior to and post-surgery.

Are services at this trust responsive?

We rated responsive as requires Improvement because:

- Referral to treatment times (RTT) were worse than the England average in all but one measurement (urgent two week referrals where they were better) and below the operational standards.
- Between December 2016 and March 2017, 28.5% outpatient clinics started late. No reasons were given for the late starts. Radiology staff told us that some outpatients in Beta X-Ray could wait as long as 90 minutes when the department was busy to be seen and then return to clinic.
- Clinic cancellations between August 2016 and July 2017 ranged between 11.1% in November 2016 and 18.8% in July 2017 (more than six weeks' notice). The rate for clinics cancelled with less than six weeks' notice ranged between 6.8% and 12.7%.

Requires improvement



Summary of findings

- The trust had a process in place for fast track discharge, however it was acknowledged by the trust to not always be rapid or fast, with some cases taking up to 189 hours (7.8 days) in May and 119 hours (five days) in June to get a patient discharged.

However:

- Significant improvements were made to establishing the patients preferred place of care.
- The trust had undertaken audits into the use of the Last Days of Life (ICRLDL) and preferred place of care compliance.
- The trust had introduced a “red day and green day” system. The system enabled nursing staff to identify patients as “red” if they required further intervention or services, or “green” if their care pathway was on track.
- Specialist nurses were available including a learning disabilities hospital liaison nurse specialist, acute stroke nurse specialist, diabetic nurse specialist and cancer nurse specialist. The medicine division had two dedicated dementia care specialist nurses, who were soon to become Admiral Nurses.

Service planning and delivery to meet the needs of local people

- In May 2016, Colchester Hospital University NHS Foundation Trust (CHUFT) committed to entering a long-term partnership with Ipswich Hospital NHS Trust (IHT). A Strategic Outline Case for the partnership was published in February 2017 to consider three different scenarios. A merger or acquisition would not necessarily require clinical services to move, but may mean that services would work together more closely, for example, sharing best practice in delivering high quality care.
- Between March and July 2017, several advisory groups took place. These involved patients, staff, commissioners and partnership stakeholders to ensure that the outline business case (OBC) received input of all groups to develop the configuration of services for the benefit of patients. The recommendation of the OBC was to form a single combined organisation with fully integrated clinical services. This sees the trusts developing working arrangements in line with the Sustainability and Transformation plan (STP), with one Chief Executive for both trusts. STPs outline how health and social care organisations will continue to work together to sustain and transform services over the next five years.
- The trusts will go on to develop detailed plans for the combined organisation. A final decision to form a single organisation will

Summary of findings

then be taken by both Trust boards around June 2018. This decision will also require approval from regulators NHS Improvement and the Competition and Markets Authority (CMA).

- Within the medicine division the trust had implemented a nurse led discharge process on Peldon ward in May 2017. The ward operated strict patient admission criteria, and staff actively worked with the hospitals discharge teams to discharge patients back into the community to their own home or appropriate care facilities. During autumn 2017, the trust is planning to launch the frailty short stay unit, on Tiptree ward with the aim to treat patients quickly and provide early intervention of other services.
- There were four contingency beds reserved on the childrens ward to allow for capacity increases. This meant that children and young people were rarely seen and treated in adult areas.
- At the last inspection in September 2015, the hospital was not recording patient's preferred place of care/death (PPC/D). However, at this inspection patient's PPC/D was captured through the My Care Choices Register (MCCR), a locality wide register. On average 40% of those who died in North East Essex were on MCCR. A review of the locality data from MCCR showed that between January and June 2017, on average 68% of patients achieved their first or second choice of PPC/D.
- Within the trust, for the months of May and June 2017, 79% and 83% respectively of palliative care patients or those at the end of life were discharged to their preferred place of death. This is lower than the trust target of 90%.
- The SPCT worked collaboratively across the locality whereby the clinical lead and head of cancer nursing attended the locality group for EoLC. The trust was involved with the NHS Improvement end of life care improvement collaborative, which supports providers to improve how they deliver end of life care. The trust told us that as part of this collaborative, they would be looking at the discharge of rapidly deteriorating patients as an improvement project as they were aware it was an area that required some focused work.

Meeting people's individual needs

- The trust chaplains have links with Colchester NHS Christian Fellowship, Community faith representatives and local parishes of different dominations in order to accommodate different

Summary of findings

faith requests. A service level agreement (SLA) was established with a nearby Mental Health Trust to provide Community Mental Health chaplaincy to nine different sites and community groups.

- There were leaflets available on a number of different procedures and conditions. These were available in different languages and larger print on request.
- People admitted to the hospital with a known diagnosis of diabetes are flagged up through the portal alert system. All patients have a Think Glucose assessment within 24 hours of admission, which includes their diabetes status, and foot assessment. 'Think glucose' magnets are applied next to patient names on ward boards.
- The staff had access to a learning disabilities hospital liaison nurse specialist (LDHLN) who was notified of patients attending the hospital with a learning disability by ward staff, care homes, parents, carers, social workers, and community health team members.
- Speech and language therapy (SaLT) team saw patients who had had a stroke promptly to reduce the time patients spent nil by mouth. Records reviewed showed a prompt review by SaLT, and staff we spoke with spoke highly of the specialist support offered specifically in relation to swallowing.
- A range of birthing options were offered and included free hypnobirthing technique which offered natural birthing with limited medicinal input to pain relief, as well as water births and home births.
- There were a number of designated clinics and services for children. The children's urology service was the only dedicated one in the county. They held clinics to help with conditions including constipation, soiling, and night time wetting.

Dementia

- The trust had a dementia strategy 2016-2019 and delirium pathway in place, which was developed to improve access to high quality diagnosis, treatment, support and advice for all people living with dementia and their carers
- There were two dementia care nurse specialists (DCNS) within the trust. The DCNS are notified of every patient over 75 admitted as an emergency via the dementia assessment tool (DAT). All suitable patients are assessed as per FAIR (Find, Assess and Investigate, Refer) utilising the DAT tool for dementia and delirium.

Summary of findings

- The trust utilised 'Link' nurses and was developing new 'Link' nurses, who linked to specific specialism to offer support, guidance, and advice to staff, for example for patients with diabetes or dementia.

Access and flow

- Referral to treatment times (RTT) were worse than the England average in all but one measurement (urgent two week referrals where they were better) and below the operational standards.
- There were 2,863 patients out of 12,194 patients who had waited 13 weeks and over for a first appointment. The number waiting had been below 1,500 for most of the year, April 2017 – May 2017, but had increased in the month prior to our inspection.
- There were significant medical staff shortages that contributed to long waits in the following specialities; ear, nose and throat, ophthalmology, neurology, trauma and orthopaedics and urology.
- The trust overall cancellation rate was around 25% for the period April 2016 to March 2017. However patient cancellations were high at around 14%. The hospital cancelled around 8% of clinics at short notice (less than 6 weeks' notice).
- The trust had a process for reviewing the patients waiting on the waiting list however each speciality had individualised escalation procedures. There were weekly meetings at various levels which included clinicians to prioritise patients who were waiting on the list. This was raised at the previous inspection, action had been taken and systems were in place to mitigate the risk of harm to patients.
- In June 2017 there were 12,194 patients awaiting their initial appointment in the outpatient department and 817 patients awaiting follow up appointments. The trust monitored these patients on a weekly basis through the clinical reference group.
- The trust had identified an issue with the electronic system which meant that in some instances, once a patient had been discharged, the referral was not recorded as being closed. This required manual checking. Senior staff acknowledged that there were issues in the booking service that needed rectifying and there were new managers in post to address this. The booking and reception staff were being trained to correctly close referrals and work was ongoing to check each individual open referral to identify those that should have been closed.
- Trust figures provided prior to inspection showed an increase from the previous year in the number of patients having two or more ward moves, particularly in patients with two moves, which increased from 14% to 20%.

Summary of findings

- The trust had a process in place for fast track discharge, however it was acknowledged by the trust to not always be rapid or fast, with some cases taking up to 189 hours (7.8 days) in May and 119 hours (five days) in June to get a patient discharged.
- The trust's referral to treatment time (RTT) data between April 2016 and March 2017 has been consistently worse than the England average, which meant patients were not receiving treatment within recognised timeframes.
- The Every Patient Every day programme included two work streams, planned care and patient flow, to encompass RTT, theatre cancellations, delayed transfers of care, discharges and length of stay. As such there was a recognised focus for the trust to drive quality and productivity improvement and efficiency.
- The trust had introduced a "red day and green day" system. The system enabled nursing staff to identify patients as "red" if they required further intervention or services, or "green" if their care pathway was on track.

Learning from complaints and concerns

- Between April 2016 and March 2017 there were 690 complaints about the trust. The trust took an average of 41 days to investigate and close complaints. The most common primary theme was attitude, 127 complaints (18%), followed by treatment plan with 93 complaints (13%).
- Staff were able to give examples of talking to a patient and their relatives as a result of a complaint in an attempt to resolve the issue quickly.
- Complaint investigation involved the staff concerned. All staff we spoke with knew how to report a complaint and that feedback from complaints would be shared on a one-to-one basis where necessary or via team meetings. Complaints discussion was a standard agenda item at monthly governance meetings.

Are services at this trust well-led?

We rated well-led as good because:

- Clarity and direction has been provided by the new executive team, specifically the chief executive and managing director.
- The senior executive team were aware of the risks and specific areas of concern.
- The trust vision and strategy had been aligned, with the Every Patient, Every Day programme focussing the trust on improving patient care.

Good



Summary of findings

- The culture of the trust had changed through role modelling. The focus of the trust was to personalise care. Breaches in waiting times and delayed discharges were now not considered as targets to be met but of the potential impact on a patient that these had. For example the lost days a patient could have spent with their loved ones or the delay in treatment leading to being in pain longer. This shift in perspective was noticeable in all staff in the hospital.
- There had been a restructure at divisional level resulting in three newly aligned clinical divisions.
- Ownership, accountability and responsibility of risk and quality care provision was beginning to occur at a local level.
- There was clear involvement and information routes from ward to board.
- Support and training had been initiated for leadership skills amongst the nursing senior team.
- Staff were positive and engaged, with growing confidence in the new executive team.
- In several areas, trainees had taken up substantive posts once qualified as they felt the trust was a good hospital to work in.
- A full review of risk, structure and quality monitoring had taken place to outline the depth of the issues at the Trust. These new structures and processes now need to begin to embed and have traction.

However:

- Workforce remained a risk across the organisation. Leadership at a local level was inconsistent.
- Mortality and morbidity meetings were inconsistent across the trust.
- Policies and procedures needed to be reviewed and updated in line with best practice.
- The trust needed to continue to improve access and flow through improved RTT.
- Success and good practice needed to be celebrated and increasingly shared to encourage further learning and improvement.

Leadership of the trust

- The organisational structure at the trust comprised of a board of directors and a council of governors, with the board having a chair and chief executive officer (CEO) supported by ten executive directors and six non-executive directors.

Summary of findings

- The chief executive, chair and managing director had been in position since 17 May 2016. The managing director / deputy chief executive became substantive on 1 December 2016. This had created stability in the senior executive team that had not been previously in place.
- Five of the ten executive directors had been in post since 2015. The newest appointments, in 2017, included the director of nursing, acting medical director, director of operations and director of communication and engagement.
- The longer standing executives expressed that one of the tangible changes that had occurred, since May 2016, was an increased confidence in the executive leadership and clear direction of the trust. Previous leadership had been transient with changes not having the opportunity to bed down. The team in place now worked together with more structured disciplines being embedded around executive and performance behaviours and responsibilities. Within the every patient, every day programme (EPED), the responsibility, accountability and ownership of service improvement had been given back to the local leaders. Local leaders and senior staff were engaged in seeking solutions to improving performance.
- The executive team understood the challenges to good quality care and the wider challenges faced by the NHS, and could see the importance of exploring solutions such as the long-term partnership with Ipswich Hospital. The chief executive is also lead for the Sustainability and Transformation Plan (STP) for East and West Suffolk and North East Essex.
- Following the Strategic Outline Case identifying proposals and potential scenarios for the partnership with Ipswich hospital a clinical plenary meeting was held on 23 March 2017 to enable clinicians and nursing staff, from both hospitals, to discuss how they could help influence the direction of the partnership. 150 people attended, staff were encouraged to get involved and to find clinically led solutions to enable closer working, sharing of best practice and improve delivery of high quality care.
- Work to address problems and seek some strategic solutions with other healthcare providers was already beginning. The managing director had recently met with the nearby NHS Mental Health Trust to discuss improving the ambulatory pathways for those patients referred due to self-harm or overdose.
- We found that there was clarity in the direction provided to the trust from the executive team. Visibility of the executive senior team was evident. Both the chief executive and managing director visited the wards and all grades of staff spoken to

Summary of findings

during the inspection were aware of who they were. All members of the executive team were “buddied” to different ward areas. Visits were not formally recorded as this was considered business as usual. This system had been used to escalate issues quickly. For example, the finance director, during a recent ward visit, had been informed of concerns over nursing staff allocation to other ward areas. This was shared with the director of nursing who then responded to the concern.

- There was a clear focus on involvement of staff from ward to board. There was an appreciation by the senior leaders to understand the issues within the trust and support individuals’ leaders, at both divisional and ward levels, with operational understanding. For example, the director of finance met and provided support to budget holders at a local level, to enable full understanding of where spending was occurring and provide advice and development. This had resulted in financial improvement in Q4, following some enhanced controls, which the finance director stated was testament to staff managing their budget and realising that finance was a corporate responsibility and not just executive responsibility.
- Some areas remained where leadership at ward level was inconsistent. Steps were being taken in those areas identified, such as Brightlingsea, Layer Marney and Birch wards.
- A licence to lead programme had been developed in the last six months (January to August 2017), and had just been introduced to provide skill based training for managers. This included aspects such as budget, IT, recruitment and development of policies and procedures and had executive director involvement. A new manager induction programme was also launched in April 2017, with a programme for new consultants due to commence in September 2017.

Vision and strategy

- The trust's updated vision "Delivering great healthcare to every patient, every day" was approved at the Trust Board on 27 October 2016. The new vision is underpinned by three corporate objectives; acting in the best interests of every patient, every day, supporting the workforce to look after every patient, every day and achieving clinical, operational and financial resilience.
- The trust strategy aligns with the vision. The strategy is delivering care in the right place at the right time, ensuring a positive patient-centred culture and creating clinical, operational and financial resilience.

Summary of findings

- The vision, values and strategy had been developed through a structured planning process in collaboration with people who use the service, staff and external partners.
- Following previous inspections a programme oversight group (POG) had been established to monitor and provide constructive challenge to the trust. This had previously been ineffective. Following the long-term partnership commitment in April 2016 This group was strengthened and the new culture at the trust constructive challenge was welcomed and enacted. This group comprises of multi regulatory partners, including NHSI, HEE and relevant clinical commissioning groups. POG meets monthly to have oversight of progression and provide system wide support and challenge to the Trust.
- The every patient, every day programme (EPED) was formally launched on 8 September 2016. The programme centred on three key modules of work: Quality & Governance, Operational Improvement & CIP and Delivery and Crosscutting improvements (performance and efficiency). The EPED was initially devised as a transformation programme which replaced a number of former action plans. This programme of work continues to be embedded throughout the trust and has produced improved outcomes for patients.
- The EPED programme combined the financial, quality and operational aspects of the trust together. The Trust managed a reduction in expenditure and achieved the control total set by NHSI between April 2016 and March 2017. The trust, in month four July 2017, was on track to deliver against the new control total for 2017/2018.

Governance, risk management and quality measurement

- There was an established organisational framework for governance at the trust. Since our last inspection the trusts corporate governance structure had been reviewed and agreed (March 2017). The new structure included three domains, corporate (oversight at board level), management committees and divisional governance.
- All board members shared corporate responsibilities such as formulating the strategy, ensuring accountability, ensuring effective operations and shaping the culture of the organisation. In addition, each member had a distinct role and responsibility aligned to each of the board and management committees and reflective of their organisational responsibility.

Summary of findings

- There was a divisional reporting structure to ensure flow of information from ward to board. Escalation of information routes, ward to board, had been made clear with the introduction of two at the top and three at the top leadership models at ward and divisional levels.
- The operational management of the trust was via three newly aligned clinical divisions; each having its own leadership team and divisional board. The divisional governance work programme was agreed and commenced in May 2017. Terms of reference and standardised documentation for escalation from committee to board were in place. Divisional governance meetings were scheduled monthly to discuss risk, incident and audit findings and share learnings. Having just been established these divisional groups needed to be embedded.
- Oversight of divisional performance was provided by the Integrated Performance meeting that is led by the Director of Operations, with KPIs mapped to the Board Assurance Framework. Divisional governance groups report into management committees, which in turn report into executive management committees into board assurance committees and then up to board. Assurance committees included quality and patient safety, finance and performance, people and organisational development and audit & risk.
- At the time of inspection these committees were in their infancy, for example the quality and risk executive management committee had just had its inaugural meeting. The senior team acknowledged that the new structure was still committee heavy and would need further streamlining. However due to the depth of the issues at the trust and lack of structure to the previous governance system this was required currently to ensure oversight. Members of the senior team described that they were “still peeling the onion” and discovering further areas of focus but were confident the new structure meant these would be captured and addressed.
- Each management committee, (patient safety and experience, trust investment group, education and training, staff partnership forum and clinical effectiveness) had an annual work plan and calendar for reporting, aligned to the compliance requirements of the organisation with information aligned to each committee’s terms of reference. For example, the patient safety and experience committee receive information against complaints and the clinical effectiveness group receive information regarding clinical audits.

Summary of findings

- The governance framework and EPED programme linked to ensure there was clear accountability and oversight of quality, performance and risks management. Quality improvement was encompassed within the EPED programme. The EPED had eleven work streams with identified key performance indicators to monitor quality and performance across each of the work streams. The KPI data provided demonstrated that, between the baseline in November 2016 and April 2017, 21 of KPIs had improved, three remained static and 12 had decreased.
- Associated with the EPED programme, the Red to Green process (including super-weeks) had been implemented across the Trust. The Red to Green approach, designed by NHS England is Urgent & Emergency Care Intensive Support Team (ECIST), is used to reduce internal and external delays as part of the SAFER patient flow bundle (a standardised way of managing patient flow through hospitals and prevent unnecessary waiting for patients).
- The senior executive team were aware of the risks within the organisation which was a significant improvement since our last inspection. They recognised that the initial quality review and implementation of new divisional and governance structure needed to become embedded. They were aware of specific areas for focus and inconsistency in some areas such as local leadership, MCA and DoLS (application and documentation), and mortality and morbidity (M&M) meetings where there was limited evidence that learnings were shared. At the time of inspection, these meetings were not happening in critical care at all.
- Some concerns were raised in several ward areas around information governance and the appropriateness of information written on white boards that could compromise patient confidentiality.
- Multiple policies were out of date and required review. This was recognised and had been identified as an action for the task and finish group to undertake.
- Medical and nursing workforce remained a risk across the organisation and was cited on the risk register and the BAF. A workforce group had been established and recruitment was ongoing with alternative solutions being sought, for example different nursing models such as assistant practitioner roles. There had been 20 staff that had completed a nursing foundation programme that had remained in junior positions, which had been picked up and rectified by the director of nursing. Two new cardiologists had been appointed.
- Financial information was reviewed at each divisional accountability framework meeting, at the finance performance

Summary of findings

assurance committee and at board, with finance and performance information being used together to make decisions at both service and trust level. Six business cases had been submitted and approved between June 2016 and May 2017. These included a renal dialysis tender, endoscopy outline and picture archiving and communication system (PACS) replacement.

- The trust had a business continuity plan, for responding to any internal or external emergency that had been reviewed in May 2017. The plan outlined command and control, operational and communication arrangements in the event of an incident and details roles and responsibilities of key staff. The trust had been part of the NHS cyber-attack in May 2017, the trust was proud of the staff input and hospital response. For example, the trust alerted nearby NHS trusts quickly enough to allow them to be taken off line prior to any effect and within three hours, every area within radiology had at least one room working.

Culture within the trust

- The senior team were committed to improving culture in the trust and were confident that slow and steady progress was being made. Many staff expressed that the effect of being in special measures since November 2013 had been detrimental. Staff felt “picked on” and some had been in denial that the previous ratings had been fair. However the new executive team had made it clear that the organisation was being held to account and found wanting. The restructure of divisions, alongside changes in senior posts, had been instrumental in providing direction. Staff expressed they felt that cascade of responsibility was now happening, although it was slower in some specialties than others. The senior team used data in an accessible format to highlight to staff where things were not working at the trust. They then encouraged staff to come up with solutions. Staff had ownership and felt that they were working with the senior executive team to effect change.
- The senior team also recognised the role that the non-executives had to play in turning the trust around. Non-executives now lead on each of the governance committees to provide understanding and constructive challenge to the hospital.
- There was a notable change in staff attitude and positivity. Staff we spoke to, across all grades and specialty, were overwhelmingly positive and open to exploring and developing working in partnership, both internally and externally, to improve patient care.

Summary of findings

- The trust were promoting staff to focus and recognise the impact on a patient, family or relative when an incident where care had been compromised had taken place or when the trust had failed to meet national targets. The “human factor” was being put back by initiatives such as instigating a reflective statement from every staff member, nursing or clinician, and the use of a personable patient example in staff training was putting the patient at the centre of everyone’s practice. Staff we spoke with could recite the patients name and the impact of poor care on them. There was a drive not to use terms such as delayed discharges or breaches when the trust failed to meet these targets. The senior team and others were now describing these incidents in terms of the impact on patients. Another example of this was the terminology used when a patient was receiving care on a different speciality ward. Instead of referring to these patients as outliers, staff were calling them “guest patients”. This was a consistent term across all wards. The leadership team described instances where they had found care had been less than patient focused and had encouraged staff to consider the impact of their actions on patients.
- There were nominated executive leads responsible for duty of candour. Duty of candour compliance was monitored via the patient safety and experience group as well as the quality and patient safety committee. There were established training packages for duty of candour with principles of being open and honest included from the start of employment as part of corporate induction.
- Poor performance was beginning to be appropriately managed. One member of senior staff provided the example that a concern had been raised around a bullying culture in bed meetings where there was pressure put on staff to move from red to green. This had been escalated to the matron and director of nursing. The situation was picked up and addressed quickly, and time taken by the matron to feedback to the member of staff involved and ensure they were all right.
- Senior nursing staff, in Trauma and Orthopaedics, stated they had felt let down by clinical colleagues after the trust had been put in special measures. They had told the doctors how they felt and there had been definite improvements. Previously there had been no consultant ward rounds; these now occurred three times a week, communication took place, and the doctors worked with the nurses to drive change. The orthopaedic nursing team helped collaborate the non-weight bearing pathway. Positive improvements had been achieved in fractured neck of femur, pressure ulcers and length of stay was

Summary of findings

better than the national average. The senior nurses were very proud of these results. Similar pockets of good practice occurred across the trust but there was limited evidence that the trust celebrated success as much as it could.

- We had a number of contacts from the community midwifery team expressing concern at work load pressures and the impact of these on patients. When we raised this with the senior team we found that a meeting was already in place to discuss this issue. This demonstrated that staff were being listened to and action being taken to understand the issue with action to be agreed with the team.

Equalities and Diversity – including Workforce Race Equality Standard

- There was an executive lead for Equality and Diversity. At the time of inspection, this had been the director of workforce and organisational development. In August 2017, the responsibility changed to the finance director who had undertaken workforce oversight as a dual role following the resignation of the workforce (HR) manager.
- The trust had produced an Equality and Diversity monitoring report 2015/16. This included the ethnicity, gender, disability and age profile of the Trust.
- The trust had a workforce race equality standard (WRES) action plan in place for 2017/18. This had previously been absent from the ED agenda. Equality objectives were for better health outcomes, improved patient access and experience, a representative and supported workforce and inclusive leadership. The WRES plan identified actions for workforce recruitment, training and employee relations with nominated individuals responsible for each indicator.
- Black and minority ethnic (BME) groups were represented on the trust non-executive board which equated to 12.5% of the board overall, with 58% of the board (executive and non-executive) being female.
- Equality and diversity oversight was via the Equality and Diversity (ED) Steering Group, ED operational group, executive management committee and Trust board.
- There were support mechanisms identified for staff, in relation to ED, which were included in the WRES action plan. These included health and well-being contact officers, diversity champions and the Freedom to Speak up Guardian.

Fit and Proper Persons

Summary of findings

- There was a formal process in place to meet the requirements related to the Fit and Proper Persons regulation (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 5).
- The executive responsibility for fit and proper persons sat with the trust secretary, who oversaw the checklist and reviewed the insolvency register prior to any executive appointments being made.

At the time of inspection, the Trust was keeping a copy of individuals' disclosure barring service (DBS) check but were aware that this needed to change, as the updated requirement is to keep a record of the DBS number only. If a DBS was pending, the trust had a self-declaration form for individuals to complete.

- The senior team had the experience, capacity and integrity to enable delivery of the strategy and address key risks to performance. The chief executive and managing director had extensive operational management and leadership experience. The finance director and four non-executive directors had credible and financial business backgrounds.
- We reviewed thirteen records held (eight members of the executive team four non-executive directors (NED) and the Speak up Guardian). The majority of which were completed in full. Renewal dates were recorded for those with professional registration checks. Insolvency checks had been completed in all 13 records reviewed. Self-declaration and occupational health checks had been completed in 12 of the 13 and DBS held in nine of the 13. Three of the 13 records had only one previous employment reference.

Public engagement

- The patient survey 31 May 2017 demonstrated that Colchester Hospital University Foundation Trust was the most improved trust in special measures.
- The trust had undertaken a patient engagement programme to engage with the public prior to the decommissioning of the midwifery led birth unit in Harwich. This engagement had incorporated two public meetings, regular stakeholder briefings and request for feedback throughout. Similarly, a patient advisory group had been included in the preparations of the outline business case regarding potential merger between Colchester and Ipswich.

Staff engagement

Summary of findings

- The new senior team and divisional structure have been instrumental in driving change in staff engagement since the last inspection. We found a developing sense of stability and permanency, as the number of interim appointments at the Trust have reduced.
- Staff morale has been a mixed picture however we found staff providing good compassionate care to patients and wanting to be more involved and outward facing. We held a number of focus groups throughout the inspection and staff were keen to verbalise their support for the new senior team.
- There were areas of good innovation from within the organisation, such as the introduction of staff lead “Schwartz rounds”, improvements in sepsis including the development of more junior staff into sepsis champions which recognised that staff at all levels could make a difference and be valued.
- The senior executives talked about increased clinical involvement in improvement issues and in governance groups. Staff told us that they felt more empowered to make changes within their own area. The medical director cited that the doctors were involved in implementing the new deal for doctors and were creative in how this could be implemented.
- The results from the 2016 staff survey showed a decrease in overall staff engagement compared to 2015, both internally and when compared to other acute trusts. The trust remains in the bottom 20% when compared to other trusts of a similar size with 15 of the 31 key finding indicators scored in the worst 20%.
- A key recommendation from Sir Robert Francis' Freedom to speak up report into the culture of raising concerns within the NHS, published in February 2015, was the introduction of Freedom to Speak up Guardians with responsibility for ensuring staff feel confident about raising concerns. The Trust had appointed a Freedom to Speak up Guardian in December 2016.
- Data provided by the trust was that between December 2016 and May 2017 there had been 23 incidences of whistleblowing, with the vast majority relating to issues with relationships in the working environment. Actions taken, case dependent, included team away days, one to one coaching, stress risk assessment reviews and supported team meetings and mediation. There were two trained mediators in the Human resources (HR) department. During the intervening times of our inspections covering 2014 -2016 we had received a significant number of contacts from staff who wanted to whistle blow but felt that the trust were not listening to them. Since spring 2016 the number of contacts from staff at the trust has declined as staff began to feel listened to at the trust.

Summary of findings

- The executive team had improved engagement with staff side. Members of the unions stated that there was evidence of change however they remained concerned that at times investigations into alleged bullying and harassment were not decisive enough and gave an example of one manager receiving additional training four times.
- The senior team recognised that for culture and engagement to improve, leaders must be open and responsive to staff when they speak up. Staff verbalised they felt as if they had a voice and that “fundamentals were back in place”.
- Doctors within oncology and orthopaedics informed us that they had chosen to come back to the trust once qualified, as it was a positive place to work. Senior nurses in trauma and orthopaedics stated that 15 student nurses had requested to come back as newly qualified.

Innovation, improvement and sustainability

- The trust were aware that integration with other healthcare providers will be important in the longer term for both sustainability and improvement to patient care. As well as the commitment to partnership with IHT, the trust were also looking to recognise opportunities and make better use of resources. One example was the development, of a new state of the art diagnostic imaging centre on site, in partnership with an external company.
- The trust were also working on developing a strategic partnership with a nearby private provider of healthcare for jointly procuring elective activity with the clinical commission group (CCG).
- The trust were already undertaking collaborative working with IHT with joint roles across both sites beginning, for example the Head of Litigation and Freedom to Speak up Guardian.
- Several specialties across the trust were proactive in improving services. These included, but were not limited to, initiatives such as “baywatch” to reduce patient falls and nurse led discharge in medicine. To strengthen contingency plans in the event of increased critical care demand, and to respond to the deteriorating patient outside of critical care, several initiatives in Critical care had been undertaken which included specialist programme of rotations between critical care, ED and recovery. As part of the trust’s end of life care improvement plan, a working group had been set up to develop a Time Garden in the hospital grounds. As part of the locality wide end of life care strategy, My Care Choices Register (MCCR) was developed to register people that were deemed to be potentially in the last year of life.

Overview of ratings

Our ratings for Colchester hospital are

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

Our ratings for Colchester Hospital University NHS Foundation Trust

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

Outstanding practice and areas for improvement

Outstanding practice

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

Areas for improvement

Action the trust **MUST** take to improve

Action the trust **MUST** take to improve

- The trust must ensure that nursing and medical staff complete all safeguarding and mandatory training including basic life support.
- The trust must ensure that all equipment is maintained and fit for purpose.
- The trust must ensure that initial assessments within the emergency department are undertaken and documented to maintain an accurate clinical record based on clinical judgement, and that initial assessments in the emergency department are documented.
- The trust must ensure access to a designated mental health assessment room.
- The trust must take action to ensure that patients are clinically risk assessed as safe to wait for outpatient appointments.
- The trust must ensure that medical records contain completed risk assessments relevant to patient care.
- Ensure that patient's records are appropriately stored in accordance with legislation at all times
- The trust must ensure that staff administering contrast for diagnostic imaging investigations use a patient group direction or have it prescribed.
- Ensure that do not attempt cardiopulmonary resuscitation (DNACPR) decisions are undertaken in accordance with national guidance and best practice.

- The trust must ensure that the design and layout of the paediatric emergency department enables effective oversight of paediatric waiting areas to ensure patient safety.
- The trust must ensure that there is an effective governance and risk management framework in place to identify and assess all risks relevant to the emergency department.
- The trust must ensure that patient's dignity is protected in changing cubicles in In Beta X-ray.
- The Trust must ensure that the doors for Beta X-ray are fully fitted and a risk assessment is in place to ensure patients are not a risk of unnecessary exposure of ionising radiation.
- The trust must ensure there is an effective process in place for timely review of policies and procedures and that these comply with national guidance and best practice.

Action the hospital **SHOULD** take to improve

- The trust should improve its overall performance in the management of referral to treatment times.
- The trust should ensure that clinics are not cancelled without exploring every option in order to contribute to reduced waiting times.
- The trust should ensure the clinics start on time.
- The trust should ensure that all staff are aware of translation services for non-English speakers.

Outstanding practice and areas for improvement

- The trust should ensure that clinical audit is undertaken and where data is not submitted, that it is followed up.
- The trust should ensure that all staff have received an appraisal and frequent supervision.
- The trust should review admission times and fasting periods for patients awaiting surgery to meet the nutritional and hydration needs of the patient.
- The trust should ensure managers and senior staff have the relevant level of skill and experience to perform their roles.
- The trust should ensure that staffing levels reflect the needs of patients at all times.
- The trust should ensure that it reviews its existing staff practice in relation to MCA and DoLS specifically in relation to the cohorting of patients in supervised bays.
- The trust should ensure that domestic staff follow infection control procedures, wear correct uniform, identification and personal protective equipment at all times.
- The trust should improve its overall performance in the management of patient falls.
- Continue to work to improve delayed discharges and discharges that occur between the hours of 10pm and 7am.
- Continue to work to improve attendance and documentation of meeting minutes at mortality and morbidity meetings.
- To ensure that patients diaries are being completed in line with guidance, and that these diaries are used throughout the patient journey.
- To improve the recording of actions following governance meetings and ensure that these are followed up and that evidence of learning or changes in practice are recorded.
- Ensure there are appropriate formal systems to share actions and learning from incidents consistently among all staff in the service.
- Update the policy for safeguarding children in line with best practice and national guidance, for example to ensure all child protection cases are overseen by a paediatrician.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>How the regulation was not being met:</p> <p>Mandatory training amongst staff was not at the trusts target with some notable improvements required in some areas such as medical staff training and safeguarding training.</p> <p>Not all equipment was maintained and serviced in a timely manner. Specifically within the Outpatient department 24% of equipment was out of date for planned preventive maintenance.</p> <p>The emergency department did not have a dedicated mental health assessment room. Plans were in place for this to be in place by October 2017. However mental health patients were accommodated in an isolation room adjacent to the majors' area in the emergency department. This room had one point of access and exit, no panic buttons and lacked direct oversight from staff. There were ligature points on the door handle. There were no formal risk assessments in place to show that patients would be assessed on an individual basis if they were appropriate to be admitted into this area.</p> <p>The trust did not have a standardised formal process or policy to risk assess patients who were awaiting follow-up appointments that were delayed. This was raised at the previous inspection but had not been fully addressed.</p> <p>Medical records did not always contain completed risk assessments relevant to patient care.</p> <p>A clinical assessment tool was built in to computer systems however, this was not being used within the emergency department. Decisions were being based on clinical judgement, without formal documentation.</p>

This section is primarily information for the provider

Requirement notices

Medical records were not always stored securely to prevent a potential breach of confidential personal information.

There were no patient group directives in place for diagnostic imaging staff administering medium in diagnostic radiology

26% of do not attempt cardio pulmonary resuscitation (DNACPR) records reviewed during the inspection were not accurately completed, with a lack of documented discussions of the decisions with patients noted. Of those not completed in line with guidelines, in three cases the patient had a DNACPR order in place when the patient did not have capacity and there was no evidence of a mental capacity assessment undertaken.

The design and layout of the paediatric waiting area within the emergency department did not allow for the safe and effective oversight of patients within this area.

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The trust must ensure that there is an effective governance and risk management framework in place to identify and assess all risks relevant to emergency the department.

Not all risks were identified on the emergency department's risk register. For example the use of three different early warning scoring systems (EWS) for paediatrics and lack of appropriate documented triage tool.

Divisional governance meetings and senior staff meetings appeared to lack a standard agenda and attendance by representative from the emergency department was not consistent.

Not all policies and procedures had been updated. We found some guidance out of date and significantly overdue for review. Some audits reflected that further work was required to meet national standards.

This section is primarily information for the provider

Requirement notices

Regulated activity

Diagnostic and screening procedures

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

In Beta X-ray patients in hospital gowns were waiting in the same area as other patients, we could not see whether dressing gowns were provided for patients and the curtains in cubicle areas did not fully close which was a patient dignity concern. Staff told us that some patients were advised to bring their own dressing gown for their appointment.