Care Quality Commission

Colchester Hospital University NHS Foundation Trust

Colchester General Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement
Accident and emergency	Requires improvement
Medical care	Requires improvement
Surgery	Good
Critical care	Good
Maternity and family planning	Requires improvement
Services for children and young people	Requires improvement
End of life care	Requires improvement
Outpatients	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Colchester General Hospital is part of the Colchester University Hospital NHS Foundation Trust. The hospital is an acute hospital providing accident and emergency (A&E), medical care, surgery, critical care, maternity, children and young people' services, end of life care and outpatient services, which are the eight core services always inspected by the Care Quality Commission (CQC) as part of its new approach to hospital inspection.

Colchester General hospital was a 600-bed district general hospital, in Colchester. The trust as a whole employs over 4,000 staff, the majority of whom are based at Colchester General. The hospital provided a range of elective and non-elective inpatient surgical and medical services as well as a 24-hour A&E, maternity and outpatient services.

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

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

Overall, we rated this hospital as 'requires improvement'. We rated it 'good' for providing caring care, but required improvement for safe, effective, responsive and well-led care.

We rated critical care and surgery services as 'good', but A&E, medicine, maternity services, children and young people's services, end of life care and outpatient services all required improvement.

Our key findings were as follows:

- Staff were caring and compassionate and treated patients with dignity and respect.
- Patients largely spoke positively about the care that they received although at some times communication needed to be improved.
- The hospital was clean and staff were observed to wash their hands appropriately.
- A review of nurse staffing levels had been undertaken and staffing levels had been increased. Safe staffing levels were being monitored and maintained but there was a heavy reliance on nurse bank and agency staff in some areas. Staff recruitment was continuing.
- The hospital had worked hard to understand the causes for its high Summary Hospital Mortality Indicator (SHMI) but it was still statistically high.
- Improvements were required in terms of the reporting and learning from incidents.
- Governance structures at a departmental level needed to be more consistent.

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

Importantly, the hospital must:

- Ensure that there is a robust incident and accident reporting system in place; including reporting staff shortages and that lessons learnt from investigations of reports are shared with staff to improve patient safety and experience.
- Ensure that all equipment has safety and service checks in accordance with policy and manufacturer's instructions and that the identified frequency is adhered to, including emergency equipment requiring daily checks, portable appliance testing and regular maintenance.
- Ensure that all patients' records are kept up to date and appropriately maintained to ensure that patients receive appropriate and timely treatment.
- Review the process for referring safeguarding concerns to the local authority to ensure that these are undertaken appropriately for the safety and wellbeing of patients.

Summary of findings

- Ensure that there are sufficient numbers of qualified, skilled and experienced staff at all times, particularly in A&E, medical wards and children's services including the high dependency unit.
- Review handover arrangements to ensure that they are effective and the necessary information is passed to the next responsible staff team so that patients receive appropriate treatment in a timely manner.
- Ensure that staff complete their mandatory training and have access to necessary training, especially safeguarding and resuscitation, and development to ensure they maintain the appropriate skills for their role.
- Ensure that patients are assessed by appropriately trained and experienced staff within the A&E department.
- Review the recording of necessary information such as arrival and discharge times in the A&E department to ensure that the information on performance is robust and correct.
- Review the patient flow from the A&E department to ensure that patients are assessed to meet their needs and there are no unnecessary delays.
- Review the complaints process to ensure that appropriate lessons can be learned and improvements made in service delivery.
- Ensure all staff adhere to the infection prevention and control of infection policy and procedures, particularly with regard to hand washing and cleaning procedures on the maternity unit.
- Ensure that all sterile fluids and medicines are stored in accordance with manufacturers and legislative guidance and that expiry dates are adhered to.
- Review the arrangements for dealing with controlled drugs to ensure that they comply with national standards and legislation and that these are implemented and adhered to by staff.
- Ensure that patients' records are appropriately stored in accordance with legislation at all times.
- Ensure that a patient's mental capacity is assessed appropriately and that records are up dated and maintained in accordance with national guidance and recommendations.
- Ensure that the assessment for a do not attempt cardio-pulmonary resuscitation complies with best practice and national guidance, involves the patients or their representatives and that these discussions are recorded, including when discussions have been deemed inappropriate.
- Review the arrangements for internal transfer of patients in the night and ensure that this is kept to a minimum, particularly for frail and elderly patients.
- Review the involvement of staff in trust-wide issues to ensure that staff are fully conversant with the trust vision, strategies and objectives and can contribute to the development of services.
- Review the cancellation of outpatient appointments and take the necessary steps to ensure that issues identified are addressed and cancellations are kept to a minimum.
- Review waiting times in outpatients' clinics and take the necessary steps to ensure that issues identified are addressed.

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

In addition, the hospital should:

- Review the blood testing processes in the A&E department to ensure that they are efficient and timely.
- Review information given to patients on why they are waiting in the A&E department to allay anxieties.
- Review the information following clinical audits and ensure that any actions and learning are shared with staff.
- Review the training available to staff on caring for people living with dementia or with a learning disability and provide training to ensure that staff have the appropriate skills for their role.
- Review staff communication and engagement to ensure that they are aware of the trust strategies and vision, including new initiatives such as the clinical care strategy for end of life care.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Accident and emergency	Requires improvement 	The emergency department (ED) at Colchester General Hospital required improvement for safety. We found that the cleanliness met required standards and that equipment needs were met, or requirements acted on, by senior nursing staff. We also found that, although there was extensive building work being carried out, this was being managed effectively. We found that staff nursing levels were not always optimal but that although there was a shortage of consultant staff, the hospital had mitigated this potential risk to patient safety. We also observed that nursing handovers did not fully involve or engage relevant staff and that information was relayed from the most senior nurse's memory of patient status with the aid of prompts from the white board. We noted, from audits, that patient records required improvement. We observed that records were not securely stored in the department. Incidents did not always contain the required level of detail. Safe staffing and other incidents were not always reported.
Medical care	Requires improvement 	Medical and nursing staff were observed to enter and leave wards without using hand sanitising gels. Staff were also observed removing gloves after tending to patients and move to other tasks without washing their hands. Overall we found the medicine areas to be clean and tidy. Equipment was generally clean and appropriate, but medicine was missing from one resuscitation trolley when it was checked. Concerns were raised about staffing levels and the skill mix on a number of medical wards. A nursing staff analysis review had been carried out on a number of medical wards and two wards were identified as being at risk. The trust was not meeting its targets for mandatory training within the medical directorate. Nursing records were not consistently completed and areas for assessing risks to patients were not completed in a number of care records we viewed

Summary of findings

across all ward areas where we visited. Staff across the directorate reported that learning from incidents needed to be improved, as many said that there was only learning after Serious Incidents.
Although the trust has worked hard to identify areas where care needs to be improved, it continues to have an elevated Summary Hospital-level Mortality Indicator (SHMI). There was evidence of participation in national and local clinical audits, but staff reported a lack of feedback and learning where improvements were identified. There were good arrangements for multidisciplinary working within the directorate.
Patients and the relatives we spoke with told us that staff were caring, kind and compassionate. They said that medical staff were approachable. We observed medical and nursing staff treating patients sensitively and discreetly. The majority of patients we spoke with said that they had been involved in making decisions about their care and treatments and that they had been given advice and information. Some people told us that they had not been involved in making decisions about their care and treatment. Some said that they were unaware of their plan of treatment or the arrangements for their discharge from hospital.
The medical directorate services were generally responsive to the needs of patients. Improvements were needed in managing the flow of patients between EAU and other ward areas to reduce the number of transfers overnight.
The service requires improvement in leadership. Staff across the directorate reported a lack of engagement with senior management at executive-level. Nursing staff reported good support and engagement with the director of nursing, but said that there was a lack of visibility of other senior managers including the chief executive. Staff were aware of the vision and strategy for the trust, which had only been very recently introduced. Staff did not feel 'listened to' or involved in making decisions and there were issues around learning from incidents.

Surgery Good

Safety of the service required improvement. We found that consent was not always taken in line recommended guidance and that mental capacity assessments were not always completed. We found

that only 41% of staff had undergone basic life support training. The environment on the surgical wards and theatres was clean and there was evidence of learning from incidents in most areas. There was adequate equipment to ensure safe care although we found some equipment that had not been checked in line with trust policy.
Surgical services at this hospital used evidence-based care and treatment and had a clinical audit programme in place. There was evidence of multidisciplinary working and access to seven-day services. Effective pain relief and nutritional arrangements were in place. Patients received care and treatment from competent staff, although appraisal rates for staff were variable.
The surgical services provided at this hospital were caring. All patients and relatives we spoke with supported our observations and the results of patient surveys and the NHS Friends and Family Test, which was above the national average.
Services were responsive. Discharge planning was commenced prior to admission for elective patients and on admission for those admitted as an emergency. Ward areas had designated dementia champions and patients, with all religious beliefs were respected.
Staff reported good leadership at all levels within the directorate and improvements in staffing levels. Governance, risk and quality systems were in place. Staff spoke enthusiastically regarding the department and were positive around the quality of care they were providing.

Critical care

Good

The critical care service provided at this hospital was safe, as patients were protected from avoidable harm and abuse. There were sufficient nursing and medical staff on the unit at all times, and the unit was clean and equipment was checked regularly. Incidents were reported and learned from appropriately.
Staff respected patients' privacy and dignity. For example, we saw staff pulling curtains around patients' beds while caring for their needs.
Family members referred to care in the intensive care unit (ITU) as "first class". They were regularly kept updated on the condition of their relatives. They told us that staff "could not do enough for

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them". We observed how a member of staff came out to update the family members in the family room next to the ITU and requested that other people in the room not related to the relative leave so that personal information was not shared with others. This showed that patient confidentiality was maintained.
The critical care service provided was responsive to patients' needs. The majority of patients were discharged from the unit in a timely way and complaints were handled appropriately.
The leadership of the unit was visible. Nursing staff wore different uniforms according to their role and patients were able to identify different grades of staff on the unit.
Staff were aware of their roles and responsibilities and how to escalate concerns. The unit had a clearly identified leadership structure.

Maternity and family planning

Requires improvement

The maternity wards were generally clean, but some areas were dirty and equipment was not always checked. There were systems in place to identify women whose condition was deteriorating and staff knew what action to take. There was evidence of investigating incidents and learning from them. The average ratio of midwives to births had recently improved following the temporary closure of the coastal units. Medical staff provided adequate cover to the service. However, we found out-of-date intravenous fluid and blood bottles were stored within the wards. Although they scored highly in their hand-hygiene audits, we saw nurses were not regularly washing their hands. The defibrillator had not been checked since 2011.
Evidence-based guidelines were followed and there was a process to monitor outcomes for patients. Women were positive about the care they were receiving and were involved in their care. Services for women who had experienced the loss of their baby were well thought out. A range of antenatal classes were offered to women and there was a counselling service for women who had experienced a traumatic birth. There was no dedicated midwife for mental health-related services.
Although leadership of the service at a local-level was good and there was evidence of coherent working between midwifery and medical staff a new

Summary of findings

management structure had been introduced in January and there was still a lack of clarity regarding roles and accountability for the service. The relationship between the service and the CCG was described as “adversarial” and needed to be improved. Staff did not have a clear understanding of the vision for the maternity service and morale among community midwives was low.

Services for children and young people

Requires improvement

Incident reporting was encouraged and we saw evidence of learning and changes to practice as a result of Serious Incidents. Ward areas were clean and secure and we saw staff washing their hands appropriately. There was sufficient medical oversight of the ward areas and consultant-led handovers.

However, mandatory training rates, especially for safeguarding children and basic life support needed to be improved and staffing levels were acknowledged by the department to be suboptimal. Not all children requiring high dependency care were looked after by nurses with the relevant training, and while the department was recruiting, current staff reported working extra hours in order to maintain the quality of care for patients. This may have impacted on the high sickness rates amongst staff.

Care was provided in accordance with evidence-based national guidelines and there was evidence of active audit activity. Pain was assessed promptly and using age-appropriate tools. Multidisciplinary working was evident and care was consultant-led.

Throughout our inspection, we witnessed caring interactions between staff and children on the wards. Parents were complimentary about the care their children received and told us they felt involved in decision-making about the care and support for their child.

The open-access CAU ensured that children referred by their GP could be seen by paediatric staff without having to wait in A&E. There was good support for children with learning disabilities and their parents. There was a good range of age-appropriate toys and children received educational support five days a

week. Parents were provided with information through a variety of leaflets. There was a clear complaints procedure and the vast majority were responded to promptly.
Although staff spoke positively regarding the quality of service they provided and were clearly dedicated to the provision of high quality care, we had significant concerns relating to the way risks were identified and mitigated against. Monthly governance meetings were held in conjunction with the women's division and minutes provided to us at the time of our inspection could not assure us that there was a robust risk management process in place.

End of life care — **Requires improvement**

The trust has a dedicated palliative care team who provided good support to patients at the end of life. The palliative care team were observed to be providing care in line with national guidance and best practice. The Liverpool Care pathway was in the process of being phased out and replaced by local guidance. On site palliative care support was provided by the team 9-5pm seven days a week. Care and treatment was given in a sensitive and compassionate way. Staff worked hard to meet and plan for patient's individual needs and wishes. Staff were very motivated and committed to meeting patients' different needs and were actively developing their own systems and projects to help achieve this. We found many examples of good compassionate care for patients and patients were very positive about the service from the specialist team.
The multi-disciplinary team worked well together to ensure that patients care and treatment was planned and coordinated. People were positive about the care they received and the support they were given. There were effective working relationships with local hospices to coordinate people's end of life care where the hospice was their preferred place of care
We found variation in the standard of records in relation to DNACPR documentation. We found little evidence of the Mental Capacity Act 2005 being considered in line with end of life care policies and completion of DNACPR forms. We also found that

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none of the DNACPR forms and patient records we examined had documented that appropriate discussions had taken place with relatives regarding the decision.
The trust had a multi-faith chapel were all faiths were welcome. There were also a number of chaplains from different denominations. Relatives were able to stay with their relative in a side room should they request to do so.
We found that the service was well led locally however was not well led at senior levels. We found that there was a lack of consideration towards end of life care when developing governance processes. End of life care was not recorded in great detail on the trust's risk register despite there being notable staff shortages and no visible executive leadership.

Outpatients

Requires improvement

Although most of the areas we inspected appeared to be clean we found two rooms with dirty cups and that some cleaning rotas were temporary and incomplete. We found out of date clinical equipment, such as acupuncture needles and sterile sodium chloride solution. Although it was reported to us that there were no vacancies within the department, it was not clear that a recent skills mix had been undertaken. Staff adhered to 'bare below the elbow' policies and there were adequate hand-washing facilities in all but one of the rooms used to examine patients.
Outpatient services were caring and most patients spoke positively about the care and treatment they received and felt they were involved in their care plan. We witnessed staff being polite and welcoming.
Although the trust had a work stream to monitor outpatient efficiency and to improve do not attend (DNA) rates, we were concerned to find a large number of cancelled outpatient appointments. Up to 9% of these occurred within one week of the original appointment time.
We saw written information about the complaints procedure and the Patient Advice and Liaison Service, but none of the patients we asked had been given any information about complaints or knew how to make a complaint. We received consistently negative feedback from patients and staff about the patient transport service and patient parking.

Summary of findings

We found senior staff each had visions for the service at local-level, yet there seemed to be a lack of combined objectives and strategy to achieve an improved service. Issues had been identified within the service, but there were delays in resolving these. We were provided with minutes from divisional governance meetings which appeared to demonstrate that outpatient services were discussed in relevant speciality meetings rather than as a separate service and within these outpatients was discussed at any length. There was no discussions minuted relating to delays in appointments or cancellations. Staff we spoke with were not aware of key performance indicator targets or results for the service and therefore were not proactively managing the situation at clinic-level. None of the staff we spoke with talked highly about the trust or acknowledged the trust vision or objectives. Despite this, managers we spoke with told us that they were proud of the staff working in the various services across outpatient services.

Requires improvement

Colchester General Hospital

Detailed findings

Services we looked at

A&E; medical care (including older people's care); surgery; critical care; maternity and family planning; services for children and young people; end of life care; and outpatient services.

Contents

Detailed findings

Background to Colchester General Hospital

Colchester General Hospital is a medium sized teaching hospital in Colchester with approximately 600 beds and is the main acute site for Colchester Hospital University NHS Foundation Trust. The hospital provides a range of elective and non-elective inpatient surgical and medical services as well as a 24-hour A&E, maternity and outpatient services to a surrounding population of around 370,000.

In 2013, the trust was identified nationally as having high mortality rates and it was one of 14 hospital trusts to be investigated by Sir Bruce Keogh (the Medical Director for NHS England) as part of the Keogh Mortality Review in May that year. Following concerns regarding the authenticity of cancer waiting times the trust was placed in Special Measures by Monitor in November 2013

At that time there was a significant turnover of the executive team. In addition the Chief Executive in post at the time of our inspection was replaced shortly afterwards.

Our inspection team

The inspection team was led by:

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

Head of Hospital Inspections: Julie Walton, CQC

Inspection Manager: Carolyn Jenkinson, CQC

The team included CQC inspectors and a variety of specialists. There were nine CQC experienced inspectors, six medical clinicians from a range of backgrounds, including children's, medicine, surgery and anaesthetics, eight nurses from a range of backgrounds that included cancer care, infection control, maternity, children and critical care.

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

How we carried out this inspection

Pre-inspection:

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

Public involvement:

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

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

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

Internal stakeholders:

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

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

Inspection

The comprehensive inspection involved an on-site review of:

- A&E
- Medical care

Detailed findings

- Surgery
- Critical care
- Maternity
- Children and Young Peoples Services
- End of life care
- Outpatients.

The on-site element of the inspection involved a team of experts by experience (service users), clinical associates (experienced healthcare professionals) and CQC inspectors. The team was divided into subteams, each of which looked at one the service lines described above. The subteams were led by an experienced inspector, supported by clinical experts as well as expert by experience. The teams undertook a number of methods of inspections from interviews to direct observations of care.

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

External stakeholders:

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

Post inspection

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

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident and emergency	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and family planning	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both A&E and outpatient services.

Accident and emergency

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

Information about the service

The emergency department (ED) at Colchester Hospital University NHS Foundation Trust provides a 24-hour service, seven days a week to the local area and sees approximately 76,000 patients per year.

Patients present to the department by walking into the reception area or arriving by ambulance. Patients transporting themselves to the department report into reception and are subsequently triaged to the most appropriate area.

The department consists of a Majors and Minors area, with a separate area for children. There is a resuscitation area, which currently has three beds. One of these is primarily for children, but beds can be flexed for adults or children, as required.

The department was undergoing extensive construction work to increase space, including adding three additional beds within the resuscitation area. Works were expected to be completed by July 2014.

Patients attending the accident and emergency department should expect to be assessed and admitted, transferred or discharged within a four-hour period. If an immediate decision could not be reached, a patient may be transferred to the emergency assessment unit (EAU), for up to 48 hours. Once patients were admitted to the EAU, they were cared for by the medical team. Therefore, this unit is discussed in the medical care section of the report.

Summary of findings

The emergency department (ED) at Colchester General Hospital required improvement for safety. We found that the cleanliness met required standards and that equipment needs were met, or requirements acted on, by senior nursing staff. We also found that, although there was extensive building work being carried out, this was being managed effectively.

We found that staff nursing levels were not always optimal but that although there was a shortage of consultant staff, the hospital had mitigated this potential risk to patient safety. We also observed that nursing handovers did not fully involve or engage relevant staff and that information was relayed from the most senior nurse's memory of patient status with the aid of prompts from the white board.

We noted, from audits, that patient records required improvement. We observed that records were not securely stored in the department. Incidents did not always contain the required level of detail. Safe staffing and other incidents were not always reported.

We found that the department followed national guidelines and monitored its targets through participation in both local and national audits. There was evidence that results from these were monitored and action points followed up on. We saw that staff had sufficient equipment and this had recently improved, as a result of staff raising equipment as a concern.

Accident and emergency

Patients were treated with compassion and respect throughout their stay in the accident and emergency department. Staff made sure patients were involved in discussions about their care and understood what was happening to them. However, lack of communication, especially when the department was under pressure, was a recurring theme.

The services in ED were not always responsive. There were mechanisms in place to maintain the flow of patients, although this did not always work well. Sometimes, this was due to a lack of beds or when staff had to wait for a specialist from another department. The support available for adults with mental health needs had recently improved, although delays for children remained, particularly out of hours.

Leadership and governance arrangements within the department were not sufficient to ensure that the patient experience and quality of care was assured although staff told us that they felt well supported by management locally. Although there was a structured governance system in place for formal monthly meetings these had not been held regularly for clinical governance or senior staff. Review of the meeting minutes demonstrated that although there were standing agenda items, clinical and quality indicator information at departmental-level was not always discussed. When it was, it did not always contain sufficient detail. We also noted that actions required were not always clear and these were not followed up at subsequent meetings.

Are accident and emergency services safe?

Requires improvement

The emergency department (ED) at Colchester General Hospital required improvement for safety. We found that the cleanliness met required standards and that equipment needs were met, or requirements acted on, by senior nursing staff. We also found that, although there was extensive building work being carried out, this was being managed effectively.

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Incidents

- The hospital used the Datix system for reporting incidents. All the staff we spoke with knew how to use the system.
- The staff we spoke with stated that they were encouraged to report incidents and that they received direct feedback from their matron or a senior nurse if they had been involved in, or reported, an incident.
- Themes from incidents were highlighted as part of the staff team days (we were told that there were seven teams in the department and that a team day was held each week so that each team had a communication day approximately every two months). A folder was available in the staff room which included learning from Serious Incidents. We saw an example of the team day communication topics for March through to June. We saw that incident trends were listed as a topic and that there were three serious investigations also listed for discussion.

Accident and emergency

- Staff told us about some examples of changes made to practice as a direct result of investigation of incidents, for example, all patients requiring a diagnostic test, were risk assessed to decide whether they required an escort and whether this should be a qualified or unqualified member of staff.
- We were provided with a summary of all incidents between March 2013 and February 2014. We noted that, through reviewing the incident report, the column to record 'action taken' was mostly quite clear about any immediate remedial action to be taken, but this was not always the case, particularly for incidents relating to staffing shortages, which were often stated, as matron informed us. We also noted that very few incidents had a recorded learning outcome. This meant that actions may not have always been taken and that staff may not have learned lessons to minimise the risk of such incidents happening again.
- We found very few examples of incident reporting relating to staffing levels, which did not correspond with our review of the rotas for the same period. One member of staff told us that they would not necessarily report staffing shortfalls as an incident. This meant that insufficient staffing levels, as a trend, may not have been formally reported and followed up.

Cleanliness, infection control and hygiene

- There was an extensive building and refurbishment programme underway during our inspection. However, despite this, the department appeared visibly clean. We did not see any dust arising from the building works.
- We observed staff washing their hands and using hand sanitising gel between patients. 'Bare below the elbow' policies were adhered to. Staff wore minimal jewellery, in line with trust policy.
- There was a system for cleaning equipment in between it being used. A sticker was placed on the equipment once it had been cleaned. This meant that it was clear when equipment had been cleaned and was ready for use.

Environment and equipment

- At the time of our inspection, the environment was dominated by the building works to increase the size of the department. However, the different areas, some of which were temporary, were clearly sign posted.
- Some areas of the department were too small to cope with the number of patients at busy times. However, it was envisaged that once the building was completed, some congestion would be relieved. However, staff told us the wait that patients had from ambulances into a public corridor would remain.
- The radiology department was situated next door to the unit and was easily accessible.
- Equipment was appropriately checked and cleaned regularly.
- We looked at the resuscitation trolleys, all of which were checked daily and after they had been used. This was recorded. All the equipment was within date.
- Specialist equipment, for example, the anaesthetic equipment in the resuscitation area, was checked daily by an operating department assistant, from the operating theatre.
- There was a blood gas machine within the unit. All blood gas results were checked by a doctor.
- During our unannounced inspection we observed that the defibrillator on the resuscitation trolley had not been checked for more than 24 hours. We spoke with the nurse in charge who immediately tested the equipment to ensure it was safe to use.

Medicines

- Medicines were stored correctly in locked cupboards, although we found that one fridge was unlocked. All the fridges we saw displayed the correct temperature. However, there was no system in place for staff within the department to regularly monitor the temperature of the fridges. We were told that this was the responsibility of the pharmacy team.
- Controlled drugs were kept in two areas within the department. Access to the key for these cupboards was kept by the nurse in charge. There was a system to check the balance of controlled drugs. We checked a sample of controlled drugs and found them all to be correct.
- We also checked a sample of other medicines throughout the department and found they were stored safely and were well within their expiry date.

Records

- We saw that patient records were placed in a storage section within the staff rest area. We noted that, although the door to the room was always closed and that there was a keypad on the door, the door was not locked. This meant that patient notes could be accessed by members of the public. We observed that there was a notice displayed in this room informing staff to ensure

their lockers (also located within the storage area) were kept locked, as some personal belongings had been stolen. This meant that patient records were not adequately secure.

- We reviewed approximately 30 sets of patient notes during our inspection. We saw that information about the assessment and treatment of each patient had been well documented and risk assessments completed, as necessary.
- The department used standard documentation to record patient details and assessments used by both nursing and medical staff for each patient. The department had developed a 'single clerking' process, which aimed to refine the process by improving the documentation and refining the medical assessment process. We were told that this was continually under review until fully refined.
- We observed that risk assessments had been completed, including the patient risk of developing a pressure sore, the risk of having a fall and so on. There was an established protocol to follow for patients assessed as high risk of pressure ulcer development to ensure that they received pressure relieving equipment at the earliest opportunity. We observed this is use during our unannounced inspection.
- Although the notes we reviewed had been completed well, we saw that the department's audits had identified that the completion of documentation for some aspects of patient notes had not met agreed targets. For example, signing and dating nursing documentation, delays in medication being administered to sepsis patients, patients with moderate to severe pain scores not always administered pain relief within 20 minutes – this was also supported by one of the patient files we reviewed, where there had been a delay of approximately two hours in administering pain relief.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All the staff we spoke with were aware of the trust's consent policy and how to gain consent from vulnerable people who may not have had the capacity to consent.

Safeguarding

- Staff were clear on the procedure to be followed if there was a concern about a child. If there were concerns regarding child welfare, the A&E department would discuss it with the safeguarding lead or the on-call paediatric registrar. There was a process in place for making referrals to the relevant social services department. Checks were not made as a matter of routine, only if a member of staff had concerns. The safeguarding team undertook daily checks to ensure referrals had been made in line with procedures.
- The children's admission form had clear guidelines in place on who the child should be referred to once discharged and every family was asked, when the child was admitted to the department, if the family had a social worker in order that they could be liaised with.
- We reviewed patient records and saw that referrals had been made for most of the children when it would have been appropriate to do so. However, we noted that in the case of one particular child, who had attended the department on seven separate occasions, it would have been relevant for a safeguarding referral to be made on each of the seven admissions. However, referrals had only been made on two occasions. The occasions missed had not been identified by the safeguarding team and this had not been picked up until the person attended the department following a seventh overdose.
- During our unannounced inspection we identified that a patients had not been referred to the safeguarding team or the local authority. The patient was admitted as a result of self-harm and attempted suicide. We raised our concerns to the nurse in charge of the department who took action to report this incident.
- We also reviewed the incidents reported between November 2013 and April 2014. We saw some good reporting on Datix of safeguarding incidents, although we noted there were 11 incidents where a safeguarding referral had not been made and there were concerns for their welfare. Ten of these had subsequently been picked up by the safeguarding team. One had been brought to the attention of the hospital by an external party.

Mandatory training

- The staff we spoke with outlined the mandatory training they had completed. Most of this was done via e-learning. We spoke to some staff, who had recently joined the trust. They told us that the corporate and local induction process had been very helpful and informative. We were also told that additional training took place as part of the team days. For example, clinical skills training.
- We were provided with trust-wide training data. This was separated out by staffing group, as opposed to

individual department. Training data for nursing and midwifery staff had been grouped together for the whole of the trust and medical staffing for emergency medicine reported on separately. This meant that it was difficult to conclude meaningful results for the ED. From the data available, we observed that the medical staff training data up to February 2014 showed that there was a low uptake of a significant proportion of fitness to practice training and essential skills training. Overall, the percentage of staff having completed the training within these categories was 59% and 50% respectively. This was an improvement on the previous year.

- We noted that safeguarding at level 1 and 2 had been reasonably well attended but attendance for level 3 training was poor (between 42% and 62% depending on the type of level 3 training).
- We saw that completion of life support training for adults was less than 60% and for children was less than 16%. There was greater emphasis on customer care training, which had been completed by almost 80% of medical staff.
- We reviewed the local training data for healthcare assistants and nurses who worked in the emergency department. Most mandatory training sessions had been completed by over 70% of permanent nursing staff (excluding new starters and members of staff on long-term leave), with the exception of risk management, information governance and the local authorities safeguarding training session. We noted that bank nurses attendance at training was poor, with the exception of Deprivation of Liberty Safeguards, manual handling and basic life support training, which had been completed by most of the temporary workers employed by the trust.

Management of deteriorating patients

- Patients who came in by ambulance were admitted via a separate entrance. They were seen initially by a healthcare assistant (HCA) who completed a baseline set of observations of the patient's general condition, their pain score, their temperature, pulse and blood pressure. However, some of the ambulance personnel and the nursing staff told us that when the department was busy, although an initial assessment took place quickly, the ambulance crew was responsible for caring for that patient, reassessing them and alerting staff if they thought the patient was uncomfortable or deteriorating. This meant that there was no robust system in place to ensure patients were reassessed regularly by a registered nurse.
- The ambulance crews we spoke with told us that it was not unusual for patents to have to wait for up to an hour in the corridor on the ambulance trolley, awaiting an appropriate bay in the department.
- Colchester General Hospital consistently failed to reach the target for ambulance handovers exceeding 60 minutes and was also well below the target. However, we were told that there were issues in the data collection and that, as yet, this had not been resolved.
- Walk-in patients were booked in by a receptionist and assessed by a band 6 or above nurse. They used Rapid Assessment and Treat (RAT) guidelines to stream patients appropriately. Those with higher risk then underwent more formal triage (using the Manchester triage system). Patients with chest pain were transferred immediately to the Majors area for an electrocardiogram (ECG).
- Children were seen in a separate area in the department, with its own entrance and waiting area.
- The hospital used the national protocol for assessing and treating patients with sepsis. There was a side room, which meant patients who were at risk of developing an overwhelming infection could be isolated. Most of the oncology patients who may have developed neutropenia (low white blood cell count) and may have been at risk of developing sepsis, were usually treated at the oncology centre at Essex County Hospital. However, the A&E at Colchester General Hospital did have a protocol to treat these patients, if this was not possible.

Management of the deteriorating patient

- The unit used the national early warning score (NEWS) and paediatric early warning score (PEWS) tools to monitor patients. There were clear directions for escalation printed on the reverse of the observation charts and staff spoken to were aware of the appropriate action to be taken if patients scored higher than expected. We saw evidence that the patient scores were being monitored and recorded.

Accident and emergency

- The department audited completion of NEWS and PEWS documentation each month. Performance had been below expectations in February and March 2014 but improvements were seen in April and the department had met or exceeded the target for both.

Nursing staffing

- The matron had recently completed a staffing business proposal based on the Royal College of Nursing Baseline Emergency Staffing Tool (BEST). An initial proposal had been partially approved, which had allowed the department to increase staffing levels by 10 whole time equivalents (WTEs). The department had previously been staffed to this level, but the establishment had not been agreed as a baseline. This meant that the department had exceeded their budget for use of bank and agency staff. A subsequent proposal had been developed to further increase staffing levels and to extend hours covered by emergency nurse practitioners, as well as to staff the additional spaces created as a result of the ongoing building work.
- Ideal and actual staffing numbers were displayed for each shift in the department. Staff reported that there had been historic problems with low staffing levels and the high use of temporary and agency staff.
- It was the perception of most of the staff that we spoke with that the department could become very busy and that they were frequently short staffed. We were told that agency nurses were used to provide cover and that, where possible, these were regular agency staff. We were told that the use of ad hoc agency nurses slowed down the functioning of the department because they required additional support. Added to that, regular checks on their work had to be undertaken by the nurse in charge.
- The staff we spoke with told us that a recent recruitment drive had resulted in 10 new registered nurse and three healthcare assistant (HCA) vacancies being filled. Their commencement dates had been staggered, so that the department was not inundated with new staff.
- We reviewed the rotas for the period January to March 2014 and found that a significantly high percentage of shifts did not have the full staffing requirements, even with the use of bank and agency staff. Providing adequate cover was a particular issue for the late shift.
- We were told that the skills mix was generally appropriate when the department was fully staffed. There were two emergency nurse practitioners in post who were able to work autonomously, prescribing medicines, suturing and ordering x-rays. Support from the medical staff was provided as well, if necessary. One of the healthcare assistants was trained and competent in applying plaster of paris to a variety of injured limbs.
- The children's area was staffed by at least one registered children's nurse. We were told that during the previous four weeks, staffing arrangements within the department had improved and that there were regularly two members of staff.
- There was no children's nurse present in the department from 2am until 7am daily. The children's area linked very closely with both the main A&E department and the nearby children's department. Paediatricians were readily available to see children should this be necessary.
- Since November 2013, all children under the age of one year, or who had a score of three or more using the PEWS, were seen by a paediatrician, regardless of their injury or complaint.

Medical staffing

- There was consultant presence in the ED from 8am until 12pm, with overnight middle-grade doctor cover. The College of Emergency Medicine recommends that EDs have 16 hours of consultant presence per day.
- We spoke to a range of medical staff, who told us that although locums were used, there was adequate cover on the department and that they had no concerns around medical staffing.
- Due to the medical staffing vacancies, there was a high usage of locums and it was reported the locum budget was £1m in overspend.

Medical and Nursing Handover

- Nursing handovers occurred at every shift change.
- We observed the nursing handover at lunchtime. This took place around a whiteboard, which contained information about all the patients in the Majors area. Staffing for the shift was discussed as well as any high risk patients or potential issues. The handover was for the incoming shift. However, we observed that it took place between the two band 6 nurses who were handing over and taking over the shift. The area was noisy and there were constant interruptions. For example, medical staff wanting information and nursing staff squeezing past the nurses while they were handing over to put nursing notes in a 'pigeonhole' under the whiteboard. The other nursing staff who arrived for duty did not

appear to be involved. There was no interaction between the senior and more junior members of staff, who were allocated tasks and patients after the handover had taken place. We observed that, during the handover, most of the information was shared from the information on the board and what the nurse in charge recalled as having occurred during the shift rather than using the patient's notes routinely. This meant that essential information may not have been recalled and, therefore, was not shared with the oncoming shift leader.

- We observed the consultant on duty conduct a 'board round' of the department's patients one by one. The latest early warning score was immediately available. The consultant received a summary of each patient's presenting complaint and the information gained so far from physical examination, x-ray and biochemical investigation. We saw that the consultant recommended the next appropriate actions, delegated or assumed personal responsibility for the patient's continued management, discharge or onward referral.

Major incident awareness and training

- We requested evidence of training for major incidents for all staff within the ED. We were provided with training data for nursing staff only. This demonstrated that 58% of nursing staff had completed major incident training and that 70% of nursing staff had completed chemical, biological, radiological and nuclear training. We were also told that all staff had completed major incident training, as part of their induction.

Security

- The ED had its own security team situated directly next to the department. We were told by staff that security responded promptly when called. There was an intruder alarm in the paediatric department.
- Staff within the wider ED could contact security by pager or telephone. The staff we spoke with were satisfied with the level of support received from the security department.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

We found that the department followed national guidelines and monitored its targets through participation in both local and national audits. There was evidence that results from these were monitored and action points followed up on. We saw that staff had sufficient equipment and this had recently improved, as a result of staff raising equipment as a concern.

Evidence-based care and treatment

- The ED used a combination of NICE and College of Emergency Medicine (CEM) guidelines to determine the treatment they provided. Local policies were written in line with this and were updated as national guidance changed.
- We reviewed patient records against a sample of national guidelines and found that patients had been assessed and treated in accordance with guidance.
- Trainees were encouraged to undertake clinical audits to assess how well guidelines were adhered to. We were provided with a copy of the clinical audit priorities for the year, which had nine audits planned and two re-audits. Six were listed as complete with an action plan being developed, others were reported as ongoing.
- We saw that the departmental clinical governance meeting regularly discussed any updated guidance relevant to the ED.

Patient outcomes

- The department took part in the national College of Emergency Medicine (CEM) audits.
- In 2013, 79% of patients were first seen by a ST4 or above, compared with the national total of 41%. In addition, 98% of ED notes were reviewed by a senior doctor after discharge, which was significantly higher than the national rate.
- In the renal colic audit (2012-13), although the department scored well in recording pain scores, they were in the lower quartile (quartiles are the values that divide a list of numbers into quarters) for provision of timely pain relief.

Accident and emergency

- In the severe sepsis and septic shock audit (2011-2012), again they scored well at recording and documenting vital signs. They were around the median for the length of time before intravenous (IV) crystalloid and antibiotics were given to patients.

Nutrition and hydration

- Some patients required food and drinks while they were in the department. There was an area where drinks could be made. If someone required a meal, it was usual to order a 'snack box' from the catering department. These comprised of a sandwich, biscuit and fruit juice. Hot meals could be ordered from the main kitchen, if required. One member of staff told us, "They usually arrive quite quickly after we order them. Sometimes there's a wait, but that's quite rare."

Competent staff

- We were told that there had been a recent drive to ensure that all staff received an annual appraisal, but, prior to this recent initiative, staff told us that they had not received an appraisal for around two years.
- We were also told that appraisal were not linked to the trust's strategic objectives and, therefore, trust priorities had not been promoted and aligned to appraisals to promote the vision and values of the trust.
- Data provided to us demonstrated we saw that nursing appraisals had improved significantly between April 2013 and March 2014 from 42% to 75%. However, the percentage of medical staff with an up-to-date appraisal had increased from 90% in May 2013 to 92.3% by March 2014.

Equipment

- There was appropriate equipment to ensure effective care could be delivered. Some members of staff told us that there had been a shortage of basic equipment, for example, electronic blood pressure, pulse and oxygen saturation machines. However, we were told that these issues had been picked up by the nurses in charge through the 'monthly rounding', a system where the nurse in charge asked staff if there were any issues that needed resolving. Staff were satisfied that these were on order and that they had felt listened to.
- There was a blood gas machine in the department, but no other means of gaining routine blood results rapidly. The nearest laboratory was off the trust site. Staff reported to us that the quickest that blood results could be obtained was an hour. This increased to three hours during the night and at weekends, as it involved the nurse in charge calling the driver. Although the blood results were posted onto the system electronically, there was no flag in the patient's electronic record, so that staff had to repeatedly check the system to check if blood results were available; staff told us this was time consuming.

Seven-day services

- The department was supported by other services and had access to radiology department 24 hours per day.
- We were told that there were specialist stroke nurses who worked on the ED 24 hours per day.
- Physiotherapy support was provided two to three days per week, mornings only and it was reported that it would be beneficial for patients if the service hours could be extended.
- The pharmacy was open daily until 5pm, out of hours on-call arrangements were in place if stock or non-stock medication was required and not available.

Are accident and emergency services caring?

Good

Patients were treated with compassion and respect throughout their stay in the accident and emergency department. Staff made sure patients were involved in discussions about their care and understood what was happening to them. However, lack of communication, especially when the department was under pressure, was a recurring theme.

Compassionate care

- Feedback from patients through the NHS Friends and Family Test was above the England average.
- Throughout our inspection, we witnessed patients being treated with compassion, dignity and respect. We saw that call bells were answered promptly in most cases. One patient told us that staff were caring but that there were long waits. Although the relative of one person told us that people were treated differently depending on their age. They told us that they'd brought their daughter and mother to the hospital on a few separate occasions and that staff had always been

very kind and talkative with her daughter, but that this was not the case for her mother, who was elderly. The elderly relative of another patient told us that their relative was being cared for well by staff.

- We were told that the department did not undertake hourly comfort rounds to ensure patient's needs were being met, for example, to see whether they needed assistance to the toilet, or if they needed a drink, amongst other things. We were told that this had been initiated across the rest of the hospital and that this would be rolled out to the ED in the near future.

Patient understanding and involvement

- Some patients waiting in the Minors area told us that they were unclear how the triage system worked and that they were left waiting for a long time without knowing what was going on. There was no indication within the reception area about how long people were likely to wait. We observed that there were no information leaflets or magazines for patients waiting in reception. One person told us, "I was seen by a nurse very briefly when I arrived and was told that someone would see me shortly. It was then an hour before I saw a doctor. I was told I would be having observations, but I've not seen anyone since and that was about half an hour ago."
- Patients and relatives who were being assessed, or had received treatment in the Majors area reported that communication from staff was good and that they felt involved.

Emotional support

- We spoke with a member of the trust chaplaincy service, who told us that there was a chaplaincy member in the department four to five times per week. They told us, "My job is just to be here to help the staff, patients and relatives and provide comfort. That may be just chatting, a hug or getting someone a blanket, if they feel cold. It's completely non-religious and if people don't want to talk to me, that's fine."

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

(for example, to feedback?)

Requires improvement

The services in ED were not always responsive. There were mechanisms in place to maintain the flow of patients, although this did not always work well. Sometimes, this was due to a lack of beds or when staff had to wait for a specialist from another department. The support available for adults with mental health needs had recently improved, although delays for children remained, particularly out of hours.

Service planning and delivery to meet the needs of local people

- There was a hospital rapid discharge team (HRDT), which comprised of a nurse, physiotherapist, occupational therapist and a social worker. This team were called if a vulnerable elderly person was admitted to the unit, in order that rapid discharge back into the community or into a care home could be accessed swiftly. This meant that frail elderly patients, who were not able to manage by themselves, were not admitted to the hospital unnecessarily.

Access and flow

- The ED had specific national and local targets, which were reported and updated on the dashboard monthly. For example, patients were to be admitted, transferred or discharged from hospital within four hours. There were targets for safe patient handovers between the ambulance service and the hospital, as well as minimising the number of patients who left the emergency department without being seen.
- We spoke to nursing and medical staff and found that although they were aware of the targets, they were not kept informed of ongoing achievements against the target or what impact this would have if targets were not met.
- The department had met the target for seven months out of twelve of the past year, with dips in performance during the winter months at the end of the 2013/14.
- In addition, we identified discrepancies in the recording of the time the patient had arrived in the department for some patients. We observed that some patients who

had arrived (either by ambulance or their own transport) had their arrival time recorded as later than the time of their first assessment. We found that, in some cases, observations were documented as being taken between five to fifteen minutes prior to the patient's arrival, as recorded. For two patients, the time lag in recording their arrival was much longer, approximately 30 minutes for one and approximately two hours for the other. This meant that performance against the four-hour target may be distorted if the time the patient arrived was not accurately recorded and reported on.

- We were told that patients were assessed by specialist departments during their time in the ED. For example, patients would be seen by an orthopaedic or paediatric specialist. However, there were frequently delays in patients being assessed by the relevant specialty, which impacted on the length of time a patient remained in the ED. We were told that there was no communication between departments to understand why the delays occurred or how improvements could be made.
- We reviewed the reason patients remained in the ED for more than four hours and found that in March 2014 12% of these were attributed to a delay in obtaining a specialist opinion. In April this was 16%.
- We were told by staff that the department was frequently busy and that workloads were very demanding. Staff told us that it was their perception that the team worked well together and this helped. However, we were told that there were hold ups in the system, this could be caused by a number of factors, for example, timeliness in obtaining blood results, which could take between one and three hours. Staff had to check and recheck on the system to see when these results had arrived, as well as: checking agency nurses' work and there were also delays in other specialties coming to assess patients as well.
- We reviewed the breach data available for March and April and saw that the main cause fluctuated. In April 2014, 38% of patients who breached were delayed because they were waiting for an assessment, or for treatment. In March, the combined total was 58%. Patients in the ED who waited for more than four hours, as a result of waiting for a bed on a ward was 32% in April and 18% in March. This demonstrated that, although there was a high demand for beds, which impacted on patient flow, there were also issues with assessing and treating patients within the department.
- There was an emergency admissions unit (EAU) within the medicines directorate. The EAU could be used to admit patients for up to 24 hours. EAU accepted transfers from the ED for short stay patients as well as accepting GP referrals directly – this helped to relieve pressure while patients waited for a bed on a ward in the main hospital. However, we were told by staff that the EAU often closed once it was full, which caused extra pressure on the ED to keep patients while they were awaiting a bed. This meant that GP patients referred directly to the EAU were diverted to the ED, which further increased the pressure. This also impacted on paramedics waiting to transfer patients into the department.
- We were told that when the ED and EAU became busy, that a contingency ward would be opened. There were two wards available to open and the purpose of opening the wards was to maintain flow through the department. Usage was discussed at the daily bed management meetings and the policy was to ensure that the contingency wards were closed at the earliest opportunity. However, we were told by staff that one of the contingency wards had been open for the entire year to date.
- There was a system in place whereby a member of the administration staff would check each area in the department, every hour, to assess numbers of patients and their waiting times. This information was relayed immediately by email to the senior staff in the hospital, in order that there was an awareness of activity in the hospital and that the escalation plans could be implemented.

Meeting people's individual needs

- Support was available for patients with dementia and learning disabilities. 40% of staff had had training in dementia awareness and 25% of staff had been trained in learning disability and autism at levels one and two.
- The trust had a learning disability specialist nurse, who could be called during the week if needed. However, staff told us that the nurse mostly saw people with a learning disability on the EAU or after they had been admitted. It was rare that a referral was made while they were in the department.

Accident and emergency

- There was a private waiting area in the children's department for young people who had mental health problems. They could be observed via a one way window. This was to ensure they were safe while in the department.
- A translation telephone service (LanguageLine Solutions) was available at the reception desk, so that patients for whom English was not a first language were able to communicate with the receptionist at initial triage. Within the department, it was possible to request a translator within working hours, though staff admitted that they would rarely do this.
- There were information leaflets for people in English. However, there were none available in other languages. We were told that most of the people who attended the hospital were able to speak English and that there had not been a need or demand for information in other languages.
- We observed that there was a quiet room within the department, which was private and could be used by relatives who needed some time to themselves or for staff to discuss bad news to a patient's relatives.
- There were processes in place for patients to be assessed by the mental health team. Patients attending the ED, who may have mental health needs, were assessed using a standard form. Once the patient was medically fit, the psychiatric liaison team for adults was informed. For children and young people, the child and adolescent mental health team (CAMHS) were informed. The mental health teams both worked for another local trust. The psychiatric liaison team had a base on the Colchester General Hospital site and were present from 12pm until midnight and provided on-call cover outside of these hours. The mental health team had recently moved their base to be on the hospital site and we were told by ED staff that this had led to a much improved service from the team. We reviewed patient notes and found that the team had been contacted by the emergency team in line with standards.
- Children's mental health services were limited and most staff told us that it was difficult to get children assessed even during working hours. After 5pm, children attending the department were admitted onto the paediatric ward until CAMHS were able to undertake an assessment, the next working day. We were told that children over the age of 13 were assessed by the adult team, if they felt competent to do so.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint then they would speak to the shift coordinator. If they were not able to deal with their concern satisfactorily, they would be directed to the Patient Advice and Liaison Service. If they still had concerns following this, they would be advised to make a formal complaint.
- We reviewed the February 2014 complaints report for the ED. The purpose of the report was listed as providing an update on complaints and Patient Advice and Liaison Service activity, with a recommendation to review the enclosed report. Data presented was inconsistent in that some information was reported by department, other data reported by directorate.
- The report contained information on the number of complaints outstanding for the department. The percentage of complaints responded to within agreed timescales by directorate, had almost halved from 61.7% in August 2013 to 33.3% in January 2014, with a sharp decline in November 2013 when the response rate was at 18%. The top complaint issues were attitude and communication from staff. Again, this was reported by directorate.
- The report also lacked important information, for example, it did not state the number of complaints received in month, action required based on trends or action taken. It was also unclear from the information presented, where the delays had occurred, whether this was at departmental-level or within the complaints department.
- The fact that the information was not reported consistently by department and much of the data was at divisional-level, and because the report lacked vital information, this meant that the ED did not have an accurate picture of their own performance with complaints and the causes of complaints. Therefore, there was no clear structure for improvement. We noted that the top five issues for January 2014 were consistent with the year-to-date top five issues.
- We were told that the service manager met with a member of the complaints team on a weekly basis to discuss new and ongoing complaints.

Are accident and emergency services well-led?

Accident and emergency

Requires improvement

Leadership and governance arrangements within the department were not sufficient to ensure that the patient experience and quality of care was assured although staff told us that they felt well supported by management locally. Although there was a structured governance system in place for formal monthly meetings these had not been held regularly for clinical governance or senior staff. Review of the meeting minutes demonstrated that although there were standing agenda items, clinical and quality indicator information at departmental-level was not always discussed. When it was, it did not always contain sufficient detail. We also noted that actions required were not always clear and these were not followed up at subsequent meetings.

Vision and strategy for this service

- We were told by senior staff within the ED that the vision for the trust was constantly changing, but that the current vision and strategy was available on the intranet. We asked staff if they knew what the trust's vision was. The staff we spoke with were not familiar with the trust vision. All staff we spoke with told us how their role was about providing the best care to patients.
- There were separate action plans from the Keogh Mortality Review and ECIST visits, as well as the urgent care Task and Finish Recover Group. However, managers within the ED, although aware of actions assigned to them individually, did not have an oversight of each of the action plans and there was no action plan at department-level which brought this together. Strategies and plans appeared to be fragmented and not cohesive to improve the flow and performance of the ED.
- The NHS Emergency Care Intensive Support Team (ECIST) review in 2011, reported recommendations as a result of the weaknesses identified within the ED. The NHS ECIST followed up the recommendations in early 2014 and reported evidence of good progress and practice, although further improvements were still required. The trust developed an action plan in response to the latest review. The plan itself did not state how each action was going to be achieved, only what needed to be done. For example, in response to the concern: 'staffing levels and skills in the ED need to reflect the increasing demand on our service', the recorded action was, 'ensure that nurse staffing levels and experience match capacity and demand in the ED'. It was unclear how this action would be met and precisely what needed to be done to increase the staffing and to meet demand. It was also noted that this was rated as green. Green indicates achievement and implementation of an action. However, during our inspection, we found that nursing staff arrangements were not currently meeting demand.
- We were told that there was no cross-working between departments to understand each other's limitations and how the functionality of the service could be improved.
- The medical division had developed an annual business plan for 2013/14. The plan listed new initiatives, which for the ED focused on staffing arrangements; there were two other initiatives, common clerking and live tracking of patients. Performance reported on 'at our best' training attendance, recruitment and staffing spend. Commissioner intentions and priorities were listed, and there was one scheme report on as 'in progress', which was the redevelopment of the ED and urgent care model. Based on the information provided, it was not clear what the objectives were for the department and there did not appear to be linkage to the trust's strategic objectives. There was no evidence of the previous year's objectives or anything to show whether they'd been achieved or not.
- We saw that representatives from the trust attended the urgent care Task and Finish Recovery Group, a healthcare community-wide project, chaired by the CCG. Actions agreed by the group were discussed, including actions for the ED. However, it was unclear how this was translated into a trust or ED plan.
- The ED were undergoing extensive building work, which involved increasing the number of 'spaces' within the department, including three additional resuscitation beds. We were told that although the beds were almost ready and would be fully equipped, there were no definitive plans to open them, due to lack of staffing. We were told that plans prior to the build did not include staffing arrangements. A business proposal had been submitted in December to increase the number of nursing staff within the department. The nursing establishment had been increased as a result, although

the increase was only to meet current needs. A subsequent plan was in the process of being drafted that included an increase in staffing for the additional resuscitation beds.

- Both nursing and medical staff (except more senior staff who attended governance or senior meetings) we spoke with told us that they were not aware of the department's achievement against key targets. This demonstrates that staff were not involved in the function of the department and may not have understood how their role and responsibilities could improve the overall performance of the department.

Governance, risk management and quality measurement

- The department held a monthly clinical governance meeting, jointly, with the stroke unit. The committee was used to discuss risks, finance, performance, patient safety, and patient experience, as well as audit findings. We noted that, although meetings were scheduled to be held monthly, one had not taken place since January 2014. We reviewed the minutes for May 2014 and saw that a range of issues had been discussed under set headings. We saw that there was good use of standing agenda items and parts of the meeting had been structured well. However, we noted that a complaints report was not presented at the May meeting, even though a meeting had not been held since January. Some information received by the committee was at trust-wide level rather than departmental-level. For example, the number of outstanding incidents. This meant that members would not have accurate information about their own department. The ED dashboard focused only on the four-hour target, it was reported this had been met for the month; other targets were not recorded as having been discussed. There were not always actions documented for areas of improvement and where actions were recorded they formed part of the main body of the minutes, which made it difficult to follow through to completion, there was no evidence of any actions being carried forward or followed up at subsequent meetings.
- Monthly senior meetings were arranged for senior staff within the department to meet and discuss any general ongoing or arising issues. We were told that, due to capacity issues, meetings had not taken place regularly; the most recent meeting had taken place at the end of March.
- We noted that the emergency care dashboard reported on a range of targets, including the four-hour wait, 15 minute ambulance handover target (80% of patients were expected to have their handover completed within 15 minutes of arrival). However, according to the most recent data provided, current achievement was around 30%. We noted that the emergency care dashboard did not report on the number of ambulance handovers which had exceeded 60 minutes. Data provided to us at departmental-level reported a total of 317 breaches for the 60-minute target.
- We were told that, at present, the trust was liaising with the ambulance service over handovers, because there were discrepancies in data produced by the trust and the ambulance service. There were no minuted meetings for us to review to confirm progress made with discussions. This meant that patients who arrived by ambulance may have experienced long delays and, because resolution had not been reached with the ambulance service, improvements were not being made.
- We noted from patient records that patients who had arrived by ambulance the observation time often preceded the time the patient was recorded as having arrived within the department.
- The ED maintained a risk register, which, at the time of inspection, recorded 16 risks. Two of these were categorised as 'high' or 'extreme'. All other risks were categorised as low or moderate. We were told that the high and extreme risks were transferred onto the trust-wide risk register and discussed at the department and directorate monthly governance meetings. However, review of the department's governance meeting minutes for May 2014 did not indicate that the risks had been reviewed or discussed at the meeting. It was reported that the message was to increase the number of risks on the register and to ensure it was maintained and up to date. We observed that the high-level risks had not been reviewed since the end of March 2014, other risks had either not been reviewed at all, or not since 2013.
- We were informed that low and moderate risks were monitored by the matron on a monthly basis, but that there was no formal process to do this. This meant that these risks were not considered by the wider governance structure and, therefore, may not have been adequately considered or managed.

Accident and emergency

- High and extreme risks related to the paediatric nursing staff deficit and the general nursing staff deficit within the ED. The risk register specified a description of the risk, the lead responsible and the date the risk was last reviewed. Under the risk description, a detailed summary of the risk was recorded as well as information under a heading of 'existing controls'. The register did not have separate headings to set out what actions were required to mitigate the risk, nor when actions should be completed by. We saw that the control measures recorded were not always controls and rather actions required. For example, a control measure for the lack of children's nurses in the ED was "to continue to fill the vacancy that currently exists within the funded establishment". The control measures did not state what measures were actually in place to minimise the risk, only actions required in order to minimise the risk. We also saw that some information was out of date, for example, in the existing control measure for paediatric nursing deficit, it stated that a one-day course for paediatric life support had been attended by five staff in November 2010, almost four years ago.
- In addition to the two high-level risks, which both related to nursing staffing, there were no other high-level risks, for example risks around capacity/ availability of beds within the hospital or internal/ external major incidents had not been considered. There was extensive building work being conducted within the department, but this had not been identified as a risk on the register.
- Lower-level risks reported on details of specific Serious Incidents, which had occurred rather than recording generic risks. Each of these risks provided a description of the event and action taken. It was not always clear what the risk was, or what the controls were, or how risks could be mitigated. For example, one of the low-level risks summarised how a patient discharged from the ED re-attended later that day having suffered a cardiac arrest. The control measure recorded that the patient was transferred to the critical care unit.
- This demonstrates that the department did not have an understanding of the best way to utilise a risk register, or how it should be used to ensure sufficient action is taken to manage the risk effectively and improve systems and processes to reduce or mitigate the risk long-term.
- Patient safety alerts were communicated throughout the department. For example, there was a recent alert from the National Patient Safety Agency (NPSA) from March 2014, regarding identification for patients after an electrocardiogram (ECG.) The two staff we spoke with were aware of this alert and its impact on the department.

Leadership of service

- There was a clinical director for medicine, who was supported by a clinical lead for the ED. The clinical lead was responsible for ensuring medical staffing requirements were met and that doctors had clearly defined responsibilities during their shift. However, roles beyond daily clinical duties had not been formalised. We were told that this was in hand and that the clinical lead was developing a shared action plan for medics, as well as formally assigning responsibility for clinical governance.
- Nursing staff were led by a matron who was supported by band 7 nurses, who led a team of more junior staff. There was a nurse in charge of the ED, whose role was supernumerary, the nurse was responsible for ensuring that staff had clear direction and were supported throughout their shift. The nurse in charge maintained an overview of capacity and staffing arrangements within the department and diverted resources to where they were most needed.
- All of the staff we spoke with told us that they felt very well supported by management within the department and that management supported them at an operational-level, when needed.

Culture within the service

- Staff told us that they felt supported by their colleagues and senior staff. One told us, "If I've had a bad day, I know I can call my manager for a chat." All nursing staff that we spoke with reported that the matron was very supportive and that her door was 'always open' if they needed anything.
- Staff within the department spoke positively about the service they provided for patients. Caring for patients was seen as a priority and everyone's responsibility. One member of staff told us, "If I can look after my patients how I want to, it's a really good day. Since the staffing has increased, it's really so much better." A porter told us, "I try my best to be where it's busy, so if I'm needed I can just lend a hand without them having to call me."
- Staff appeared to work well together. Staff of all levels reported they felt well supported and could ask a senior person if they were unsure about something.

- Most of the staff did not feel that the changes at trust board-level had affected their day-to-day role. However, senior management within the department reported more of an impact with constant changes being introduced.

Innovation, improvement and sustainability

- The department had a clinical skills sister, whose role it was to devise induction programmes for new staff and support them during their first weeks. The clinical skills sister also provided training for staff in the department, including advanced and intermediate life support. The induction programme for all new staff lasted for three weeks. During this time, the member of staff was supernumerary.
- Bank and agency staff were also required to complete a short induction to the department, which outlined key policies and procedures. This was signed when read. All temporary staff were required to read this folder before commencing work.
- We saw there were systems in place to learn from, and make improvements, following Serious Incidents, as well as complaints and most staff were able to tell us about specific examples.
- We were told that two major internal incidents had occurred due to capacity and staffing levels. We were told that these had been managed well, although one person reported that more could have been done to ensure staff were notified earlier that they may be needed to come into work. However, there was no learning analysis of either incident, which meant the department had not formally reflected on the events which took place and whether this could be improved on or not.
- We reviewed the investigation reports for two Serious Incidents, the framework for completing the investigations was clearly defined and the template report was clearly structured. Investigations had been completed well, detailing the terms of reference, providing a full chronology, identifying the issues and clearly reporting on the recommendations required as a result.
- Most of the staff we spoke with stated that they were encouraged to report incidents and that they received direct feedback from their matron or a senior nurse if they had been involved in, or reported an incident. Themes from incidents were highlighted as part of the staff team days (we were told that there were seven teams in the department and that a team day was held each week, so that each team had a communication day approximately every two months) and a folder was available in the staff room, which included learning from Serious Incidents. Staff told us about some examples of changes made to practice as a direct result of investigation of incidents. For example, all patients who required a diagnostic test were risk assessed to decide whether they needed an escort and whether this should be a qualified or unqualified member of staff. We saw an example of the team day communication topics for March through to June. We saw that incident trends were listed as a topic and that there were three serious investigations also listed for discussion.
- We saw that incidents were discussed at the departmental clinical governance committee meeting. However, the format was not easy to follow. For example, from the review of the May meeting, we noted that trends were not listed, the number of Serious Incidents that had occurred since the previous meeting had not been reported on. The number of outstanding incidents were reported at trust-wide level rather than departmental-level. Other ad hoc information about incidents was discussed, but it lacked the structure for good decision making and planning.
- We were provided with a summary of all incidents since November 2013. We noted that, through our review of the incident report, the column to record action taken was mostly quite clear about any immediate remedial action taken, but this was not always the case, particularly for incidents relating to staffing shortages, which often stated, 'matron informed'. We also noted that very few incidents had a recorded learning outcome. This meant that actions may not have always been taken and that staff may not have learned lessons to minimise the risk of such incidents happening again.
- The ED had recently started assessing performance against nursing quality indicators. Audits were conducted each month to review management of chest pain, sepsis, pain, NEWS, PEWS, stroke, fractured neck of femur, transfer and discharge, privacy and dignity, infection prevention, head injury, safety, as well as general documentation and communication. Performance was reported per month against an agreed target. We saw for April 2014, that the department had achieved targets in two of the thirteen areas audited: for NEWS and PEWS. The department scored particularly low in pain management (giving patients analgesia

within 20 minutes and reassessing patients' pain scores). Although the findings listed issues to be addressed, there was no clear action plan setting out how this would be addressed or who was responsible. We saw that performance was displayed in the staff team room, and we were also shown a presentation for the sister's meeting held in December 2014.

Medical care (including older people's care)

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

Information about the service

The hospital provides medical care on 11 wards. Four wards are dedicated to the care of the elderly patients. The service also provides a ward dedicated to acute stroke care. A specialty isolation ward within medicine provides care for patients identified as at high risk of infection or having a diagnosed infection. Other medical wards provide acute medical care for patients in respiratory care, short stay care and cardiac care.

During our inspection we visited ten of the 11 medical wards and spoke with staff, patients and relatives. We looked at patient medical records, observed care and reviewed documentation.

Summary of findings

Medical and nursing staff were observed to enter and leave wards without using hand sanitising gels. Staff were also observed removing gloves after tending to patients and move to other tasks without washing their hands. Overall we found the medicine areas to be clean and tidy. Equipment was generally clean and appropriate however medicine was missing from one resuscitation trolley when it was checked.

Concerns were raised about staffing levels and the skill mix on a number of medical wards. A nursing staff analysis review had been carried out on a number of medical wards and two wards were identified as being at risk. The trust was not meeting its targets for mandatory training within the medical directorate.

Nursing records were not consistently completed and areas for assessing risks to patients were not completed in a number of care records we viewed across all ward areas where we visited. Staff across the directorate reported that learning from incidents needed to be improved, as many said that there was only learning after Serious Incidents.

Although the trust has worked hard to identify areas of where care needs to be improved it continues to have an elevated Summary Hospital-level Mortality Indicator (SHMI). There was evidence of participation in national

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and local clinical audits however staff reported a lack of feedback and learning where improvements were identified. There were good arrangements for multidisciplinary working within the directorate.

Patients and the relatives we spoke with told us that staff were caring, kind and compassionate. They said that medical staff were approachable. We observed medical and nursing staff treating patients sensitively and discreetly. The majority of patients we spoke with said that they had been involved in making decisions about their care and treatments and that they had been given advice and information. Some people told us that they had not been involved in making decisions about their care and treatment. Some said that they were unaware of their plan of treatment or the arrangements for their discharge from hospital.

The medical directorate services were generally responsive to the needs of patients. Improvements were needed in managing the flow of patients between EAU and other ward areas to reduce the number of transfers overnight. The service requires improvement in leadership. Staff across the directorate reported a lack of engagement with senior management at executive-level. Nursing staff reported good support and engagement with the director of nursing, but said that there was a lack of visibility of other senior managers including the chief executive. Staff were aware of the vision and strategy for the trust, which had only been very recently introduced. Staff did not feel 'listened to' or involved in making decisions and there were issues around learning from incidents.

Are medical care services safe?

Requires improvement

Medical and nursing staff were observed to enter and leave wards without using hand sanitising gels. Staff were also observed removing gloves after tending to patients and move to other tasks without washing their hands. Overall we found the medicine areas to be clean and tidy. Equipment was generally clean and appropriate however medicine was missing from one resuscitation trolley when it was checked.

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Incidents

- There have been no recent Never Events (these are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented) in relation to medical directorate and the number of Serious Incidents reported, was in line with expected for the size of the trust.
- As expected, due to the predominant number of beds in the medical directorate, they accounted for the highest number of reported patient safety incidents for the hospital within the previous two years. These included a number of accidents and falls. Work was ongoing in falls reduction and it was reported that incidents of falls resulting in injury had been halved on Tiptree Ward over the past two years.
- Any Serious Incidents were investigated and a full root cause analysis carried out. The results of this were disseminated to staff by way of emails and through staff meetings and the relatives of the affected patients fed back to.

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- All staff we spoke to stated that they were encouraged to report incidents using the Datix system. However staff on Langham, Tiptree, Birch, Nayland and Peldon Wards told us that they did not receive direct feedback, information or learning from incidents. Some staff commented that they only received feedback if the incident was 'very serious'. The majority of staff we spoke with felt that improvements were needed in feeding back from incidents that occurred within the medical wards.

Safety thermometer

- Safety Thermometer information (safety crosses), were clearly displayed at the entrance to each ward. This included information about all new harms, falls with harm, new venous thromboembolism (VTE), catheter use with urinary tract infections (UTIs) and new pressure ulcers. The information was updated weekly. The trust was performing within the expected range for these measures, except for UTI's and new VTE's.
- Risk assessments for the above were being completed appropriately on admission and prophylactic treatments were provided to reduce the occurrence of VTE's.

Cleanliness, infection control and hygiene

- Ward areas appeared clean and we saw that equipment was regularly cleaned and had dated 'I am clean' stickers that indicated when equipment was last cleaned. Curtains in all areas with the exception of the emergency assessment unit (EAU) were labelled with the date at which they were last changed.
- Patients and their relatives who we spoke with said that the wards were regularly and thoroughly cleaned. People spoken with commented that the wards were "spotless" and "extremely clean".
- There was hand wash and hand sanitiser gels available throughout the wards and information available to remind staff and visitors of the importance of good hand hygiene, so as to minimise risk of infection.
- Monthly hand hygiene audits were carried out across all medical wards and the results of these audits carried out between December 2013 and February 2014 demonstrated an improvement in staff adherence to hand hygiene policies and procedures.
- However, during our visit we observed that staff did not routinely wash their hands and use hand sanitising gel between patients. On numerous occasions on the ward areas we visited, we witnessed medical and nursing staff who were providing personal care and support to patients, remove gloves and aprons and attend to other patients or undertake other tasks without washing their hands. We also observed staff of all grades and disciplines enter and leave wards without cleaning their hands with the sanitising gels, which were available at the entrance to all ward areas.
- 'Bare below the elbow' policies were adhered to by staff.
- Methicillin Resistent Staphylococcus Aureus and Clostridium difficile (C-Diff) rates for the trust were within expected limits.

Environment and equipment

- The environment on the medical wards was safe.
- Equipment was appropriately checked and cleaned regularly in most of the areas where we visited. One electrocardiogram (ECG) machine was labelled as 'broken' on Layer Marney Ward.
- Resuscitation trolleys and equipment were checked and records were kept. Naloxone (which is used to treat an overdose of opiod drugs)
- All sharps bins were dated, signed and partially closed as per trust policy.
- We examined the patient hoisting equipment in the area and found that it had been recently inspected. We viewed the certificates of inspection for the hoists across the service except for EAU and Dedham ward which was not available to us as at the time of inspection. We found that some damage was identified. For example, 'charger faulty and charger lead missing,' 'Faulty wiring' and 'Chair safety catch not working correctly.'

Medicines

- Medicines were stored correctly, including in locked cupboards or fridges where necessary. Fridge temperatures were checked.
- Staff were aware of the procedures for reporting medication errors and near misses and told us that they were encouraged to do so. Staff said that there had been learning from a Serious Incident involving the administration of medicines in another directorate and learning from this incident had been fed back to staff.
- Medication administration records we checked across the medical wards were well maintained and indicated that medicines were administered, as prescribed, and the reason for non-administration was recorded.
- Procedures for maintaining registers for controlled drugs were carried out consistently, with the exception

of Peldon and Birch Wards, where records were not completed consistently. Entries which had been crossed out in error were not signed. A number of entries in relation to administration of controlled medicines were not countersigned by nursing staff who witnessed/ administered the medication.

- On Peldon and Birch Wards, we saw that records for patients who self-administered controlled medicines were not completed accurately when patients were admitted or discharged from the ward. There was no clear audit for checking controlled medicines received and returned to patients.

Records

- All records were in paper format. Nursing notes were generally kept at the end of patients' beds and medical notes were stored in trolleys on the ward areas. We observed the medical notes trolley in the corridors on Layer Marney and Tiptree Wards, where they were accessible to anyone visiting the wards.
- Healthcare professionals filled out specified areas of both nursing and medical records.
- There were standardised care pathway modules for patients for each area where they were admitted. These included a care module for the EAU, general and specialist medical care pathway modules. The consistency of record keeping varied within ward areas and across the medical wards we visited. Admission checklists and patient safety checks were not consistently completed and risks around falls, venous thromboembolisms and moving and handling were not consistently assessed. Assessments in relation to patients' capacity to make decisions were not routinely completed.
- Documentation audits were undertaken by the wards on a monthly basis and feedback from these were discussed at ward meetings with areas for improvements identified.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were consented appropriately and correctly where people were able to give their consent to care and treatment.
- We examined the training matrix provided by the trust which showed that approximately 84% of staff had completed the Mental Capacity Act 2005 training at level 1 and 60% at level 3. We also found that 57% of staff had completed training in the Deprivation of Liberty Safeguards at level 3.
- We saw examples of patients who did not have capacity to consent to their procedure and where The Mental Capacity Act 2005 was not adhered to appropriately. Patients' capacity to make decisions was assessed as part of the nursing assessment on admission to wards. Records of assessments were not consistently completed to indicate whether patients had the capacity across all of the medical wards we visited. Nursing staff we spoke with on Birch Ward were unable to tell us who, if any, patients lacked capacity to make decisions, or if any assessments had been carried out. The ward manager told us that they and one other member of staff had training in assessing people's mental capacity. They told us that no assessments had been recently carried out.
- There were no reported Deprivation of Liberty Safeguards applied to patients on the wards we visited.

Mandatory training

- We looked at staff mandatory training records. These were divided into two sets of competencies. The fitness to practice competencies including basic life support training, information governance and safeguarding training. Essential skills competencies included the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, infection control, manual handling and Control of Substances Hazardous to Health (COSHH) training. The trust had a target of each directorate achieving 80% compliance. Records confirmed that 70% of staff were up to date with their fitness to practice competencies and 58% had completed the essential skills competencies. Senior nursing staff reported that it was a challenge to get all new staff through their competencies.
- All grades of nursing staff reported some difficulties in accessing training due to work pressures. Some staff reported that training and learning days were often cancelled in recent months. One consultant told us that the impact of the cancer services review had meant that a lot of resources had been diverted away from day-to-day business as usual activities and that this had affected some training and learning delivery.

Medical care (including older people's care)

- The results from the General Medical Council (GMC) National Training Survey (March to May 2013) showed that the trust scored similar to most in terms of clinical and educational supervision of trainee doctors.

Assessing and responding to patient risk

- There was a policy document based upon relevant guidance such as National Institute for Health and Care Excellence (NICE) and National Confidential Enquiry into Patient Outcome and Death (NCEPOD). This set out the roles and responsibilities for all grades of staff in relation to managing the deteriorating patient and escalation procedures.
- The medical wards used a recognised early warning tool. There were clear directions for escalation printed on the reverse of the observation charts and staff spoken to were aware of the appropriate action to be taken if patients scored higher than expected.
- We looked at completed charts and saw that staff had escalated patients' conditions correctly, and repeat observations were taken within the necessary time frames.
- There was a critical care outreach team who were present on site 24 hours a day, seven days a week. These could be contacted by any member of staff and their contact details were clearly displayed on all wards as well as on the observation recording document.
- The systems for managing the care of the deteriorating patient were monitored monthly and staff told us that where areas for improvement were identified, these were shared among staff, so as to ensure learning and improvement in patient care.
- Staff on one ward (West Bergholt) told us that, occasionally, when they escalated concerns around the deteriorating patient to the medical team, the response was not in line with the trust's procedures and that, occasionally, the medical team did not attend to the patient promptly.
- Between December 2012 and January 2014 suboptimal care of the deteriorating patient accounted for the most incidents reported by the medicine service. There were systems in place for monitoring and reviewing the care of deteriorating patients. Incident reporting was subjected to a root cause analysis investigation and staff told us that learning from such incidents was disseminated through ward-level meetings.

Nursing staffing

- Nursing numbers were assessed using a recognised staffing tool. An analysis of funded full-time equivalent against nursing staff in post identified those wards deemed to be 'at risk'. A number of medical wards were assessed as being at risk. Staff uplifts in the numbers of nurses had been agreed for these wards. Staffing cover was provided through the use of temporary agency staff, while new permanent staff were recruited into posts.
- Senior nursing staff reported that Birch and D'Arcy Wards were among those that had been assessed as being at risk, in terms of staff numbers and skills mix. Staff from these wards were often moved to provide cover on other wards including the West Bergholt Ward.
- Ideal and actual staffing numbers were displayed on every ward we visited. During our inspection, boards indicated that the ideal numbers of staff were maintained on those days.
- Ward staff reported that they were sometimes understaffed and that vacancies were filled with agency staff wherever this was possible.
- Senior nurses on the EAU reported that there were difficulties in recruiting to the seven vacancies within the unit. They told us that the unit had not been part of the recent staffing review and that the current funded established nursing numbers did not meet the increasing needs and numbers of patients admitted to the unit from the ED and GP referrals.
- We spoke with 24 senior nursing staff, nurse specialists and matrons across all directorates. Staff within the medical directorate said that, while staffing levels had been reviewed on many ward areas and the numbers of nurse had been increased, concerns still remained about the skills mix. They reported that there were concerns that the newly appointed nurses required time for training and 'upskilling' and that put pressure on the wards and delivery of care to patients.
- Many nurses we spoke with reported that both they and agency staff worked long hours. Some senior nurses told us that they regularly worked extra hours for which they were not paid. They told us that they were not required to do so, but that they felt that they needed to so as to ensure the safety of care on their wards.
- Staff on the contingency ward (West Bergholt Ward) raised concerns that this was predominantly staffed with agency staff. This ward was used an 'overflow ward' for the EAU. Staff rotas showed that there was always at least one member of permanent staff on duty on the

ward. The unit had been open since October 2013 and the majority of agency staff who worked there did so on a regular basis. All agency underwent appropriate local induction on arrival for their shift.

Medical staffing

- There was consultant presence on the EAU 14 hours a day, seven days a week. On other medical wards consultants undertook wards rounds daily, with the exception of Langham Ward, on which ward rounds occurred twice weekly.
- Patients were seen within six to eight hours during the day, as the EAU consultants undertook rolling ward rounds. 85% of patients admitted overnight were seen within 12 to 14 hours.
- Once patients were transferred from the EAU to a speciality ward, they were seen by a consultant within 24 hours, seven days a week.
- The junior doctors told us that they had appropriate support from middle grade, registrar and consultants.
- Vacancies at senior house officer (SHO) and registrar-level were filed with long-term locum staff.
- Consultants and senior nursing staff commented that there were gaps in consultant-level activity due to 'infill' to cover where consultants had been reassigned to do work around improving cancer patient services.
- Junior doctors told us there were adequate numbers of junior doctors on the wards out of hours and that consultants were contactable by phone if they needed any support.

Are medical care services effective?

Requires improvement

Although the trust has worked hard to identify areas of where care needs to be improved it continues to have an elevated Summary Hospital-level Mortality Indicator (SHMI). There was evidence of participation in national and local clinical audits however staff reported a lack of feedback and learning where improvements were identified. There were good arrangements for multidisciplinary working within the directorate.

Evidence-based care and treatment

- The medical department used a combination of NICE, and Royal College guidelines to determine the treatment they provided. Local policies were written in line with this and were updated every two years, or if national guidance changed.
- The unit used a daily ward round pro forma, which was completed during the morning ward round. Clear objective outcomes were identified and documented clearly.
- There were specific care pathways for certain conditions, in order to standardise the care given. Examples included stroke, sepsis and acute coronary syndrome.
- At the monthly departmental meetings, any changes to guidance and the impact that it would have on their practice was discussed. Trainees were encouraged to undertake a clinical audit to assess how well guidelines were adhered to. The trust provided us with a list of all ongoing and completed audits during their past year.
- The majority of national and local audits were ongoing. Where completed audits identified areas for improvement in clinical effectiveness and outcomes for patients there were action plans in place to address issues raised and to improve the service.

Patient outcomes

- There were no outliers for mortality associated with medical conditions. Emergency readmissions were within expected parameters (tier one indicator) and the standardised readmission rates, comparing favourably with national rates.
- A summary of the clinical audits undertaken, including: Myocardial Ischaemia National Audit Project (MINAP), Sentinel Stroke National Audit Programme (SSNAP), the National Heart Failure Audit, National Diabetes Inpatient Audit (NaDIA),
- The department achieved level 'B' for their stroke services. Although the highest award is 'A', no trust has yet achieved this.
- The medical directorate participated in all the audits they were eligible for and the clinical audit was a clear priority for the directorate.
- The hospital continues to have an elevated SHMI. We examined the action plans submitted by the trust in response to their increased mortality levels. These were still being worked through and not all identified actions from the reviews undertaken had been implemented.

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Multidisciplinary working

- Patients underwent an assessment of their rehabilitation needs, where needed, within 72 hours of admission to the wards and the subsequent plan for their rehabilitation needs was clearly documented in the notes.
- There was a dedicated team of physiotherapists and occupational therapists in the medical directorate.

Seven-day services

- There was a daily ward round on the EAU, including on weekends. Medical patients on other wards would not be seen routinely and would be seen by on-call physicians if they became unwell or there were concerns about deterioration.
- An on-call physiotherapist was available out of hours and at weekends.
- Routine radiology was available at weekends with radiologists on site from 9am to 5pm. Computerised tomography (CT) scans were available alongside a limited ultrasound service, but there was no access to magnetic resonance imaging.
- Pharmacists were in the hospital from 8am until 1pm on both Saturday and Sunday. Out of those hours there was an on-call pharmacist available on the phone.

Are medical care services caring?

Good

Patients and the relatives we spoke with told us that staff were caring, kind and compassionate. They said that medical staff were approachable. We observed medical and nursing staff treating patients sensitively and discreetly. The majority of patients we spoke with said that they had been involved in making decisions about their care and treatments and that they had been given advice and information. Some people told us that they had not been involved in making decisions about their care and treatment. Some said that they were unaware of their plan of treatment or the arrangements for their discharge from hospital.

Compassionate care

- In the February 2014 inpatients NHS Friends and Family Test results, nine ward areas scored below the trust average of 71.1% of people who would recommend the hospital. Of the nine wards that scored below the trust average, six of these were medical wards. Medical wards displayed individual results and the hospital results for patients' and relatives' information.
- In the Cancer Patient Experience Survey 2012/13, the trust scored better than other trusts nationally for eight of the 69 questions asked relating to information about services available, side effects of treatment and confidence in nurses. The trust was rated in the bottom 20% of all trusts nationally for three questions. These related to information they received and their involvement in decision making about their care and treatment.
- The trust participates in patient-led assessments of the care environment (PLACE). Colchester General Hospital scored 88.8% for privacy, dignity and wellbeing.
- Throughout our inspection, we witnessed patients being treated with compassion, dignity and respect. We saw that call bells were answered promptly. Patients and their relatives who we spoke with told us that staff were caring, kind and compassionate. People commented that nursing and care staff were 'extremely kind and friendly' and that medical staff were 'helpful and approachable.'
- We saw that comfort rounds (intentional rounding) were undertaken and call bells were answered promptly. Patients we spoke with told us that they did not have to wait long for assistance when they needed this. People said that staff were 'always available' to assist.
- We watched a number of ward rounds and consultations between doctors and patients. We saw that doctors introduced themselves appropriately and that curtains were drawn to maintain patient dignity. Discussions between doctors, nurses and patients were carried out discreetly and sensitively, so as to maintain privacy.
- Each ward area displayed the visiting times. Staff on all ward areas we visited told us that visiting times were flexible and took into account people's needs. Patients and relatives we spoke with told us that they had been able to visit at any reasonable time. Relatives told us that staff had been very accommodating and flexible on occasions where their loved ones were unwell.

Patient understanding and involvement

- The majority of patients and relatives we spoke to stated they felt involved in their care. They had been given the opportunity to speak with the consultant

looking after them (and the named consultant was written above their bed). Most patients could tell us who their doctor was and they knew that they had a nurse allocated to their care.
- Some patients told us that they had not been involved in discussions about their care. Some patients on Tiptree, Birch and Peldon Wards, said that they were unaware of their planned care and treatment, or the arrangements for their discharge home. Some people made comments such as, "I don't really know what is going on," or, "I am not sure what is happening."
- The sisters and senior nurses on the wards told us that they had an 'open door' policy, where relatives could come and speak with them.

Emotional support

- Patients and their relatives we spoke with told us that they received emotional support from nursing and medical staff.
- Clinical nurse specialists were available to offer advice and support to patients and relatives about diagnosis and treatments.
- Patients' emotional wellbeing, including anxiety and depression were assessed on admission to each ward area and appropriate referrals for specialist support were made, where required.

Are medical care services responsive?

Requires improvement

The medical directorate services were not sufficiently responsive to the needs of all patients. Improvements were needed in managing the flow of patients between EAU and other ward areas to reduce the number of transfers overnight.

Service planning and delivery to meet the needs of local people

- Bed occupancy, at 84.1%, was below the national 85% target.
- Ambulatory patients referred by their GP were admitted via EAU. These were coordinated by the care coordinator, who was based in the EAU.

Access and flow

- The trust had a clear policy to reduce the number of bed moves experienced by each patient. It was trust policy that bed moves were to be avoided after 9pm. However staff reported that elderly people were often transferred from EAU between the hours of 10pm and 5am.
- Daily board rounds were undertaken at 9am, seven days a week on the EAU and five days a week on all other medical wards. Physiotherapists, occupational therapists (OTs), nursing staff and discharge coordinators attended. Board rounds identified patients who were fit for discharge so that the discharges could be arranged in a timely way. Staff reported variances in the success of these measures. Estimated discharge dates were identified as soon as possible after a patient was admitted and these were displayed on whiteboards, discussed at daily board rounds and amended, as necessary.
- The trust's site operations department business contingency plan was available to advise and instruct staff on the arrangements for dealing with emergencies or pressures of demand for inpatient beds. This included arrangements for opening a contingency ward on Easthorpe Ward, or West Bergholt Ward and the responsibilities for managing and staff cover.
- Weekly multidisciplinary team meetings were held which social workers, OTs and physiotherapists would attend. All staff we spoke with reported that there were effective arrangements and multidisciplinary working around discharge planning.
- There was a discharge lounge and staff reported no concerns as to how the flow of patients for discharge to the lounge was managed.

Meeting people's individual needs

- Support was available for patients with dementia and learning disabilities. Two specialist dementia nurse were employed across the hospital. They were responsible for assessing and referring patients for appropriate treatment within 72 hours of admission. An audit of the assessment and referral tool showed that there was a 99.6% rate of assessment to referral rate. However only 49% of staff in the medical directorate had received updated training in dementia awareness.
- A learning disability hospital liaison nurse specialist was employed to provide support and advice to patients,

relatives and staff. There were also specialist facilities in a disability suite located on Layer Marney Ward. Only 37% of staff had received training in learning disabilities and autism training levels 1, 2 and 3.

- Interpretation services were available and staff were aware of how to access these. Details were posted throughout the medical wards.
- There was 24-hour specialist stroke nurse cover on the stroke unit.
- There were multiple information leaflets available for many different minor complaints, diseases and medical conditions. These were not always available in all of the main languages spoken in the community, or formats for people who were visually impaired. There was a relative's room on every ward where more sensitive conversations could be undertaken.
- Staff on a number of medical and care of the elderly wards reported concerns that elderly people were transferred from the EAU between the hours of 10pm and 5am. We were shown evidence of this practice on Birch Ward, where five elderly patients had been transferred from EAU overnight on one occasion and twelve patients had been transferred overnight within the previous week. Staff commented that they felt elderly patients were transferred at these times because "they did not have a voice". The care coordinator confirmed that transfers from EAU to other wards occurred overnight, due to beds becoming available later in the day and the lack of available portering staff to assist in transfers. They told us that this was an area for concern and that it was reported at weekly meetings. However, they were unaware of what actions were in place to minimise these overnight transfers.

Learning from complaints and concerns

- The hospital had received a notable increase in complaints in the light of the review into services provided to cancer patients. This had impacted upon the investigation and response time for complaints received and meant that some complaints were not consistently handled in line with the trust policy. Some ward managers reported having to investigate and respond to complaints dating as far back as December 2013. One patient on Layer Marney Ward told us that they had raised a formal complaint five weeks previously and had not received any acknowledgement or response.
- The majority of patients and relatives we spoke with during our visit told us that they did not have any complaints about their care and treatment. Many of the people we spoke with told us that they had been provided with written information as to how they could raise concerns or make complaints.
- The complaints process was outlined in information leaflets, which were available on the ward areas. Some patients told us that they had been provided with copies of the leaflets. However, this was not consistent practice on all ward areas.
- Complaints and complaint handling was analysed on a six-monthly basis. The analysis covered numbers and themes of complaints and response times. Senior nursing staff told us that complaints about their areas were discussed at weekly and monthly meetings. They told us that providing feedback was often a challenge, as it was not possible for all staff to attend meetings so that feedback was sometimes 'ad hoc'. Nursing staff told us that they were not always made aware of complaints and did not receive feedback about complaints or learning from these.

Communication with GPs and other departments within the trust

- A discharge summary was sent to the GP on discharge from the unit. This detailed the reason for admission and any investigation results and treatment undertaken. GPs were provided with information where patients had undergone dementia screening. There were some issues with achieving the set target of 98% discharges sent to the right GP within 24 hours of a patient's discharge. There was an action plan in place to ensure that these targets were achieved and that there was an efficient provision of GP discharge summaries.

Are medical care services well-led?

Requires improvement

The service requires improvement in leadership. Staff across the directorate reported a lack of engagement with senior management at executive-level. Nursing staff reported good support and engagement with the director of nursing, but said that there was a lack of visibility of other senior managers including the chief executive. Staff

were aware of the vision and strategy for the trust, which had only been very recently introduced. Staff did not feel 'listened to' or involved in making decisions and there were issues around learning from incidents.

Vision and strategy for this service

- The trust vision was visible throughout the wards and corridors and, in addition, this had been sent out to all staff in March 2014. However it had only been very recently introduced to the trust and was yet to be embedded.
- Staff were able to discuss the vision with us, at focus groups and during individual conversations. Staff repeatedly expressed concerns about the changes to the executive board and questioned the loyalty and commitment of the people in interim posts to the trust, concerning the vision and strategy.
- Senior nursing staff we spoke with said that they did not feel involved in the decision-making processes within the trust.

Governance, risk management and quality measurement

- Consultants we spoke with commented that improvements and moving forward with safety and quality had been slower than anticipated, due to the focus on the concerns around cancer patient services.
- Quarterly governance meetings were held within the directorate and all staff were encouraged to attend, including junior members of staff.
- Complaints, incidents, audits and quality improvement projects were discussed.
- There were regular ward governance meetings chaired by 'two at the top'. These covered areas for concern, complaints, nursing indicators and plans for improvements in the safe delivery of patient care.

Leadership of service

- All clinicians in senior leadership posts attended a clinical leadership and management course. Senior nursing and medical staff told us that there were good opportunities for leadership and development training.
- All grades of staff reported that the high level of changes within a short period of time made it difficult to get to know everyone involved and to manage all the new changes.
- Staff across all disciplines reported that there was a lack of visibility of senior management. Some staff said that 'walk arounds' by the chief executive had been cancelled, and where the visits had taken place, they were for the purposes of management, rather than to check on how things were for staff.

Culture within the service

- Staff within the directorate spoke positively about the service they provided for patients, under very difficult circumstances in light of recent reviews into the service.
- Staff told us that they were encouraged to speak up if they saw something they were unhappy with regarding patient care. Medical consultants we spoke with told us that there was an open and inclusive culture within the trust and directorate. Both medical and nursing staff we spoke with commented that learning from incidents was an area that they felt required improvement. Openness and honesty was the expectation for the department and was encouraged at all levels.
- Staff worked well together and there was obvious respect not only between the specialities, but across disciplines. Staff spoke of being 'proud' to work at the hospital and said that all staff were 'committed' and supportive of each other.
- Staff repeatedly spoke of a concerns and disillusionment with regards to the newly appointed executive board. Staff commented that they had not met or seen the chief executive and an unfavourable comparison was made to the outgoing chief executive, who staff reported was very 'visible' and who regularly visited ward areas.
- Medical and nursing staff said that they felt supported by their immediate line managers. Staff repeatedly spoke of a sense of 'disengagement' from the executive-level managements and said that they did not always feel "listened to".

Surgery

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

Information about the service

This hospital provided a range of surgical services, including general surgery, trauma and orthopaedics, gynaecology, and day surgery. There were six wards, which provided surgical services at Colchester General Hospital. There was also a day surgery unit. There were nine theatre suites, including designated emergency and trauma theatres.

We visited all of the six wards, as well as day surgery. We also visited the main theatre suites and the day surgery unit.

We talked with 54 patients and 32 members of staff, including matrons, ward managers, nursing staff (qualified and unqualified), medical staff of both senior and junior grades, and managers. We held focus groups with different grades and ranges of staff as well as listening events with members of the public.

We observed care and treatment and looked at care records for 42 people. We received comments from people who contacted us to tell us about their experiences.

Summary of findings

Safety of the service required improvement. We found that consent was not always taken in line recommended guidance and that mental capacity assessments were not always completed. We found that only 41% of staff had undergone basic life support. The environment on the surgical wards and theatres was clean and there was evidence of learning from incidents in most areas. There was adequate equipment to ensure safe care although we found some equipment that had not been checked in line with trust policy.

Surgical services at this hospital used evidence-based care and treatment and had a clinical audit programme in place. There was evidence of multidisciplinary working and access to seven-day services. Effective pain relief and nutritional arrangements were in place. Patients received care and treatment from competent staff, although appraisal rates for staff were variable.

The surgical services provided at this hospital were caring. All patients and relatives we spoke with supported our observations and the results of patient surveys and the NHS Friends and Family Test, which was above the national average.

Services were responsive. Discharge planning was commenced prior to admission for elective patients and on admission for those admitted as an emergency. Ward areas had designated dementia champions and patients, with all religious beliefs were respected.

Surgery

Staff reported good leadership at all levels within the directorate and improvements in staffing levels. Governance, risk and quality systems were in place. Staff spoke enthusiastically regarding the department and were positive around the quality of care they were providing.

Are surgery services safe?

Requires improvement

The environment on the surgical wards and theatres was clean and there was evidence of learning from incidents in most areas. There was adequate equipment to ensure safe care, although we found some equipment that had not been checked in line with trust policy. Although the majority of staff mandatory training was up to date, 59% of staff had not received recent basic life support training. 44% of the patient records we looked at did not have the appropriate mental capacity assessments.

Incidents

- There had been a surgical error Never Event within the trust in April 2013. We saw that this had been fully investigated by the trust, identifying the root causes of the error and a comprehensive action plan developed as a result.
- Surgical specialities accounted for the most severe harm incidents within the trust (seven). Two of incidents which resulted in the death of the patient were related to vascular surgery. An audit had been undertaken by the surgery service into their crude mortality and it was noted that the mortality related to non-elective care.
- Eighteen Serious Incidents were reported in operating theatres and five in day case surgery between December 2012 and January 2014 through the Strategic Executive Information System (STEIS).
- Staff said they were encouraged to report incidents and were aware how to complete this. Feedback was given to ward managers who confirmed themes from incidents were discussed at staff meetings and displayed in staff rooms (March and April 2014).
- The surgical matron attended a monthly matron forum, which had attendance from across the trust and promoted shared learning.

Safety thermometer

- Safety Thermometer information was clearly displayed and included information about all new falls with harm, and new pressure ulcers. The trust was performing within the expected range for these measures.
- We confirmed risk assessments for the above were being appropriately completed on admission, through reviewing patient records.

- The directorate had a performance and quality dashboard that it used to monitor the quality of care provided. This showed reductions in incidences of C. difficile, MRSA, falls and pressure ulcers.
- We viewed the surgical dashboard which detailed the service's performance around VTE risk assessments. We found that the service had achieved the 95% target for completing VTE risk assessments in six out of 12 months.

Cleanliness, infection control and hygiene

- We observed staff regularly wash their hands and use hand sanitising gel between patients. 'Bare below the elbow' policies were adhered to.
- Infection control information was visible in all ward and patient areas, with each ward having an infection prevention and control information board.
- Infection control audits were completed every month and monitored compliance with key trust policies such as hand hygiene. Most areas within surgery demonstrated full compliance and National Patient Safety Audit (NPSA) results were discussed at monthly governance meetings (March and April 2014).
- We saw schedules for cleaning theatres through the night and that refurbishment had recently taken place.
- We saw one surgeon contravening the uniform policy in theatre by not wearing a hat and causing a potential risk of breaching infection control.

Environment and equipment

- Equipment was appropriately checked and cleaned regularly. There was adequate equipment in the clinics and on the wards to ensure safe care.
- We saw some out-of-date, single-use equipment stored in a theatre trolley and were told this was used for training purposes, although the trolley was not marked as such.
- Although equipment had undergone portable appliance testing (PAT), we saw examples of where this had recently expired. This was raised with the trust at the time of our inspection.

Medicines

- Medicines were stored correctly including in locked cupboards or fridges, where necessary, but there was no evidence that fridge temperatures had been checked, particularly in the day surgery unit. Staff were unable to tell us their responsibility for checking fridge temperatures.

Records

- All surgical wards and clinics completed appropriate risk assessments for falls, pressure ulcers and malnutrition. Risk assessments we reviewed were comprehensively completed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was not always obtained before the patient arrived in theatre.
- Although we saw procedures in place for patients who did not have capacity to consent to their procedure, when we checked 30 patient care records specifically for compliance with assessment for mental capacity within the admission assessment documentation, only 44% of these had a completed mental capacity assessment.
- We also found during our unannounced inspection that one patient did not have their mental capacity assessed prior to being consented to surgery. The patient was declared not to have capacity by the doctors and a 'consent form 4' was completed for patients who lack capacity. This meant that that patient was not involved in the decision to receive major surgery. The mental capacity assessment was undertaken several days after surgery where it was identified that they had full mental capacity. Therefore this patient had not been appropriately consented for surgery because staff did not adhere to the requirements of the Mental Capacity Act 2005.

Mandatory training

- We looked at staff training records and confirmed that staff were up to date with the majority of their mandatory training.
- However, some staff told us they had not completed basic life support training within the last twelve months. This was confirmed through the theatres governance minutes (April 2014) reporting 59% compliance.

Five steps to safer surgery

- We saw the use of the World Health Organization (WHO) checklist and the hospital standard operating procedure for theatres ('five steps to safer surgery' – the NHS Patient Safety First campaign adaptation of the World Health Organization (WHO) surgical safety checklist).
- We observed both medical and nursing handovers. Staffing for the shift was discussed, as well as any high risk patients or potential issues.

Surgery

- The service is required to use a World Health Organisation Safe Surgery Checklist prior to undertaking surgical procedures. We found that the service consistently met their 100% target for completing the WHO checklist since their never incident in April 2013.

Nursing staffing

- Nursing numbers were assessed using a recognised staffing tool. Ideal and actual staffing numbers were displayed on every ward and clinic. Staff reported that they were only rarely understaffed and that vacancies were filled with agency staff.

Surgical staffing

- Surgical consultants from all specialities were on call for a 24-hour period, during which they were free from other clinical duties.
- Junior doctors told us that there were adequate numbers of junior doctors on the wards out of hours and that consultants were contactable by phone if they needed support.
- Ward rounds were carried out at times decided by the individual specialities. Not all patients were seen routinely by consultants at weekends.

Are surgery services effective?

Good

Surgical services at this hospital used evidence-based care and treatment and had a clinical audit programme in place. There was evidence of multidisciplinary working and access to seven-day services.

Effective pain relief and nutritional arrangements were in place. Patients received care and treatment from competent staff, although appraisal rates for staff were variable.

Evidence-based care and treatment

- Emergency surgery was mostly managed in accordance with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations and the Royal College of Surgeons' standards for emergency surgery. The trust's quality and audit department completed audits to assess compliance with policies and procedure.
- We observed patients being prepared for surgery and saw this was in accordance with current British Association of Anaesthetists (BAA) guidelines.

Pain relief

- Patients were assessed preoperatively for their preferred pain relief using recognised assessment tools.
- We saw nurses administer pain relief, as required, in accordance with pain assessments and completed the pain tool within the documented care pathway. A dedicated pain team was in place and pain relief was managed between theatre and recovery areas

Nutrition and hydration

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

Patient outcomes

- The directorate participated in all national audits that it was eligible for and, overall, performance was satisfactory.
- The surgery service participated in the trust's Mortality Review Group (MRG) and the newly formed HSMR Task Group. This reviews the specific to mortality within surgery with a view to reduce the overall mortality for the service.
- This hospital participated in the National Hip Fracture Database.

Competent staff

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

Multidisciplinary working

- There was good access to radiology, microbiology and pathology services, as required.

Surgery

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

Are surgery services caring?

Good

The surgical services provided at this hospital were caring. All patients and relatives we spoke with supported our observations and the results of patient surveys and the NHS Friends and Family Test, which was above the national average.

Compassionate care

- Throughout our inspection at this hospital we observed patients being treated with compassion, dignity and respect. We saw that patients were spoken to and listened to promptly. Patients told us staff were "excellent, I have no complaints". Patients also said staff were "approachable and caring", that they "work[ed] together" and "[had] time for you".
- All patients spoken to commented positively on the dedication and professionalism of staff and the high quality of care and treatment received.
- We saw that doctors introduced themselves appropriately and curtains were drawn to maintain patient dignity.
- The trust's NHS Friends and Family Test rate was higher than the England average between November 2013 and February 2014. Three surgical wards in this hospital scored less than the trust average.

Patient understanding and involvement

- We observed patients being kept informed throughout their time within the anaesthetic room and theatres.
- Patients and relatives said they felt involved in their care and they had been given the opportunity to speak with the consultant looking after them.
- We saw that the ward and clinic managers were visible on the wards/clinics so that relatives and patients could speak with them.
- Ward information boards identified who was in charge of wards for any given shift and who to contact if there were any problems.

Emotional support

- Patients said that the felt able to talk to ward staff about any concerns they had either about their care, or in general. Patients did not raise any concerns during our inspection.

Are surgery services responsive?

Good

Services were responsive. Discharge planning was commenced prior to admission for elective patients and on admission for those admitted as an emergency. Ward areas had designated dementia champions and patients with all religious beliefs were respected.

Access and flow

- The Department of Health monitors the proportion of cancelled elective operations. The trust scored similar to expected on the number of patients not treated within 28 days of last-minute cancellation due to non-clinical reasons.
- However, cancellations did take place, due to surgical lists overrunning and this was sometimes at short notice. In response to this, a regular rota meeting was held on a Monday to try and resolve (and if it was not possible) resolve this.
- The discharge planning process commenced at the pre-assessment stage, and for emergencies, at the admission stage.
- Patients admitted as an emergency were frequently taking up beds on elective surgery wards. This was causing difficulties in admitting elective patients and also with discharge arrangements.
- Every ward and clinic had identified staff to undertake discharge planning and this was begun as soon as patients were admitted. Staff explained to us that the directorate worked closely with local authority services as part of discharge planning.
- A discharge summary was sent to the GP on discharge from the wards and clinics. This detailed the reason for admission and any investigation results and treatment undertaken.

Meeting people's individual needs

- Support was available for patients with dementia and learning disabilities.

Surgery

- Clinics and wards inspected had dementia and learning disability champions designated, who were responsible for ensuring that staff were appropriately aware of the needs of individuals.
- We checked 30 patient care records specifically for compliance with assessments for learning disabilities. 80% of records had a completed a learning disabilities assessment.
- A translation service was in place and advertised throughout the hospital.
- Policies were in place to ensure patients with different religious beliefs were treated with dignity and respect.

Learning from complaints and concerns

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

Are surgery services well-led?

Good

Staff reported good leadership at all levels within the directorate and improvements in staffing levels. Governance, risk and quality systems were in place. Staff spoke enthusiastically regarding the department and were positive around the quality of care they were providing.

Vision and strategy for this service

- The trust vision had only recently been developed, however, staff we spoke to were aware of it. In addition, it was visible on wards, staff rooms and corridors.

Governance, risk management and quality measurement

- Quarterly governance meetings were held within the directorate and all staff were encouraged to attend, including junior members of staff.
- Staff on the wards and in clinics were able to express the same concerns as those in more senior positions within the directorate.
- Complaints, incidents, audits and quality improvement projects were discussed at regular staff meetings and we saw 'quality' boards displayed throughout the hospital.
- Feedback from these meetings was given to ward managers and at weekly meetings.
- Managers could provide examples of where they had identified issues and had taken action to address these. Examples were given of learning from root cause analyses (C. difficile), risk reduction measures (MRSA) and learning from incidents. These were confirmed through the Quality Improvement Bulletin (April 2014).
- Wards and clinics used a quality dashboard and Safety Thermometer to measure their performance against key indicators. Where wards were consistently falling below the expected levels of performance, action was taken to improve performance.
- A surgical risk register was in place. This had controls and assurance in place to mitigate risk and we saw it was regularly reviewed – resuscitation training and staffing levels within the intensive therapy unit had recently been added (April 2014). We saw minutes (March 2014) of governance meetings informing staff of risks on the register.

Leadership of service

- There was a surgical divisional lead, and each of the specialities had a clinical lead.
- Nursing staff stated that they were well supported by their managers although we were told one-to-one meetings and appraisals were irregular.
- Junior medical staff stated that they were supported by their consultants and confirmed they received feedback from governance and action planning meetings.

Culture within the service

- Staff spoke positively about the service they provided for patients and emphasised that quality and patient experience was a priority and everyone's responsibility.

Surgery

- Staff worked well together and there was respect not only between the specialities, but across disciplines. Staff were well engaged with the rest of the hospital.
- We saw good team working on the wards and clinics between staff of different disciplines and grades.

Public and staff engagement

- The trust's NHS Friends and Family Test response rate was higher than the England average.
- The computerised 'Meridian' patient tracker was widely used on wards to capture patient feedback. We saw notice boards throughout the hospital, wards and clinics identifying issues raised by patients ('You said, we did') and the trust's response.
- There was information about the Patient Advice and Liaison Service throughout the hospital.

Innovation, improvement and sustainability

- Managers and staff told us that they were supported to try new ways of working to improve the effectiveness and efficiency of the wards and clinics.
- A quality team notice board in each theatre displayed patient experience data, safety, staff welfare and theatre utilisation.
- The Surgical Division Newsletter (April 2014) explained the governance structure within the division and highlighted themes from incidents, complaints and plaudits.

Critical care

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

Information about the service

The critical care service at Colchester Hospital University NHS Foundation Trust has 14 beds in the intensive care unit (ICU). However, they are only funded to have 12 beds operational at one time. They deliver care to adult patients with life-threatening illnesses and postoperative patients. All beds in the ICU can be used for high dependency care or critical care. A critical care outreach team assists in the management of critically-ill patients on wards across the hospital and is available 24 hours a day, seven days a week.

The critical care unit adhered to national guidelines and Intensive Care National Audit & Research Centre (ICNARC) data demonstrated that outcomes were within expectations. Multidisciplinary input to the unit was good.

We talked with three patients, this included one that had returned to the ward, four relatives and 27 staff. These staff included: nurses, doctors, consultants and senior managers. We observed care and treatment and looked at care records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

The critical care service provided at this hospital was safe, as patients were protected from avoidable harm and abuse. There were sufficient nursing and medical staff on the unit at all times, and the unit was clean and equipment checked regularly. Incidents were reported and learnt from appropriately.

Staff respected patients' privacy and dignity. For example, we saw staff pulling curtains around patients' beds while caring for their needs.

Family members referred to care in the intensive therapy unit (ITU) as "first class". They were regularly kept updated on the condition of their relatives. They told us that staff could not do enough for them. We observed how a member of staff came out to update the family members in the family room next to the ITU and requested that other people in the room not related to relative leave so that personal information was not shared with others. This showed that patient confidentiality was maintained.

The critical care service provided was responsive to patients' needs. The majority of patients were discharged from the unit in a timely way and complaints were handled appropriately.

The leadership of the unit was visible. Nursing staff wore different uniforms according to their role and patients were able to identify different grades of staff on the unit.

Critical care

Staff were aware of their roles and responsibilities and how to escalate concerns. The unit had a clearly identified leadership structure.

Are critical care services safe?

Good

The critical care service provided at this hospital was safe, as patients were protected from avoidable harm and abuse. There were sufficient nursing and medical staff on the unit at all times, and the unit was clean and equipment checked regularly. Incidents were reported and learnt from appropriately.

Incidents

- There have been no recent Never Events attributed to the unit. There were three Serious Incidents between December 2012 and May 2014. No incidents were reported to the National Reporting and Learning System (NRLS).
- The most recent Serious Incident led to a full root cause analysis. The results of this were displayed in the staff coffee room and the relatives of the affected patient had been fed back to.
- All staff we spoke to stated that they were encouraged to report incidents and received direct feedback from their matron. Themes from incidents were discussed at weekly meetings and staff were able to give us examples of where practice had changed as a result of incident reporting.

Safety thermometer

- Safety Thermometer information was clearly displayed in the main corridor to the unit. This included information about all new harms, falls with harm, new venous thromboembolism (VTE), catheter use with urinary tract infections (UTIs) and new pressure ulcers.
- The trust was performing within the expected range for these measures. Risk assessments for all patients were being completed appropriately on admission.

Cleanliness, infection control and hygiene

- The unit appeared clean, bright and uncluttered. We saw staff regularly wash their hands and use hand sanitising gel between patients.
- 'Bare below the elbow' policies were adhered to. The Safety Thermometer data informed us the unit-acquired MRSA rates were low compared to other areas in the hospital.

Critical care

Environment and equipment

- The environment on the unit was safe and fit for purpose. Equipment was appropriately checked and cleaned regularly.

Medicines

- Medicines were stored correctly, including in a locked room. Fridge temperatures were not recorded. The ward manager informed us that both fridges had audible alarms and we saw the protocol for the nurse in charge to report any issues to maintenance.

Records

- Standardised nursing documentation was kept at the end of the patients' beds. Observations were well recorded. The timing of such was dependent on the activity of care the patient may have been receiving.
- All records were in paper format and all healthcare professionals were documented in one folder.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were consented appropriately and correctly. We saw examples of patients who did not have capacity to consent to their procedure. The Mental Capacity Act 2005 was adhered to appropriately.

Mandatory training

- We looked at staff mandatory training records. The trust had a target of each directorate achieving 80% compliance. Records confirmed that 86% of staff were up to date with their mandatory training.

Assessing and responding to patient risk

- The critical care outreach team was present and on site 24 hours a day, seven days a week. The team member could be contacted by any member of staff and their contact details were clearly displayed on all wards as well as on the observation recording document. They would also see all discharges from the critical care unit within 24 hours of discharge.

Nursing staffing

- All level 3 patients were nursed one-to-one, and all level 2 patients one to two. Staff reported that they rarely used external agency staff, any staffing gaps were filled with regular bank staff.
- There was a supernumerary educational coordinator on the unit to assist with formal and one-to-one training. Just under 50% of the nursing staff had their post registration award in either high dependency or critical care nursing.

Medical staffing

- There was a consultant presence on the unit from 8am to 6pm, seven days a week. Outside of these hours the consultant was able to attend within 30 minutes. The consultant covering the unit had no other clinical responsibilities. The consultant to patient ratio did not exceed 1 to 12.
- Junior doctors told us there were adequate numbers of junior doctors on the unit both in and out of hours and that the consultants had a very low threshold for coming into the unit out of hours. All potential admission to the unit had to be discussed with the on-call consultant.
- Consultants undertook ward rounds twice daily.
- All potential admissions had to be discussed with a consultant and all new admissions were reviewed in person by them within 12 hours of admission.

Medical and nursing handovers

- We observed both medical and nursing handover, in and out of hours. Nursing handovers occurred twice a day. Staffing for the shift was discussed as well as any high risk patients or potential issues. Medical handover took place at 8am on the unit.
- The handover was structured, documented and attendance was recorded.

Are critical care services effective?

Good

The critical care unit adhered to national guidelines and ICNARC data demonstrated that outcomes were within expectations. Multidisciplinary input to the unit was good.

Evidence-based care and treatment

- The critical care unit used a combination of NICE, Intensive Care Society and Faculty of Intensive Care Medicine guidelines to determine the treatment they provided. Local policies were written in line with this and were updated every two years or if national guidance changed.

Critical care

- At the monthly departmental meetings, any changes to guidance and the impact that it would have on their practice was discussed. Trainees were encouraged to undertake a clinical audit to assess how well guidelines were adhered to. The unit provided us with a list of all completed audits during their past year and the dates that they were presented to the monthly departmental meeting.

Care plans and pathways

- The unit used a daily ward round pro forma which was completed during the morning ward round. Clear objective outcomes were identified and documented clearly.
- Nursing documentation was kept at the end of the bed and was completed appropriately. Care bundles were in place for specific situations, for example, if the patient was ventilated.

Patient outcomes

- The unit contributed to the ICNARC database. This demonstrated that the mortality ratio for the unit was within statistically acceptable limits and unplanned readmissions were within a statistically acceptable range.

Multidisciplinary working

- There was a daily ward round which had input from nursing, microbiology, pharmacy physiotherapy and a dietician. At the weekends, microbiological and pharmacy support was provided by telephone.
- Patients underwent an assessment of their rehabilitation needs within 24 hours of admission to the critical care unit and the subsequent plan for their rehabilitation needs was clearly documented in the notes. There was a dedicated team of non-specialists physiotherapists and occupational therapists (OTs) for the unit.
- The respiratory physiotherapist would attend the morning ward round and attend to any urgent patients. After midday, they covered the rest of the hospital and so were not based on the unit.
- There was a critical care pharmacist who was allocated to the unit. All patients with a tracheostomy were assessed by a speech and language therapist.

Seven-day services

- A consultant was present on the unit from 8am to 6pm at the weekend. They were supported by a senior registrar and a senior house officer-level doctor.
- There was no dietician or OT input available at the weekend.
- Routine radiology was available at weekends when the radiologist was on site from 9am to 5pm. computerised tomography (CT) scans were available alongside a limited ultrasound service, but there was no access to magnetic resonance imaging.
- Pharmacists were in the hospital from 8am until 1pm on both Saturday and Sunday. Out of those hours there was an on-call pharmacist available on the phone.

Are critical care services caring?

Good

Staff respected patients' privacy and dignity. For example, we saw staff pulling curtains around patients' beds while caring for their needs.

Family members referred to care in ITU as "first class". They were regularly kept updated on the condition of their relatives. They told us that staff could not do enough for them. We observed how a member of staff came out to update the family members in the family room next to ITU and requested that other people in the room not related to relative leave so that personal information was not shared with others. This showed that patient confidentiality was maintained.

Compassionate care

- Throughout our inspection, we witnessed patients being treated with compassion, dignity and respect. Relatives we spoke to told us, "The care here cannot be faulted and the staff are so helpful."
- We looked at patient records and found that they were completed sensitively and were clearly documented, detailing discussions that had been had with relatives.
- Relatives were encouraged to visit and routine visiting hours had recently been extended from 10am to 10pm. Visiting time was at the discretion of the nurse in charge for new admissions and patients who were at their end of life.

Patient understanding and involvement

- Due to the nature of the care provided in a critical care unit, patients could not always be directly involved in their care. Where possible, the views and preferences of patients were taken into account.

Critical care

- Nursing staff kept patient diaries by the bedside outlining what events had taken place, while patients were ventilated (and therefore not conscious).

Emotional support

- Following admission to the unit, the consultant covering the unit would arrange to meet with relatives to update them on their progress. They were given a written overview of the intended plan for the patient alongside what they could expect from the unit. One of the nursing staff would also attend this meeting.
- When necessary, further face-to-face meetings were organised, and all relatives we spoke with stated that they had been kept fully updated and had had opportunities to have all their questions answered.

Are critical care services responsive?

Good

The critical care service provided was responsive to patients' needs. The majority of patients were discharged from the unit in a timely way and complaints were handled appropriately.

Service planning and delivery to meet the needs of local people

- 95% of patients were admitted to the unit within four hours of making the decision to admit and 81% of patients were discharged to the ward within four hours of making the decision to discharge.

Access and flow

- Prior to discharge, the critical care registrar would verbally hand the patient over to the accepting team's registrar. Nursing staff would perform face-to-face handover on the ward.
- There was a standardised discharge document that was completed by the critical care unit prior to discharge to the ward. This outlined the treatment received while on the unit, as well as a decision regarding whether readmission to the unit would be appropriate. It clearly outlined the discussions that had been had with the patient and relatives.

Meeting people's individual needs

- Support for patients with physical and learning disabilities was available, if needed.
- Interpretation services were available, both by phone and in person.
- Some written information was available in different languages.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint then they would speak to the shift manager. If they were not able to deal with the concern satisfactorily, they would be directed to the Patient Advice and Liaison Service. If they still had concerns following this, they would be advised to make a formal complaint. This process was outlined in leaflets available in the relatives' waiting area.
- The critical care matron for the unit received all of the complaints relevant for the unit. They would then speak directly with the staff member involved and they would write together to the complainant, offering to meet with them. The department had an initial response turnaround time of five days. Themes from both formal and informal complaints were collected. The department met monthly (all staff working in the unit, including ward clerks, where possible) in order to help disseminate messages. In addition, the matron produced a monthly newsletter, which was emailed to staff detailing the most recent complaints.

Are critical care services well-led?

Good

The leadership of the unit was visible. Nursing staff wore different uniforms according to their role and patients were able to identify different grades of staff on the unit.

Staff were aware of their roles and responsibilities and how to escalate concerns. The unit had a clearly identified leadership structure.

Vision and strategy for this service

- The trust vision was visible throughout the wards and corridors.
- Staff were able to repeat the vision to us at focus groups and during individual conversations.

Critical care

Governance, risk management and quality measurement

- Monthly governance meetings were held within the directorate and all staff were encouraged to attend, including junior members of staff.
- Complaints, incidents, audits and quality improvement projects were discussed.
- A quality dashboard was presented, so that all levels of staff understood what 'good looks like' for the service and what they were aspiring to be able to provide.
- Staff on the frontline had the same 'worries' as those at the top of the directorate.

Leadership of service

- There was a matron and ward manager on shift Monday to Friday. There was a sister on every shift to coordinate and run the unit.
- All clinicians in senior leadership posts attended a clinical leadership and management course

Culture within the service

- Staff within the directorate spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority and everyone's responsibility.
- Staff repeatedly spoke of a flattened hierarchy and how they were encouraged to speak up if they saw something they were unhappy with regarding patient care. One junior nurse told us, "I do not feel foolish when asking simple questions and all the staff including the consultants will listen to your suggestions."
- Openness and honesty was the expectation for the department and was encouraged at all levels.
- Staff worked well together and there was obvious respect for all levels of staff including the visiting specialists, for example, physiotherapy and the nutritionist.
- Staff were engaged and worked well with other departments within the hospital. Staff spoken to on the wards told us that patients accepted to critical care were fully handed over to the staff and support is available from the outreach team, post discharge.

Innovation, improvement and sustainability

- Innovation was encouraged from all staff members, across all disciplines. Every junior doctor and student nurse was involved in a quality improvement project and staff were able to give examples of practice that had changed, as a result.
- Each sister on the unit was responsible for a team of nurses and for providing support and learning sessions. Each team attended 'away days' in these teams to have independent learning, team building and peer teaching.

Maternity and family planning

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

Information about the service

The trust had one maternity service which provided services within the Colchester General Hospital as well as in the community. There was both a midwife and a consultant-led unit at the hospital. In March 2014, the trust temporarily closed the facility for women to give birth in the midwife-led birthing units in Clacton and Harwich. A full antenatal service was currently being provided. A review of the maternity services was underway and was due to be reported to the trust board in June 2014. There were 4,400 births between October 2012 and November 2013 across the trust.

We visited the hospital maternity services. We talked with 26 women and 21 staff. These included midwives, doctors, and managers. We observed care and treatment and looked at care records. Before the inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

The maternity wards were generally clean, but some areas were dirty and equipment was not always checked. There were systems in place to identify women whose condition was deteriorating and staff knew what action to take. There was evidence of investigating incidents and learning from them. The average ratio of midwives to births had recently improved following the temporary closure of the coastal units. Medical staff provided adequate cover to the service. However, we found out-of-date intravenous fluid and blood bottles were stored within the wards. Although they scored highly in their hand-hygiene audits, we saw nurses were not regularly washing their hands. The defibrillator had not been checked since 2011.

Evidence-based guidelines were followed and there was a process to monitor outcomes for patients. Women were positive about the care they were receiving and were involved in their care. Services for women who had experienced the loss of their baby were well thought out. A range of antenatal classes were offered to women and there was a counselling service for women who had experienced a traumatic birth. There was no dedicated midwife for mental health-related services.

Although leadership of the service at a local-level was good and there was evidence of coherent working between midwifery and medical staff a new management structure had been introduced in January and there was still a lack of clarity regarding roles and accountability for the service. The relationship between

Maternity and family planning

the service and the CCG was described as “adversarial” and needed to be improved. Staff did not have a clear understanding of the vision for the maternity service and morale amongst community midwives was low.

Are maternity and family planning services safe?

Requires improvement

The maternity wards were generally clean, but some areas were dirty and equipment was not always checked. There were systems in place to identify women whose condition was deteriorating and staff knew what action to take. There was evidence of investigating incidents and learning from them.

The average ratio of midwives to births had recently improved following the temporary closure of the coastal units. Medical staff provided adequate cover to the service.

However, we found out-of-date intravenous fluid and blood bottles were stored within the wards. Although they scored highly in their hand-hygiene audits, we saw nurses were not regularly washing their hands. The defibrillator had not been checked since 2011.

Incidents

- There had been no ‘Never Event’ (these events are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented) attributed to the maternity or family planning service.
- There had also been four Serious Incidents in 2014, but this increase was due to a change in the reporting criteria. Three of the four had involved the interpretation of cardiotocography (a technical method of recording the foetal heart beat) and these were being investigated.
- Serious Incidents were reported and investigated. These involved supervisors of midwives, medical staff and midwives. The trust had identified some underreporting on the Datix system, compared to their manual records. Staff had been reminded about the Datix reporting system in the monthly newsletter.
- Learning from incidents took place and changes to practice had been implemented. For example, following incidents relating to cardiotocography, new machines had been purchased and a training programme, which was competency-based, had been introduced.
- Staff told is they knew how to report incidents and there were trigger lists to help staff identify when they needed to report.

- Staff confirmed that they received feedback following any incidents they had reported.

Cleanliness, infection control and hygiene

- The maternity ward areas at Colchester General Hospital were generally clean, but we did find that some areas were dirty.
- There was a lack of storage space on the ward areas, which meant that some equipment was stored in patient areas.
- Refurbishment work was underway and a risk assessment had been carried out to maintain patient and staff safety. We saw that actions had been put in place to mitigate the risks.
- We saw some nursing staff did not consistently wash their hands between patients, however, there were monthly hand-hygiene audits and women's services had scored 100% every month since October 2013.
- Infection rates for MRSA and C. difficile were within an acceptable range. There were no reported cases of MRSA between March 2013 and February 2014.

Environment and equipment

- Equipment was appropriately checked and cleaned regularly. We saw green stickers on equipment that said 'I am clean' and so ready to use.
- There was an adequate supply of equipment on the wards to support safe care. This included cardiotocography and resuscitation equipment.
- There were some pieces of equipment that had not been serviced or had their electrical testing completed. The defibrillator on the ante/postnatal wards had not been inspected since 2011. We also found the emergency trolley was dusty and had not always been checked on a daily basis. The suction kit was very dirty.
- Blood sample testing bottles had expired, which meant that there was a risk that the testing would be affected.
- The four midwife-led birthing rooms were made to feel like a home from home and had emergency equipment, as well as birthing balls, mats and a birthing pool.
- The consultant-led delivery rooms were large and had resuscitation equipment for babies.
- There was an operating theatre in the delivery unit and a second operating theatre was being built as part of the unit's refurbishment programme.

Medicines

- We saw that intravenous fluids had expired in October 2013 and were stored on the ante/postnatal ward. Although these were not commonly used fluids, they had not been identified by the department until it was pointed out to them during our inspection.
- We saw the controlled drugs on the ante/postnatal ward had not consistently been checked and during April 2013, there were 15 days when they had not been checked.
- Fridge temperatures were recorded and were within the required range.
- Medicines were stored in locked cupboards.
- There was a policy for the self-administration of medicines, which was being followed.

Records

- The trust was using the local maternity notes, which were carried by the expectant mother.
- Records were stored securely in the antenatal clinic, but on the postnatal ward we saw records were left on a table in the middle of each bay and were not secure.
- Changes to the maternity IT system were in progress. Clinical antenatal records had been entered onto the computer. The labour and postnatal notes were still in a handwritten format. The move to a computerised entry was planned to start in August 2014.
- Staff reported difficulties in accessing appropriate information in a timely way, because the antenatal records were separate from the written records.
- We saw good record keeping in most of the records we reviewed.
- Records were audited and the findings for improvement were presented in the risk management newsletter to enable key messages to be cascaded.

Consent

- There was evidence that consent was appropriately sought in line with national and local guidance.

Safeguarding

- There were clear procedures for safeguarding and child protection concerns. The trust employed a safeguarding lead nurse. Staff could demonstrate their understanding of the policies and procedures for safeguarding children and adults.

Maternity and family planning

- Community midwives demonstrated a good understanding about safeguarding and explained how they worked with other health and social care professionals.
- The maternity unit used a baby identification system, but this was not robust. All babies were given an electronic tag. Staff told us that the tags often came off and a new one would be applied. Staff reported that they would apply a new tag without checking that all other babies were with their own mothers.
- Entry to the ante/postnatal ward was restricted, but people could let themselves out of the ward. The ward doors were left open at visiting times.
- There was a baby abduction policy in place, but staff reported that it had never been tested.

Mandatory training

- Newly qualified midwives and those new to the trust underwent a period of preceptorship.
- Compliance with core training (the trust's term for mandatory training) was 63% in February 2014. In women's and children's services it was higher, at 71%. We saw some other data, which contradicted this and stated 92% of staff were up to date with their core training. In the nursing staff focus groups we held, midwives reported a different experience to that of their general colleagues and told us they always got to do their training and it was very rarely cancelled.
- Training was monitored and organised by a practice development midwife.
- Midwives and medical staff received at least four days of training a year. This contained subjects such as cardiotocography interpretation, emergency drills and mental health updates. This training was multidisciplinary.

Management of deteriorating patients

- The service used the modified obstetric early warning score (MOEWS). This was used to escalate care if women became acutely ill. Records of women's observations were well kept and there were clear instructions for staff.
- Staff were able to explain what action they would take if women scored a higher than expected MOEWS score.
- The critical care outreach team provided support to the maternity service, if required. The junior medical staff told us they provided a good service, which was very responsive.
- We observed the daily handover meeting on the delivery unit. The location of the handover did not afford patient confidentiality, however, this would improve once the unit refurbishment had been completed.
- The handover was used to identify any issues with the women in labour and discuss their plan of care.
- There was a weekly case review meeting led by the medical staff to discuss cases where shared learning would be of benefit. Records of these meetings were kept.
- The Royal College of Obstetrics and Gynaecologists (RCOG) had identified that there was no dedicated high dependency unit (HDU) in the women's service – this was a known risk. The mitigating action was to have trained senior midwives who could provide care for women with higher needs on duty at all times. We saw there was always one on these trained midwives on duty. Women would be transferred to the general critical care and HDU, as required.

Midwifery staffing

- The average midwife to birth ratio had recently improved, following the temporary closure to births of the midwifery-led units at Clacton and Harwich. This had resulted in the trust being able to increase the midwife to birth ratio at Colchester General Hospital to 1 to 30. This was still above the national recommendation of 1 to 28, but funding had been secured for an additional 5.6 midwives. Recruitment to these posts was underway. None of the women we spoke with raised any concerns about the number of midwives available.
- The midwife to supervisor ratio was 1 to 15, which was within the required ratio. A supervisor of midwives was on call every night and we were told that they provided a good level of support.
- Community midwives had caseloads that were, on average, one midwife to 78 patients. We were told that the caseload for community midwives was generally manageable and there was flexibility in the system to reduce them if they had more complex patients to care for.
- There were five community midwives on call each night to support the home birthing service. Midwives told us that the number of women opting for home births had risen since the temporary closure to births in the coastal units.

Maternity and family planning

- We saw that the numbers of staff on duty were in accordance with the trust's own template. The pager holder on duty had the overview of the staffing levels both in the community and in the hospital. Community midwives would be brought into the hospital to assist with staffing as required. Some staff told us that staffing levels had increased because of our inspection.

Medical staffing

- There were nine consultants in post covering obstetrics and gynaecology. Consultants were present on the labour ward for an average of 76 hours per week and there was sufficient cover of the service across the seven-day week.
- There were two registrar vacancies, which were proving difficult to recruit to. Staff were covering this amongst themselves and there was use of a regular locum.
- The consultants had a second on-call system, which was an informal arrangement, but allowed them to call for additional help if required.

Are maternity and family planning services effective?

Good

The maternity service followed evidence-based guidelines and clinical and procedural guidance was available to staff. The service had a process to monitor outcomes for patients and identify any outcomes that fell outside of expected levels. Clinical audits and outcomes for women were undertaken relating to puerperal sepsis. Maternal readmissions to hospital were better that the England average.

Learning from Serious Incidents had resulted in all staff receiving competency-based training on the interpretation of cardiotocography. The training was being delivered by staff who were appropriately trained in cardiotocography and understanding was being assessed through a test. There was multidisciplinary team working within the service and medical and midwifery staff reported good working relationships.

Evidence-based care and treatment

- The maternity service used evidence-based national guidance from the Department of Health, NHS Choices, the National Institute for Health and Care Excellence (NICE), Royal College of Obstetrics and Gynaecology, and the UK National Screening Committee.
- Clinical and procedural guidance were available for staff on the trust's intranet. The guidance was up to date and there was a systematic process for updating guidance based on national updates and local review.
- The maternity department dashboard was comprehensive and used to monitor outcomes and identify any that fell outside expected levels.
- There was a monthly risk management newsletter that was widely circulated and staff were able to tell us about it. They told us they found it very useful. The newsletter reported on audit findings, complaints, incident investigations and contained information on continuing professional development.

Pain relief

- Pain relief was available for birthing mothers, such as ENTONOX® and Pethidine.
- Epidurals were available 24 hours a day, seven days a week. The women we spoke with told us they were offered pain relief.
- The hospital ran courses on hypnobirthing to help women manage their pain in labour.

Patient outcomes

- Patient outcomes were monitored using a scorecard. This was reported to the monthly divisional finance and performance group.
- Between October 2012 and November 2013, the trust's normal delivery rate was higher than the England average.
- The elective caesarean section rate was about the same as the England average and the emergency caesarean section rate was slightly lower.
- The unit had a plan in place to further reduce its caesarean section rate. All emergency caesarean sections were reviewed by a consultant and senior midwife and specific cases were reviewed at the weekly multidisciplinary team case review meeting.
- Rates for puerperal sepsis and other puerperal infections were lower than the expected number.
- The rate of maternal readmissions was significantly lower than expected.

Maternity and family planning

- The trust's perinatal mortality rate was 5.4 per 1000 births, which was lower than the national average. Still births and early neonatal deaths were included on the monthly dashboard.
- Concerns had been raised by the clinical commissioning group (CCG) about the trust's perinatal mortality rate and a review of perinatal deaths between October and December 2013 was undertaken. A number of recommendations and actions had been identified from this review and the CCG were monitoring these.
- In January 2014, five perinatal deaths were reported that had triggered the CCG to commission a further review of deaths. Although it should be noted that we did not carry out a full case-note review of the perinatal deaths, we did not identify any concerns about the deaths that were reported.
- Clinical audits were taking place. A postnatal audit based on the NICE quality standards had recently been undertaken and the areas for improvement had been widely cascaded to staff.

Competent staff

- Learning from Serious Incidents had resulted in all staff receiving competency-based training on the interpretation of cardiotocography. The training was being delivered by staff who were appropriately trained in cardiotocography and understanding was being assessed through a test.
- Community midwives raised concerns that, following the temporary closure of the coastal units, they were being asked to work in an environment they were unfamiliar with. The senior management team told us the community midwives were being asked to work in the midwife-led unit only and were competent to do so. Supervisors of midwives had not been consulted on the decision to close the coastal units.

Multidisciplinary working

- There was multidisciplinary team working within the service and medical and midwifery staff reported good working relationships.
- Investigations into incidents were undertaken by a multidisciplinary team and there was evidence of shared learning across teams.

Seven-day services

- A supervisor of midwives provided 24/7 on-call support to midwives.
- There was always a consultant on call.
- There were daily consultant ward rounds, seven days a week.

Are maternity and family planning services caring?

Good

Women were positive about the care they were receiving at the time of our inspection. The NHS Friends and Family Test for maternity services also indicated that patients would be extremely likely to recommend it. Women told us they felt informed about their care and they were given written information about their birth choices.

Services for women who had experienced the loss of their babies were available and were well thought out. Staff spoke about this service with compassion and care.

Compassionate care

- The NHS Friends and Family Test for maternity services at Colchester General Hospital was positive, indicating that patients would be extremely likely to recommend it to their friends or family.
- The Care Quality Commission (CQC) survey for women's experiences of maternity services in 2013 received a response from 149 women who had given birth at the trust. The trust was performing about the same as other trusts on questions relating to care during labour and birth, staff during labour and care in hospital after birth. It performed better than other trusts on the question about skin to skin contact with the baby shortly after birth.
- We spoke to women, their partners and relatives in the antenatal, delivery and postnatal areas of the service. People we spoke with were all very positive about the care they had received. One person said, "It's been brilliant care, I cannot fault it."

Patient understanding and involvement

- Women and their partners told us they felt involved in their care. One woman said, "I felt I was in control all the way through the birth, they were lovely to me."

Emotional support

- The staff explained how they cared for women and their partners who were experiencing the loss of their baby and they spoke with compassion and care.

Maternity and family planning

- There was a bereavement midwife who provided specialist support to women.
- The trust had been accredited with stage 2 of the UNICEF UK Baby Friendly Initiative.
- There was an infant-feeding coordinator and the rates of mothers trying to breastfeed their baby were 78% against the target of 75%.
- The "Pink Ladies," were trained breastfeeding support volunteers who spent time with new mothers in hospital, as well as in the community.
- The hospital's website provided a range of links to various support groups, such as the Miscarriage Association and hyperemesis gravidarum support groups.

Are maternity and family planning services responsive?

Good

In March 2014, the trust temporarily closed the facility for women to give birth in the midwife-led birthing units in Clacton and Harwich. A full antenatal service was currently being provided. The trust and the clinical commissioning group (CCG) were carrying out a review of the maternity provision and the decision to close was due to be reviewed in June 2014.

A range of antenatal classes were offered to women and their partners at times that were accessible to them. There were some arrangements in place to provide support to women who had mental health concerns, or had a learning disability, but there was no dedicated resource for this. There was a counselling service and a debrief clinic for women who had undergone a traumatic birth. Women knew how to make a complaint and there was evidence that the service learnt from issues raised in complaints.

Service planning and delivery to meet the needs of local people

- The number of births at Colchester General Hospital between October 2012 and November 2013 was 4,344 single and 56 multiple deliveries.
- The maternity bed occupancy rate between October 2013 and December 2013 was 58%, which was slightly lower than the England average.
- In response to concerns about the birth to midwife ratio at Colchester General Hospital, a decision was made in March 2013 to temporarily close the midwifery-led birthing units and Clacton and Harwich. There was no public consultation because the closure was a temporary measure and because the reason for the closure was to maintain patient safety. We noted the units were closed very quickly once the trust board had made the decision. We did not speak to any women who were concerned about this closure during the course of our inspection.
- The trust and the clinical commissioning group (CCG) of the maternity service were carrying out a review of the maternity provision and the decision to close would be reviewed in June 2014.
- The trust provided a range of antenatal classes, such as teenage parent workshops and preparation for labour workshops. Classes were provided both at evenings and weekends.
- Hypnobirthing courses were also offered and we were told they could be accessed free of charge if it was felt there was a clinical need and the women did not have the means to pay.

Meeting people's individual needs

- The recent temporary closure of the midwife-led birthing units in Clacton and Harwich had reduced the options available for women to give birth. The trust website informed them about the closure and the options they had available to them. A full antenatal service was provided at these sites.
- There was no lead midwife for mental health. It was recognised that this was a gap in provision and we were told that it was hoped funding would be identified in the future.
- Mental health services were provided through the local mental health trust. We saw mental health was covered on the core training programme for midwives, healthcare support workers and medical staff.
- Specialist midwives for young mothers were in place and there were special classes and clinics for mothers with diabetes.
- There were formal arrangements in place to care for mothers who had a learning disability. Staff told us they could access the services provided by the mental health trusts, if required.
- Interpreters were available through LanguageLine Solutions. Leaflets were not readily available in other languages, but could be obtained on request.

Maternity and family planning

- There was a counselling service and a debrief clinic for women who had undergone a traumatic birth.
- There was a bereavement suite on the ante/postnatal ward. This was located away from the main ward areas and consisted of a lounge, kitchen area and a double bedroom. It also had an adjacent, but separate delivery room.
- Women were given written information about their birth choices and there was information available on the trust website.

Learning from complaints and concerns

- Information on how to make a complaint was available throughout the service.
- Women we spoke with told us they could speak to their midwife if they had any concerns.
- The maternity service received 92 complaints between October 2013 and March 2014. Thirty three of those related to attitude and communication and 35 about nursing treatment and seven medical treatments.
- We saw evidence of learning to improve from complaint investigations. For example, one complaint resulted in a meeting with the complainant. Following this, staff were reminded through the monthly risk management newsletter that just because a woman had a normal birth, it did not mean she was not frightened or did not feel vulnerable.

Are maternity and family planning services well-led?

Requires improvement

Although leadership of the service at a local-level was good and there was evidence of coherent working between midwifery and medical staff a new management structure had been introduced in January and there was still a lack of clarity regarding roles and accountability for the service. The relationship between the service and the CCG was described as “adversarial” and needed to be improved. Staff did not have a clear understanding of the vision for the maternity service and morale amongst community midwives was low.

Vision and strategy for this service

- There was a draft Nursing, Midwifery and Allied Health Professional (AHP) Strategy in place, which was aligned to the trust quality strategy and set out the priorities for the next three years.
- Staff had limited knowledge about the strategy for nursing and were not able to recount the vision to us during our interviews and or focus groups.
- There was a maternity risk management strategy that reinforced the approach within the service of learning from mistakes, and the processes to obtain assurance. The processes for incident reporting were not clear within this strategy.

Governance, risk management and quality measurement

- There were monthly governance meetings within the service. Complaints, incidents, audits and service performance measures were discussed and actions agreed. We saw several examples of this in practice.
- A quality dashboard was presented monthly, so that all levels of staff understood what good care looked like and what they were aspiring to provide.
- Staff on the frontline did not think that those at the top of the directorate understood the issues the service faced and had not involved them in the decisions to temporarily close the coastal units.
- There were weekly case meeting where cases could be reviewed by the multidisciplinary team. This was good practice. These meetings were documented and lessons learnt were cascaded through the monthly newsletter.
- There was a risk register in place. It did not include the risks associated with the closure of the coastal units and the concerns being raised by the community midwives.

Leadership of service

- A new management structure had been put in place in January 2014 and a divisional director had been appointed. Senior staff were unclear about the function and accountability of this role. There was also concern that, unlike the other divisions, there was no medical representation for the service at board-level. The relationship between the divisional director and head of midwifery was not clear.
- Medical staff had a named clinical lead and medical leadership was strong. We noted that the clinical lead only had one programmed activity (PA) session of allocated time for their leadership role. We were told consultant job planning was in progress.

Maternity and family planning

- In addition midwifery staff had respect for one another and had confidence in the matrons, the ward managers and the head of midwifery.
- However staff did not feel the executive team were visible and many staff felt the executive team were not committed to the long-term success of the hospital. Staff felt that the trust had lost its organisational history and there was a feeling that the executive team failed to recognise anything that happened before the trust was placed into special measures. One member of staff said, "It feels as if all the good things that have happened here in the past have been forgotten and everything that was good is now rubbish."
- Staff did not feel the director of nursing had a presence in the maternity service.
- The relationship between the CCG and the maternity service was described as "adversarial". Several staff felt that the CCG should be more supportive and they were making unreasonable demands on staff. For example, the level of investigation that was required following any incident. This had resulted in staff feeling that they were overly subjected to scrutiny and were being "micro managed" which impacted on morale.
- There was an effective system in place for the pager holder to have a good overview of the service, which also included the activity in the community.
- Community midwifery staff reported feeling undervalued and morale in the community teams was low. Some staff did not feel able to raise their concerns and felt they were discouraged from speaking out.
- Statutory supervision on midwives was in place and midwives reported feeling well supported.
- Junior doctors reported feeling very well supported by a friendly team and told us the supervision they received from the consultants was good.
- There was good succession planning from the junior grade tier to middle grade tier. The junior grades acted up into the role before they became a middle grade. They did this during the day-time when there was good supervision. This was an area of good practice.

Culture within the service

- There was a cohesive group of clinical staff in the unit. We saw evidence of strong team working with medical staff and midwives working cooperatively and with respect for each other's roles.
- There was obvious respect between the consultants.
- Morale amongst the community midwives was low. Midwives were concerned about the impact on women and their own working arrangements of the temporary closures of the midwife-led units.
- Sickness absence rates amongst midwifery staff were lower than the England average. We were told that rates of sickness in the community staff were higher, but we did not see evidence of this.
- Staff spoke about patients respectfully and quality and patient experience were seen as a priority.
- We saw a commitment to patient care and treatment.

Public and staff engagement

- Staff told us they were concerned about the temporary closure of the coastal units to allow women to give birth there. They did not feel they had been involved in this decision and were concerned about the impact on patients, particularly because one of the units was in an area of higher deprivation and had higher safeguarding concerns.

Innovation, improvement and sustainability

- A visit had taken place to another NHS trust to see if there was some good practice to learn from them as they were reporting low rates for caesarean sections.
- The service was to undergo a review of the maternity provision for the population served by the trust.

Services for children and young people

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

Information about the service

Colchester General Hospital had a children's department comprising a 24-bed children's ward for children and young people, a children's assessment unit (CAU), and a children's elective care unit (ECU). Within the children's ward there was a four-bed contingency bay, which was currently not in use and a high dependency unit (HDU) with four beds, of which, only two were currently in use. The ECU was next to the ward and was for surgical and medical patients. This unit had two bays, one with six beds and one with four beds. CAU had six beds and two side cubicles and shared facilities with the ECU. The hospital also had a children's outpatient clinic, a neonatal unit and a children's community service, provided in community clinics with the community nursing team based in the primary care centre.

We spoke with eight parents, four young people and 22 staff, including consultants, doctors, nurses and support staff. We observed care and case-tracked four patients and looked at the care records of eight post-operative, acute and medical patients. We reviewed other documentation, including performance information, provided by the trust. We received comments from parents and guardians and from people who contacted us to tell us about their experiences.

Summary of findings

Incident reporting was encouraged and we saw evidence of learning and changes to practice as a result of Serious Incidents. Ward areas were clean and secure and we saw staff washing their hands appropriately. There was sufficient medical oversight of the ward areas and consultant-led handovers.

However, mandatory training rates, especially for safeguarding children and basic life support needed to be improved and staffing levels were acknowledged by the department to be suboptimal. Not all children requiring high dependency care were looked after by nurses with the relevant training, and while the department was recruiting, current staff reported working extra hours in order to maintain the quality of care for patients. This may have impacted on the high sickness rates amongst staff.

Care was provided in accordance with evidence-based national guidelines and there was evidence of active audit activity. Pain was assessed promptly and using age-appropriate tools. Multidisciplinary working was evident and care was consultant-led.

Throughout our inspection, we witnessed caring interactions between staff and children on the wards. Parents were complimentary about the care their children received and told us they felt involved in decision-making about the care and support for their child.

Services for children and young people

The open-access CAU ensured that children referred by their GP could be seen by paediatric staff without having to wait in A&E. There was good support for children with learning disabilities and their parents. There was a good range of age-appropriate toys and children received educational support five days a week. Parents were provided with information through a variety of leaflets. There was a clear complaints procedure and the vast majority were responded to promptly.

Although staff spoke positively regarding the quality of service they provided and were clearly dedicated to the provision of high quality care, we had significant concerns relating to the way risks were identified and mitigated against. Monthly governance meetings were held in conjunction with the women's division and minutes provided to us at the time of our inspection could not assure us that there was a robust risk management process in place.

Are services for children and young people safe?

Requires improvement

Incident reporting was encouraged and we saw evidence of learning and changes to practice as a result of Serious Incidents. Ward areas were clean and secure and we saw staff washing their hands appropriately. There was sufficient medical oversight of the ward areas and consultant-led handovers.

However, mandatory training rates, especially for safeguarding children and basic life support needed to be improved and staffing levels were acknowledged by the department to be suboptimal. Not all children requiring high dependency care were looked after by nurses with the relevant training, and while the department was recruiting, current staff reported working extra hours in order to maintain the quality of care for patients, which may have impacted on the high sickness rates amongst staff.

Incidents

- No Never Events were reported for children in the period from January 2012 to the present. However, there were 5 Serious Incidents between December 2012 and January 2014 in the neonatal intensive care unit. There were 2 Serious Incidents involving child deaths reported between December 2012 and January 2014.
- A Serious Incident, regarding a missed or delayed diagnosis in January 2014, had been investigated and root cause analysis had been undertaken. Lessons had been learnt, and an action plan had been drawn up and improvements in practice were in progress. There was now a new pro forma with consultant sign off to ensure all clinical investigations were complete. A robust and consistent care pathway had been introduced and a weekly clinic supervised by a consultant had been set up. In addition, babies with prolonged symptoms now attended the CAU any day of the week for investigations. Education was incorporated into the departmental teaching programmes for doctors. All these measures were currently in progress to ensure that such an incident did not happen again.
- An investigation was in progress for another Serious Incident that happened in March 2014. This had yet to be completed.

- All staff we spoke with said that they were encouraged to report incidents. There was openness and transparency when things went wrong. Themes from incidents were discussed at weekly safety meetings. Staff were able to give us examples of where practice had changed as a result of incident reporting.

Safety thermometer

- The service used an adapted version of the NHS patient Safety Thermometer to support the provision of safe care.
- We were shown the monthly 'Safety Cross' charts that were on display on the notice board in the main entrance corridor. The safety charts covered six main areas: medicines, C. difficile infections, MRSA infections, complaints, pressure ulcers and falls. Each chart had been filled in daily or the date was crossed off if there had been no incident, such as a medication error. The charts were collated by the clinical area assessment programme (CAAP) team and a report produced containing, for example, an action plan for medication incidents.

Cleanliness, infection control and hygiene

- All the ward areas were clean and tidy. The environment was generally uncluttered.
- Separate hand-washing basins, hand wash and hand sanitising gel were available in all the units. We saw staff regularly washing their hands and using the hand sanitising gel between contact with patients.
- Personal protective equipment (PPE) was available for use by staff in clinical areas.
- Staff wore clean uniforms with arms 'bare below the elbow', as required by the policy.
- There had been no recent cases of C. difficile or MRSA infection. Not all patients were screened on admission, only those with a history of infection or those from tertiary centres were screened.

Environment and equipment

- The children's ward and units were secure. The children's department was accessed by entry phone or swipe cards.
- There was adequate equipment on the ward to ensure safe care.
- Equipment was appropriately checked and cleaned and had been serviced regularly. There were two resuscitation trolleys, one in the children's ward and one shared between the CAU and the ECU. These were checked by a designated nurse daily and appropriately labelled. A colour-coded, age-appropriate system was used to assist staff when using the equipment.

Medicines

- Senior management staff confirmed that there had been high numbers of medication errors, covering prescribing, administration and recording by doctors and nurses. Between April 2013 and March 2014, there were 54 medication errors, consisting of 24 for prescribing and 30 for administration. Incidents had been analysed, but no common themes had been found.
- A recently introduced action plan in response to medication errors included daily audits of drug charts and improved monitoring of prescriptions and the administration of medicines. It aimed to raise awareness among the doctors and nurses of the importance of accurate prescribing, administration and recording of medication. It also sought to identify any training needs. All drugs for intravenous infusion now had to be checked by two nurses. A safe prescribing zone in the children's ward was now provided for doctors, which comprised a workstation and access to the British National Formulary system for prescribing.
- We checked the controlled drug register and found the recording for the last six months had been accurate.

Records

- The patients' records had been maintained by both doctors and nurses within the children's department. We randomly checked some records and case tracked three patients' records in ECU and one in the children's ward. The recording by nursing staff was thorough and we noted that the integrated care pathway (ICP) booklets were correctly filled in by nursing staff and the care pathways were being followed.
- In the case of surgical patients, the World Health Organization checklist had been followed and the final checklist had been signed and dated to ensure safety for surgical patients.
- However, we found that one surgeon had not recorded the surgical operation notes for a tonsillectomy within the ICP folder, but had documented their findings in the patients' main clinical notes folder. We were told that not every surgeon used the ICP folder to record their surgical notes. Staff said that this had been brought to the attention of the management a few times but the

practice continued. This meant that the operation notes could not be found quickly in an emergency, which could delay treatment post-operatively, placing the patient at risk.
- All patients' clinical notes in paper format were kept in lockable trolleys within the nurses' station.

Consent

- Parents and guardians confirmed that their consent had been sought prior to treatment for their child. They described how procedures had been explained to them by both nurses and doctors. We were told how the anaesthetist visited the patient in ECU and consulted the parent to make sure the planned surgery and the correct patient had been identified before informed consent was signed and dated by the parent or guardian.
- Parental consent was recorded on all the children's notes we reviewed.
- Managers confirmed that there had been no cases subjected to Deprivation of Liberty Safeguards. Members of staff were aware of the Mental Capacity Act 2005 and in the event of a case where it was relevant, they would adhere to the Mental Capacity Act 2005 and take appropriate actions in the best interests of the child.

Safeguarding

- Staff could describe the referral process for alleged or suspected child abuse and knew the names of the lead professionals.
- The trusts training system failed to identify staff who required different types of safeguarding training. This was manually kept by the safeguarding lead. This information shows that most staff had been trained in safeguarding to level 2, but there was a large deficiency in training at level 3 for looked after children.
- There were no safeguarding cases pending.

Mandatory training

- Members of staff interviewed said that they had received mandatory training. However, the data for the year ending February 2014 showed that not all the staff had completed their mandatory training, for example, in safeguarding and basic life support.
- We were told that nursing staff had received 'basic life support – paediatric' training. However, the data for the year ending February 2014 showed that 433 staff required this competency, but only 34% had attended the course. We were told that nursing staff frequently had received scenario training organised at short notice by the facilitator when the unit was not busy. However, the data for the year ending February 2014 showed 70 employees requiring 'advanced life support scenarios practice – paediatric' training, but none of the staff had received this training. The data showed that 253 staff needed training in 'immediate life support – paediatric', but only 34% had been trained. We saw that there was a rolling programme, with a training plan for 2014. This programme had yet to be completed. It was not specified whether the data referred to nursing staff only or applied to medical and nursing staff.
- There were systems in place for monitoring training. However, the clinical area assessment programme report for children's ward, dated 12 February, stated that there were concerns regarding the accuracy of the central reporting of training data.
- There was good access to external training courses and access to trust policies and updated guidance for trained medical and nursing staff.
- There was a good range of nursing competency documents in place. We reviewed the competency documents and found they had been completed appropriately.
- Staff made considerable use of e-learning. Topics covered included safeguarding, chemotherapy drugs, food hygiene, record keeping, confidentiality and learning disability. Other training topics had included oncology internal foundation training and diabetic training in accordance with guidance from the British Society of Paediatric Endocrinology and Diabetes.
- The training in the care of children with a learning disability included communication, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Management of deteriorating patients

- The service used the paediatric early warning score (PEWS). There were clearly printed laminated PEWS charts giving staff directions for escalation, such as the pathway for children under one year of age. There were clear observation and PEWS recording charts in use.
- Staff we spoke with had knowledge of the appropriate action to be taken if a patient's PEWS score was elevated. The PEWS records were regularly audited, the latest of which had shown compliance rates of 98%.

- We looked at completed charts and saw that staff had escalated correctly, and repeat observations had been taken within the necessary time frame.

Nursing staffing

- The matron told us that 15 whole time equivalent (WTE) staff were needed across the ward, the CAU and the ECU. We were told that most of the time, nurses working in the children's ward were allocated to care for patients in HDU, where two HDU beds were in use. These nurses had been given a half-day course in HDU skills and had been supported by the HDU clinical practice facilitator (CPF) when they were on duty. However, the ward would need an additional 5.5 WTE nurses with HDU skills to support HDU and the ward, and 5-6 WTEs for the ECU to support surgical and medical elective work. The staffing of the neonatal unit needed to be increased by one grade band 6 nurse.
- Both management and nurses expressed concern regarding inadequate staffing levels, which had been ongoing for some time. However, we were told that recruitment for more nurses was in progress, but the impact of this had not yet been felt at ward-level.
- In the children's ward, the current number of used beds was 24, including two HDU beds. The staffing complement was usually five nurses, two healthcare assistants (HCAs) and one student nurse, with two nurses covering three bays and three cubicles. The allocation was based on team nursing and not patient allocation.
- We observed that a nurse was looking after a patient in the HDU and a child under six months in the cubicle near the HDU. The nurse was not HDU-trained.
- We observed nurses from the CAU being deployed to assist in the children's ward on both days. We were told that this deployment only took place when the CAU was not busy. According to staff, this practice had been ongoing for some years.
- The service had relied heavily on their own nurses working extra hours, as there was no pool of bank staff. We were told that an agency nurse had been deployed for a few days, but this practice had been discontinued.
- The deployment of nursing staff to work extra hours depended very much on the goodwill of staff. This was echoed by staff themselves. This arrangement had been going on for some years, according to staff. Staff felt they all worked very well as a team to maintain the service.
- Staff expressed concern that they had not always been paid for overtime or given back the hours as time off. The matron confirmed that, in recent months, overtime payment had been sanctioned using the budget allocated for vacancies, until these were filled.
- There was a high rate of sickness among the nurses. During the unannounced inspection on 16 May 2014, we looked at the staff duty rota for the day and night staff and noted that, between 5 May to 11 May, the number of nursing staff in the children's ward was reduced from six to five due to staff sickness. On 12 May, two nurses in CAU reported sick, a ward sister (on a long day shift) and a night sister. One of the ward sisters from the children's ward was deployed to cover the day shift in CAU, leaving the ward short of a senior nurse. The night rota was rescheduled.
- On 12 May 2014, two ward sisters, one on a long day shift (7am to 7:30pm) and one on night duty went off sick.
- The ward sister had to rearrange the following weeks' night duty rota and had to rely on the goodwill of another nurse, to change their shifts at very short notice or to do extra hours. This also meant that ward sisters and charge nurses spent considerable time on administrative work instead of nursing tasks.
- Staff told us the rota for the next month was provided only a week in advance. Ward rotas showed frequent changes and coloured entries indicated nurses working in another area. Nurses were often not able to attend the ward round due to staff shortages.
- A wide range of support and specialist nursing staff were employed, including diabetic, asthma, urology and epilepsy specialist nurses, a liaison health visitor on site, two dieticians and a clinical practice facilitator.
- We were told the e-Rostering system used had not been effective, as it did not reflect the skills mix of staff. Management had to draw up the roster manually and add it to the system.
- Mentorship was in place for student nurses. They felt well supported and said they had good opportunities to gain experience and good learning opportunities. They said they were able to get competencies signed off.
- The healthcare assistants (HCAs) had good support to develop their knowledge and skills.

- Staff had received appraisals, but there had been no follow-up. We observed an appraisal session that was held at the nurses' station instead of in private and the timescale was approximately 10 minutes. Confidentiality had not been maintained.
- We were told there had been no clinical supervision awareness system in place and the Nursing and Midwifery Council guidelines had not been followed. We noted, however, that nurses were debriefed following difficult situations. There was evidence that clinical supervision requirements had been covered in the preceptorship programme from 2011 to 2014.

Medical staffing

- Doctors were available 24 hours a day. There was consultant cover seven days a week, including nights. There was appropriate cover from junior and middle grade doctors on the children's ward day and night.
- Patients in CAU were seen by a registrar and senior house officer on shift each day.
- During our unannounced inspection, we observed that three patients in CAU were seen by a nurse within 15 minutes of arrival. Two of the patients were seen by a paediatrician and one by a surgeon within one hour of arrival. This was in line with the trust policy on waiting time in CAU.
- Children in ECU were seen by their consultant prior to admission and were seen by the anaesthetist in the unit before surgery.
- Staff handovers between the night team and the day team took place in the morning and a consultant was present.
- Doctor's ward rounds took place daily. Visits from the surgeons took place outside main ward rounds.

Nursing and medical handover

- We observed the morning (7am) nursing handover for all the staff in the staff room.
- Handover, the handover was given by means of a small Dictaphone. The name, age, diagnosis and current treatment for each child were recorded. Staff took notes on a printed sheet with names of the current patients. Further information and discussion took place in the ward among the team members allocated to each of the bays and the HDU. The night staff allocated nurses to patients, and posted the information on the notice board at the nurses' station.
- There was a good consultant-led handover. The nurse who attended gave a good summary covering discharges, child protection and other matters.

Are services for children and young people effective?

Good

Care was provided in accordance with evidence-based national guidelines and there was evidence of active audit activity. Pain was assessed promptly and using age-appropriate tools. Multidisciplinary working was evident and care was consultant-led.

Use of National Guidelines

- The trust's hospital protocols were based on the National Institute for Health and Care Excellence (NICE) guidelines. Local policies were written in line with this. Most policies and procedures were up to date, but some were currently under review. Staff knew where to find policies and local guidelines, which were available on the intranet.
- Nursing staff confirmed that they had attended departmental meetings every two months and changes to policies and procedures and guidance had been discussed.

Outcomes for the unit

- The children's service participated in all but one (child health programme) of the national audits for which they were eligible. This included the paediatric diabetes audit, the paediatric pneumonia (British Thoracic Society) audit and the neonatal intensive and special care audit programme.
- There was no formal nursing clinical supervision in place. We were told individuals could request a supervision session based on their needs. Staff appraisals were only followed up if the nurse was not achieving.

Pain relief

- We observed that a variety of tools were used to assess pain. For a patient with a learning disability we noted that an appropriate recording tool, the Face, Legs, Activity, Cry, Consolability scale, or FLACC scale, had been used. For another patient, we noted the pain

assessment tool using 'smiley' faces had been used. The child had been asked to choose a face that best described their own pain. A nurse had also recorded 'it hurts', as the identified words used for pain by a patient.

Care plans and pathway

- The department used the 'children's services focused care pathway - part 1' to assess all new patients. We observed three patients waiting to be assessed by the doctors. We noted that all three patients were assessed within 15 minutes by the nurse and within an hour by a doctor, one by a surgeon and two by a senior house officer, before they were seen by the registrar on duty. These times were within the trust's policy on waiting times.

Nutrition and hydration

- The children's menu had been improved recently and more choices were now provided as a result of patients and family feedback. The menu card was given to patients to select their menu for the next day. Hot meals were served twice a day and sandwiches and snack boxes were available throughout the day. There was a toaster in the kitchenette.
- There was a milk fridge with individual labelling for breast milk. Breastfeeding mums were given a voucher for use in the canteen.
- We saw that children had drinks by their bedside.
- The adolescent bay had a drinks machine.

Multidisciplinary working

- There was multidisciplinary team working within the department, with other services within the trust and with external organisations. For example, the shared paediatric oncology service worked closely with two other hospitals.
- There were good shared care arrangements with surgeons, and other services such as ear, nose and throat (ENT) and urology. However, we were told CAU was not always informed by the medical team in these services when a patient was being referred to CAU. This had resulted in delayed patient assessment in CAU.
- There was a weekly multidisciplinary team safety meeting to discuss safeguarding and other matters. The consultant was present for these meetings.

Seven-day services

- There was a 24-hour, consultant-led service with medical cover for the department seven days a week.

Are services for children and young people caring?

Good

Throughout our inspection, we witnessed caring interactions between staff and children on the wards. Parents were complimentary about the care their children received and told us they felt involved in decision-making about the care and support for their child.

Compassionate care

- Throughout our inspection, we witnessed good staff interaction with children and those close to them. We observed good, friendly and appropriate communication between a nurse and two children and their families.
- Parents were all complimentary about the care and the staff who cared for their children. Both children and parents were treated with compassion, dignity and respect. Parents gave the following comments, "The staff are approachable," and, "The Staff are friendly and keep us informed." They also said, "The staff are excellent, I can't fault them."
- Parents were encouraged to visit and stay with their children.

Patient understanding and involvement

- Parents felt that they had been involved in the care and decisions regarding their child's treatment. Parents felt well informed before they signed the consent form for surgery and other treatment.
- Comments received during our inspection included, "We cannot fault the care," and, "All the staff in the ward and the theatre were brilliant, including the porter."
- Plans were in place to involve children in the development of services, but the 'You're welcome' NHS standard was not yet in place.

Emotional support

- All the parents were complimentary about the staff of every discipline. Three parents mentioned that staff, including the theatre staff and the theatre porter, had helped to allay their own anxiety and "had made their child laugh" on the way to theatre.
- We were told that, in the case of long-term patients who required emotional support, the medical team had made referrals to the specialist child psychologist.

Services for children and young people

Are services for children and young people responsive?

Good

The open-access CAU ensured that children referred by their GP could be seen by paediatric staff without having to wait in A&E. There was good support for children with learning disabilities and their parents. There was a good range of age-appropriate toys and children received educational support five days a week. Parents were provided with information through a variety of leaflets. There was a clear complaints procedure and the vast majority were responded to promptly.

Service planning and delivery to meet the needs of local people

- Communication and relationships with local GPs and other healthcare providers were effective.
- The staff had received appropriate training to meet the needs of the community, including people with a learning disability.

Access and flow

- There was a good flow of patients, day cases and inpatients.
- Families did not have to wait long for appointments. Many patients were referred by their GP and there was open access to CAU, where children were seen by a nurse within 15 minutes and by a doctor within an hour. This meant that there was no need to go to A&E.
- Parents and guardians reported their child had received good continuity of care on the children's ward. A parent whose child had a learning disability felt their care needs had been met.
- Parents were aware of the plans for their child's discharge and felt well informed.
- Parents were given information and referral to community nursing if required.
- The oncology clinic in the outpatient department was temporarily using the CAU facility on Monday mornings, which resulted in CAU patients being seen in the children's ward. This had been ongoing since July 2013. We were told that all avenues had been explored and this arrangement was the best option for both patients and those close to them. There were plans to expand the outpatient department.
- The nurses and HCAs in the outpatient department and the ward were well trained, for example, in phlebotomy.

Meeting people's individual needs

- Support was available for patients with a learning disability or physical needs. A parent of a child with a learning disability spoke highly of the staff and felt that they understood the patient's care needs and the parent felt well supported.
- There was plenty to entertain young children on the wards and in the outpatient clinics and triage areas. Children were well supported in activities. There were six play activity specialists covering the ward, the ECU and the outpatient department.
- The children's department had good play areas, including an outside facility for younger children. There were ample toys and equipment to meet the needs of these children. Computer games were available for older children. There were other facilities, including bedside television, and evening Scout and Girl Guide activities for older children and adolescents.
- Children were given educational support five mornings a week. We witnessed a teaching assistant helping a child in the school room. There was a full-time teacher working three mornings a week. One of the teaching staff spoke to the children and their parents when patients were admitted. All activities were documented in accordance with education guidelines. There were pupils attending regularly. The teaching staff also provided home tuition.
- The child and adolescent mental health service, Allied Healthcare professionals and other services provided seven day cover between 9pm and 5pm.
- There was a good range of information leaflets for parents available. The information leaflets for patients had been updated regularly. However, there were no age-related leaflets, aside from child-friendly leaflets on diabetes. Discussions were in progress to provide a wider range of these.

Communication with GPs and other departments within the trust

- When a patient was discharged, a discharge summary was sent automatically to the GP by email. This detailed the reason for admission and the results of any investigations and the treatment undertaken.

Services for children and young people

- Surgical teams undertook daily ward rounds to the paediatric unit and worked well with the paediatric department. Staff stated that it was not difficult to get advice from other specialties within the trust.

Complaints handling (for this service)

- Complaints were investigated and responded to within 28 days, in accordance with the trust's complaints policy.
- The matron for the children's department received all of the complaints relevant to the department. Ward managers and staff knew their roles when handling complaints. We observed that a recent complaint had been responded to promptly and the trust's complaints procedure had been followed appropriately.
- Staff confirmed that complaints and concerns raised had been discussed in team meetings and where lessons had been learnt, an action plan had been implemented to improve the service.
- We examined the complaints analysis supplied by the trust. The number of complaints due for a response by the children's department over the period January 2014 to March 2014 was 20. Three of these were not achieved within the allotted time.

Are services for children and young people well-led?

Requires improvement

Although staff spoke positively regarding the quality of service they provided and were clearly dedicated to the provision of high quality care, we had significant concerns relating to the way risks were identified and mitigated against. Monthly governance meetings were held in conjunction with the women's division and minutes provided to us at the time of our inspection could not assure us that there was a robust risk management process in place.

Governance, risk management and quality measurement

- We had significant concerns relating to the robustness of the departmental risk register. On review this listed recent patient incidents rather than actual risks to the delivery of care. This needs to be addressed as a matter of urgency.
- In addition we were provided with three sets of minutes from the monthly governance meetings, none of which reassured us that risks were being appropriately identified and mitigated.
- The staffing levels had been of concern for a long time, although there was now a recruitment programme in progress, this had yet to have sufficient impact. In the meantime the trust had relied on the goodwill of staff to do extra hours. Staff had not been paid for overtime and although staff were sometimes able to get time in lieu, this did not always happen because of shortage of staff. It was only in recent weeks that overtime payments had been sanctioned using the budget allocated for vacancies.

Leadership of service

- The paediatric service was placed within the Division of Women and Children and was overseen by a divisional clinical director. In addition, there was a paediatric clinical lead and a children's service manager.
- Divisional Governance meetings were held monthly.

Culture within the service

- Staff within the directorate spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority. Staff told us that they were encouraged to speak up if they saw something they were unhappy with regarding patient care.
- We witnessed a dedicated team of staff at work and observed staff working well together to provide good care.

Innovation, improvement and sustainability

- Innovation was encouraged.
- A new care pathway for children under one year of age had been developed and had reduced the risk for patients.
- Although there were challenges concerning recruitment and retention of staff, existing staff were dedicated to their work and provided good care, with positive feedback from patients' families.
- The reliance on the goodwill of staff to maintain the service was not sustainable, as there was evidence of a high rate of sickness among staff. The CAAP report had acknowledged that the high sickness rate had had an impact on the day-to-day management of the children's department. The trust's sickness analysis showed a rate

of sickness for the whole trust in the range 3.06% to 4.38%, The CAAP report showed that in December 2013, 317.5 man-hours were lost to sickness in the children's ward.

- Staff felt that there has been an improvement in the staffing level in the last two months, as more nurses have been recruited, but the impact on patient care remained to be seen.

End of life care

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

Information about the service

End of Life/ Palliative care services are provided throughout the trust across the two sites, Colchester General Hospital and Essex County Hospital. Patients requiring radiotherapy in the north Essex area receive their treatment primarily at Essex County Hospital. Though the trust is currently in the process of opening a new radiotherapy centre at Colchester General Hospital. This has been commissioned to enable the decommissioning of the Essex County Hospital building.

People with palliative / end of life needs that required inpatient care were nursed on the general wards across Colchester General Hospital and were provided with specific oncology inpatient and end of life care on the wards at Essex County Hospital.

The palliative care team provided a seven day service and were available 9-5pm Monday to Sunday. The team was made up of 5.76 whole time equivalent nurses, two consultants and 15 hours administrative support per week.

We visited a variety of wards across the trust including the stroke unit, hospital mortuary, the porters lodge and the hospital chapel. We spoke with members of the palliative care team, the porters, chaplain, allied health professionals, and nursing and medical staff on the wards. We reviewed the medical records of patients at the end of life and observed the care provided by medical and nursing staff on the wards. We spoke with patients receiving end of life care and their relatives. We received comments from our public listening event and from people who contacted us separately to tell us about their experiences.

Summary of findings

The trust has a dedicated palliative care team who provided good support to patients at the end of life. The palliative care team were observed to be providing care in line with national guidance and best practice. The Liverpool Care pathway was in the process of being phased out and replaced by local guidance. On site palliative care support was provided by the team 9-5pm seven days a week.

Care and treatment was given in a sensitive and compassionate way. Staff worked hard to meet and plan for patient's individual needs and wishes. Staff were very motivated and committed to meeting patients' different needs and were actively developing their own systems and projects to help achieve this. We found many examples of good compassionate care for patients and patients were very positive about the service from the specialist team.

The multi-disciplinary team worked well together to ensure that patients care and treatment was planned and coordinated. People were positive about the care they received and the support they were given. There were effective working relationships with local hospices to coordinate people's end of life care where the hospice was their preferred place of care.

We found variation in the standard of records in relation to DNACPR documentation. We found little evidence of the Mental Capacity Act 2005 being considered in line with end of life care policies and completion of DNACPR

End of life care

forms. We also found that none of the DNACPR forms and patient records we examined had documented that appropriate discussions had taken place with relatives regarding the decision.

The trust had a multi-faith chapel were all faiths were welcome. There were also a number of chaplains from different denominations. Relatives were able to stay with their relative in a side room should they request to do so.

We found that the service was well led locally however was not well led at senior levels. We found that there was a lack of consideration towards end of life care when developing governance processes. End of life care was not recorded in great detail on the trust's risk register despite there being notable staff shortages and no visible executive leadership.

Are end of life care services safe?

Requires Improvement

There were no incidents that related directly to end of life care that had been reported although staff knew how to report incidents. We saw good hand hygiene practice by staff when they were caring for patients and we found the mortuary to be clean and following the relevant infection prevention and control guidance.

However, we found DNACPR forms where there was no evidence of mental capacity assessments being completed when the patient did not have the ability to make an informed decision about their care and treatment.

Incidents

- Staff told us they were encouraged to report incidents but could not recall any specific incidents relating to end of life care. This is not uncommon as many incidents relating to the death of a patient are reported under the specialty where the death occurred.

Cleanliness, infection control and hygiene

- We saw good practice with hand hygiene from staff when they were caring for patients. Staff were following the policies on the prevention of infection control.
- In the mortuary we found that appropriate guidance was followed for maintaining a clean environment and reducing the risk of infection.

Records

- We saw that the hospital had a resuscitation policy (implemented in October 2012) which was available to all staff via the intranet system. Staff we spoke to were aware that there was a policy in place.
- While visiting the ward areas, we reviewed medical records containing 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms. We checked a further six records during our unannounced inspection. We saw that all decisions were recorded on a standard East of England NHS form. The DNACPR form was at the front of the notes in a majority of cases, allowing easy access in an emergency. We saw that there were variations in the completeness of the forms across the hospital. We

found that all had been signed by a consultant. However all the forms we examined had the box for 'indefinite' decision ticked and therefore none had a review date listed.
- On the Intensive Care Unit (ICU) we saw comprehensive systems and processes were in place to support patients requiring end of life care including the withdrawal of treatment. Staff could tell us about the protocols they followed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We examined the records of patients who had DNACPR forms in place to determine if their mental capacity had been assessed prior to completing the decision not to resuscitate. In most cases we found that mental capacity assessments had not been undertaken despite documentation declaring that patients did not have capacity. Therefore medical staff have not followed the GMC guidance: 'Treatment and care towards the end of life: good practice in decision making (May 2010.)' or 'Decisions relating to cardiopulmonary resuscitation' A joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (October 2007.) Or the Mental Capacity Act 2005.

Are end of life care services effective?

Good

The multi-disciplinary team worked well together to ensure that patients care and treatment was planned and coordinated. People were positive about the care they received and the support they were given. There were effective working relationships with local hospices to coordinate people's end of life care where the hospice was their preferred place of care.

The palliative care team were observed to be providing care in line with national guidance and best practice. The Liverpool Care pathway was in the process of being phased out and replaced by local guidance.

Evidence-based care and treatment

- The National Institute for Health and Care Excellence (NICE) was rewriting guidance to remove reference to the Liverpool Care Pathway (LCP) following a recent independent review. The specialist palliative care team were aware of this change. We viewed the action log of meetings held between February and May 2014 to discuss the change from LCP to a new local guidance. Whilst no definitive plans were in place at the time of our inspection the trust's action plan cites a completion date for the project at June 2014.
- The trust adheres to National Institute of Clinical Excellence (NICE) End of Life Care Quality Standard (November 2011). We viewed the trusts 'End of Life and Palliative Care Strategy' dated 2013 which demonstrated that the trust had considered how to improve the service over the next three years. There was an action plan linked to the implementation of the strategy which was being led by the palliative care lead nurse.
- These meetings were held with multiple agencies including community care services and local hospices. We were informed that the group were working together to implement an 'individualised care plan for patients in the last few hours/days of life to be utilised across Acute, Community, and Hospices.' This meant that one plan will be in use across North Essex once implemented.
- The mortuary manager told us that effective systems were in place to log patients into the mortuary. We were walked through the process and were shown the ledger type book that contained the required information. A confidential area is available to secure the patients paperwork if the patient is received out of hours. We observed that the ledger was completed appropriately and patient confidentiality was maintained at all times.

Pain relief

- Anticipatory medicines were being prescribed and equipment to deliver subcutaneous medication such as pain relief was readily available.
- The hospital had syringe drivers for people needing continuous pain relief.

Competent staff

- The palliative care team provided education and training to the nurses and were external to the ward numbers. Multiple educational sessions had been developed for staff to attend. Registered nurses and health care assistants were aware that they could attend a variety of end of life and palliative care training throughout the year.

End of life care

- We found that the undertaking of end of life care training, dignity in death or palliative care training was not a mandatory training subject for staff at the trust.
- During the inspection we found that each ward we visited had identified a link nurse for end of life care.

Multidisciplinary working

- The hospital has a specialist palliative care team including doctors, clinical nurse specialists and counsellors. The team provided guidance on making decisions about end of life care and treatment options, and gave specialist holistic advice and support for patients and their relatives.
- The specialist palliative care team members attended regular multidisciplinary team meetings (MDT) for specialist teams, such as cancer services, renal and respiratory. This meant that patients under specialist teams could benefit from specialist palliative care team involvement and that care, treatment and support was delivered to meet the patients' individual needs.
- The Multi-disciplinary team worked well together to ensure that patients care and treatment were was planned and coordinated. People were positive about the care they received and the support they were given. There were effective working relationships with local hospices to coordinate people's end of life care where the hospice was their preferred place to die. The use of the palliative care team ensured continuity of care when working with community teams.

Seven-day services

- The palliative care team were on site for face to face consultations 9-5pm seven days a week. Outside of these hours telephone advice was provided by the local hospice
- Multi-faith chaplaincy services were available seven days per week. An on call rota for chaplains was also in place to provide additional support out of hours. The chaplaincy team provided support to patients, relatives and staff at times of need. The chaplaincy service utilise Lay people to support departments locally. Lay Chaplains represent all the main Christian denominations. Every ward at Colchester General Hospital has a Lay Chaplain to provide support locally.

Are end of life care services caring?

Good

Care and treatment was given in a sensitive and compassionate way. Staff worked hard to meet and plan for patient's individual needs and wishes. Staff were very motivated and committed to meeting patients' different needs and were actively developing their own systems and projects to help achieve this. We found many examples of good compassionate care for patients and patients were very positive about the service from the specialist team.

Compassionate care

- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. We saw that call bells were answered promptly. We spoke with many patients during our inspection about their experience of care. A majority of patients told us that they were either looked after well or exceptionally well.
- The trust has a policy in place regarding visiting times for visitors in ward and department areas. This policy is usually enforced by the person in charge of the department. We found in all areas we visited that the normal visiting times were waived for relatives who were visiting the hospital at the end of their relative's life.
- The chaplain told us that they were able to assist the nursing staff to ensure that care and treatment was provided to patients with due regard to their religion.
- The bereavement officer's worked closely with the coroner's office and helped advise doctors of the correct procedures after a death. The team would also provide support to families when a coroner was involved in decisions regarding the release of a body to the family.

Patient understanding and involvement

- The trust has various teams to support patients and relatives with end of life care. The trust overall has a palliative care team which is supported with a named nurse and a named doctor.
- When the palliative care teams were involved we found that patients and those close to them were actively involved in care planning and decision making. Patients were actively encouraged by the Palliative Care and Oncology Teams to ask questions, to discuss their treatment and share their concerns.

End of life care

Emotional support

- Staff showed considerable compassion towards relatives who wished to see their loved one following their death. Relatives were given the choice to participate in requests regarding religious and cultural practices to ensure that the patient received their last wishes at the time and after their death.
- Throughout the inspection we observed that the chaplaincy service provided support throughout the hospital and had developed good links in services across the hospital. One chaplain we spoke with told us that they provided a service to in and outpatients and had established close links with services across the trust. We observed that in the chaplaincy area there were quiet rooms where chaplaincy staff could meet people for bereavement and grief counselling and discussions. All of the chaplains subscribed to the Code of Ethics and Conduct of the College of Healthcare Chaplains.

Are end of life care services responsive?

Requires Improvement

We found variation in the standard of records in relation to DNA CPR documentation. We found that none of the DNACPR forms and patient records we examined had documented that appropriate discussions had taken place with relatives regarding the decision.

The trust had a multi-faith chapel were all faiths were welcome. There were also a number of chaplains from different denominations. Relatives were able to stay with their relative in a side room should they request to do so.

Service planning and delivery to meet the needs of local people

- The Keogh Review into the quality of care and treatment provided by the trust identified the need for further joint working across the economy to find solutions for patients who could appropriately be at home, or in their normal place of residence to receive end of life care. The report stated that systems currently in place were too complex with limited joined up working, flagging end of life provision across the economy as a key risk.
- As a result of this the trust is working with stakeholders and is included in the North Essex Clinical Commissioning Group's 'End of Life Strategy' which is a project being undertaken to improve end of life care. This strategy runs from 2013-2017. We saw through this strategy that the service is working with all stakeholders to plan and improve the end of life care service across North Essex.

Access and flow

- All patients within the trust, requiring palliative or end of life care have access to the palliative care team, 7 days a week. When we spoke with the palliative care team we were informed that a majority of the referrals received for palliative care related to patients with cancer.
- The palliative care team work closely with the critical care outreach team to ensure that as many patients as possible who require palliative or end of life support are captured. The palliative care team also attend MDT meetings across specialties to promote access to the services available.
- Out of normal working hours the chaplaincy can be made available to patients and staff through the on call service which is available 24 hours per day.
- We viewed audit data compiled by the trust on the number of patients who were being provided with palliative care at the time of their death in hospital. Between December 2013 and Mar 2014 we found that between 15% and 24% had received specialist palliative care support at the time of their death. This may mean that although the palliative care service is working to ensure people receive support, there is a significant number of patients who pass away who are not known to the team.
- The Bereavement Centre provided what it called a 'streamlined' service to people, so they could collect the death certificate and undertake all other paperwork as well as undertaking a viewing of the deceased without having to visit a number of different departments in the hospital.
- The office was open limited hours, Monday to Friday, 10.30am to 3.30pm however the service offers the opportunity to call the service between the hours of 8am to 4pm Monday to Friday. This meant that relative should be able to receive their relative's belongings and death certificates in a timely manner.
- The team advertise their services around the hospital, on the wards and on the trust's internet page. We viewed the internet page and information available to patient. This included leaflets on what steps to take following the death of a relative. The leaflet provided

useful information to families who had to undertake the duties of registering the death and arranging funeral services. The Bereavement service also offered additional support services in person from Monday to Friday to support people.

Meeting people's individual needs

- The palliative care teams have good liaison with discharge and community services linked to the hospital. This enabled patients identified for discharge under the Fast Track Pathway to be discharged to their preferred place for their end of life care sooner.
- We visited the mortuary viewing suite where families can come and spend time with their relatives. One hour appointments can be organised through the Bereavement or mortuary Monday to Friday. The mortuary manager encourages viewing in the afternoon due to the workings of the department in the mornings but all requests will met if possible around the needs of the relatives.
- The Mortuary manager told us that there was a 24 hour on call service is in place for viewing and mortuary support. A request for a quick release of a body can be accommodated to meet family's needs whether personal or religious. Viewings can also be accommodated out of hours if requested.
- The mortuary manager also told us that they accommodate all faith and work collaboratively with Muslim undertakers to ensure deceased patients are cared for following cultural and religious requirements. Therefore this meant that mortuary were able to support the emotional needs of families by providing a service that met their individual needs.
- The trust has an interpreter service available which can be accessed by trust staff 24 hours per day to support people whose first language is not English. Interpreter services for basic sign language (BSL) are also available for people with profound hearing disabilities. Therefore the trust has ensured that people can be communicated to and ensure that their individual needs are met.
- The service has dedicated learning disability and dementia lead nurses within the trust. Access to these nurses was available Monday through Friday and no cover was available at the weekends or out of hours. We viewed the mandatory training matrix for the trust which showed of the staff who were identified as requiring training in Dementia only 33% had been trained at Level 1. For learning disabilities and autism only 42% of staff had been trained level 3.
- Where facilities had been arranged relatives could stay in the rooms with patients as they approached the end of their life. These relatives were also offered meals, discounted parking and access to shower facilities.

Learning from complaints and concerns

- We viewed the complaints log for complaints reported by patients between October 2013 and March 2014. Of the complaints received 27 related to end of life care and bereavement services. Of these complaints a majority of concern was raised around end of life care in medicine. This information could indicate that people may not be happy with the end of life care they or their relatives have received through this specialty.
- We viewed the evidence provided by the trust on evidence of learning from complaints. This showed that the service was working to improve communication and how complaints were responded to by the services.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Decisions.

- The Resuscitation Council UK guidelines around DNACPR completion clearly states seven key points of guidance when completing these orders. We found that in a majority of cases the hospital had not undertaken the decision in line with four of the seven guideline points. This is because specific summaries around the decisions not to resuscitate and summaries of communications with patients and families were not always provided.
- We found cases throughout the hospital where DNACPR's had been completed without the patient's or relatives knowledge. The reasons for not discussing the decision with the patient varied in quality. One form we viewed stated the decision had not been discussed with the patient because they were, 'Asleep.' Another said the decision had not been discussed with the relative because they were, 'Not around.'
- Following our inspection we received a complaint from a family who were not aware that a DNACPR was in place for their relative who had been discharged home. The DNACPR form was provided to them with their discharge paper work. When we spoke with the hospital who investigated the concerns. The hospital informed us that the DNACPR decision should have been

reviewed as the patient's condition had changed however the staff did not review the decision. The hospital did take steps to resolve this concern. Therefore we are not assured that DNACPR decisions in all areas are being accurately recorded.

- Staff on the wards confirmed that the trust had systems in place to audit all DNACPR forms. We did not see the results of these audits in local ward areas and staff could not comment on their effectiveness. We viewed the trust wide audit that had been completed in 2013 which showed that of the 102 records audited: 42% had been discussed with the patient or family.
- The decision not to resuscitate was initially made by the consultant in 59% of cases and by the junior doctor in 14% of cases. 12% had not been signed by a consultant. 33% had an indefinite decision listed and no forms had a review date listed.

Are end of life care services well-led?

Requires Improvement

Whilst the trust executives and the local hospital could describe plans for this service these were yet to be implemented and staff were not aware of these plans. The specialist palliative care team felt that the hospital had not prioritised care at the end of life and that this service required further development to ensure that patients and their relatives were provided with good quality care.

Vision and strategy for this service

- We found that the trust had a clinical strategy for developing clinical services including end of life care. We viewed the clinical strategy which was completed in March 2014 and will be in place until 2019 the strategy had been to the trust board for approval.
- We spoke with staff who worked within end of life and palliative care who told us that they were unaware of the clinical strategy and were also unaware that it referred to end of life services. We found little evidence of leadership above the palliative care team that would support their involvement in the trusts strategy around end of life and palliative care.

Governance, risk management and quality measurement

- We reviewed a ward to board governance document that was provided to us during this inspection. This documented detailed the new governance structure in place for each of the specialist services including medicine, surgery and outpatients etc. We found that the core subjects to be discussed as standing agenda items did not include end of life or palliative care.
- We viewed the quality and patient safety committee minutes from a meeting held in March 2014. We found that end of life care had not been discussed as part of this meeting and was not an area that was routinely reported to the committee by the Divisions.
- We found that there was a shortage of staff affecting the delivery of the service. The end of life facilitator commenced employment in January 2014 and was currently covering acute oncology due to staff sickness. The palliative care team was down one full time nursing post due to long term sickness and maternity leave. These gaps in the structure had not been acted upon by the management team. There was also no evidence of a staffing concern within the service recorded on the risk register for the trust.

Leadership of service

- We viewed the structure for the end of life and palliative care services. We found that there was no executive director identified as a lead for end of life care. Staff we spoke with believed that this may have been the medical director but were not certain.
- We viewed a governance structure that had recently been implemented across the trust. The organisational structure does not make any reference to end of life or palliative care services.
- Staff felt disconnected from the board and felt that there was little communication between frontline staff and the trust's senior members. This meant that staff were unclear on who was leading end of life care from an Executive level.

Culture within the service

- We found little evidence of palliative care involvement in the hospitals work programme. The team were not included in the development or discussions of trust policy or strategies. For example in the development of the trusts clinical strategy. This meant that specialist knowledge may not have been maximised by the trust to ensure informed areas of clinical improvement were identified for improvement.
- The palliative care team worked well and was very responsive. There was a good working relationship between the lead clinician and the nursing staff who

wanted to improve services to patients. The staff demonstrated good relationships with wards which was evident throughout the inspection when we visited the ward areas. We spoke with staff throughout the hospital who understood the process for accessing the palliative care and end of life services.

Public and staff engagement

- We found little evidence of public or staff engagement in end of life service development.

Innovation, improvement and sustainability

- The palliative care team gave examples of practice that the team felt had worked well. This included providing a holistic approach to patients receiving palliative or end of life care; streamline processes between the hospital and community, attending the multidisciplinary team meetings and the development of clear processes for the fast track discharge to the patient's preferred place of care.
- The palliative care team also informed us that they were attending weekly mortality meetings to learn more about mortality and identify areas where they could support improvement.

Outpatients

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

Information about the service

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

Colchester General Hospital has a large outpatient department providing a variety of specialities including diabetes, urology, trauma and orthopaedics and gastroenterology. We also visited the radiology department and therapy services.

We inspected the outpatient and radiology department at Colchester General Hospital over two days. We talked with 13 patients, one relative and 26 staff. We also reviewed the trust's outpatient performance data.

Summary of findings

Although most of the areas we inspected appeared to be clean we found two rooms with dirty cups and that some cleaning rotas were temporary and incomplete. We found out of date clinical equipment, such as acupuncture needles and sterile sodium chloride solution. Although it was reported to us that there were no vacancies within the department, it was not clear that a recent skills mix had been undertaken. Staff adhered to 'bare below the elbow' policies and there were adequate hand-washing facilities in all but one of the rooms used to examine patients.

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

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

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

Outpatients

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

Are outpatients services safe?

Requires improvement

Although most of the areas we inspected appeared to be clean, we found two rooms with dirty cups and that some cleaning rotas were temporary and incomplete. We found out of date clinical equipment such as acupuncture needles and sterile sodium chloride solution. Although it was reported to us that there were no vacancies within the department, it was not clear that a recent skills mix had been undertaken. Staff adhered to 'bare below the elbow' policies and there were adequate hand-washing facilities in all but one of the rooms used to examine patients.

Incidents

- We spoke to two senior nurses in outpatient services, who told us that incident reports used to be completed for clinics that were delayed, overbooked or cancelled last minute. However, due to the high number of incidents, the staff no longer completed reports. We spoke with a nurse who felt that completing incident reports did not resolve issues and staff did not get feedback from reports. This meant that not all incidents were being reported.

Cleanliness, infection control and hygiene

- Hand sanitising gel was evident at the reception desk and there was a low-level area appropriate for patients in wheelchairs.
- There were hand-washing facilities in most of the clinic treatment and consultation rooms we inspected, along with liquid soap, paper towels and alcohol gel dispensers. We found one room in the speech and language therapy department that was an office, but was also used to treat patients. This room had no hand-washing facilities and staff told us that they had to go into the next department to wash their hands.
- We saw documentation of daily clinic room cleaning rotas in three rooms, one of which was taped to the wall with micropore. On each rota there were days where nothing had been documented that indicated rooms had not been cleaned. Two out of the five clinic rooms we inspected had dirty cups in.

Outpatients

- We saw a variety of different coloured bins. It was not clear what they were used for, as they were not labelled. This meant that there was a risk of clinical waste being disposed of in general wastage.
- There were numerous pieces of equipment being stored in the corridor, making it very crowded, including an over toilet seat and a bed.
- On entering the electroencephalogram (EEG) department, we found rubbish that had been left outside.
- All staff we saw adhered to the 'bare below the elbow' policy.
- We saw that equipment that had been cleaned had a green label. This system made it clear for users to see the date equipment had been cleaned.

Environment

- Senior outpatient staff told us that there were monthly environmental audits to ensure the environment was fit for purpose.

Equipment

- Resuscitation trolleys in outpatient services, radiology and physiotherapy were centrally located. We inspected four trolleys. We saw that they were clean, the defibrillators had been serviced and that staff documented equipment testing on days clinics took place to ensure equipment was fit for purpose.
- However, there was one trolley in alpha x-ray that had no documentation for three dates in May 2014, and another trolley in main outpatient services, for which the packaging had been opened on the non-rebreather mask (thus affecting its sterility).
- We found equipment such as a vacuum suction machine, fans and computer equipment in clinic rooms that had not had portable appliance testing (PAT) within the past 12 months. This meant that equipment was not appropriately serviced.
- We found a utility room unlocked. We discovered equipment including four boxes of acupuncture needles, sodium chloride sterile solution, catheter introducers and ribbon gauze had lapsed their expiry date, some of which had expired in June 2012. We reported this to the sister in charge. They told us that there was no audit to ensure that all equipment was within its expiry date. This meant the patients were at risk of being treated with out of date equipment and that equipment was not stored safely and securely to prevent theft, damage or misuse.
- In the interventional radiology department they had a system in place to identify out of date equipment. We saw a 'stock expiry list' that recorded each piece of equipment and its expiry date. This was a good system to ensure patient safety. We did not see that this good practice was shared across the trust.

Medicines

- We were told by a sister that there were no medicines stored within outpatient services.

Records

- Staff told us that they usually had a full set of patient records in clinic.

Mandatory training

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

Nursing staffing

- The matron for outpatient services told us that a skills mix was required to optimise staff skills and utilisation in the department, but that they were concerned that they did not want to relocate staff who had worked in outpatient services for a long time into different areas. Therefore, instead, when staff naturally left posts, the post was re-evaluated and skills mixed accordingly.
- An outpatient sister told us that they currently had no vacancies and used no agency staff within the service - if staffing was low they used bank staff that already knew the service.
- Staff from physiotherapy and speech and language therapy reported issues around lack of staff and difficulty with recruitment.

Are outpatients services effective?

Not sufficient evidence to rate

Outpatients

Are outpatients services caring?

Good

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

Compassionate care

- During our inspection, we witnessed staff being polite and welcoming. We saw most receptionists greeting patients and asking if they could help them. We witnessed nurses calling patients into clinics and greeting them through.
- We spoke with four patients in cardiology clinic. One patient told us that staff were "helpful and kind". Another commented, "My personal experience has been good," and another said that they were "very impressed".
- We spoke with three patients in the trauma and orthopaedic clinic. One told us that they received an "abrupt and stern" response from the receptionist and described the experience as "manic". Another told us that their care and treatment had been "excellent" and that, "Doctors are very good, they jiggled appointments to see me early."

Patient understanding and involvement

- Most patients told us that they felt involved in all the decisions about care so far.
- On cardiology patient told us that, "The doctor explained things very well." However, they also commented that the doctor had gone to get some written information 15 minutes prior to our conversation, but was yet to return.

Are outpatients services responsive?

Requires improvement

Although the trust had a work stream to monitor outpatient efficiency and to improve DNA rates, we were concerned to find a large number of cancelled outpatient appointments. Up to 9% of these occurred within one week of the original appointment time.

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

Service planning and delivery to meet the needs of local people

- The service manager told us that the booking of outpatient appointments was currently semi-centralised and that the trust was investigating if further centralisation would improve patient experience. The services which sat outside are therapies and breast services, which had already expressed an interest to centralise, and gynaecology, paediatrics and thoracic medicine.
- The booking centre was open Monday to Saturday, 8am to 8pm. During the appointment booking calls, patients had the opportunity to receive a confirmation text message with their appointment details. Patients could choose to have the text message sent to the mobile number the trust has on the patient administration system (PAS), or patients could enter a new mobile number. New mobile numbers were sent back to the trust to update mobile numbers in the patient record and improve data quality. In February 2014, 24% of patients (635 out of 2,609) chose to receive a confirmation text message with their appointment details.
- One patient told us that the main reception desk had recently been redesigned and that there seemed to be more staff to help making it quicker to check in. We saw that the queues for the desk fluctuated throughout the day.
- We found a patient who was quite confused about how to find the orthotics department, they told us that they had not received a map with their appointment. When we found the department, the reception door was closed and there was no indication as to where to check in, this was quite confusing and not patient-friendly.

Access and flow

- The trust had a work stream to look at outpatient efficiency. Data on the number of patients who did not attend (DNA) their booked appointment showed that the overall trust rate was 7.5% for 2012/13, which was an average for the east of England. A target was set to

deliver a reduction of 6.5% by the end of 2013/14 and further reduction to 5.5% by the end of 2014/15. We saw evidence that presented the DNA rates for February, March and April 2014 as 6.22%, 6.4% and 7.02%, respectively.

- The trust had managed to reduce DNA rates for first appointments by the implementation of contact with patients to agree the first appointment date and the call reminder service, which reminded patients of their appointment and gave patients the opportunity to rearrange or cancel appointments, which could then be reallocated to another patient quickly to reduce waiting times. The forward plan was to contact follow-up patients to deliver the further DNA reduction to meet the 5.5 % target.
- We identified pockets of excellent practice, where some clinics had managed to get their DNA rates down from 20% to 0%, such as interventional radiology, and clinics that were consistently below the target rates such as clinical oncology and dermatology.
- Senior staff told us that the trust operated a 'one-strike policy', if a patient did not attend their appointment they would be discharged from the service, unless they were categorised as vulnerable, had cancer or were a paediatric patient.
- We talked with one patient waiting for the trauma and orthopaedic clinic. They reported that they had received a phone call to ask them to attend clinic, but had received no letter, when they had arrived at the clinic the reception staff had no appointment on the system for the patient. The patient reported that they were in pain and became quite upset about the poor care she had received.
- Another patient waiting for the trauma and orthopaedic clinic reported that they had been waiting for 25 minutes for their appointment, but that they had not been told why it was delayed. And another told us that they had been waiting for 35 minutes but staff had informed them of the delay.
- We talked to two patients in gastroenterology clinic. One patient had waited 45 minutes for their appointment and was happy with their care and treatment. The other patient had waited 30 minutes. They told us that their letter did not state who their appointment was with and this had cause them anxiety.
- In radiology there was a TV displaying waiting times for each clinic. We saw that delays ranged from 28 to 43 minutes.
- We were concerned about the number of outpatient appointments cancelled by the hospital, data showed the overall trust rates were 14.17%, 14.66% and 15.29% for February, March and April 2014, respectively. A total of 77,670 appointments were cancelled between April 2013 and March 2014. Around 9% of these were cancelled within one week of the appointment.
- Reasons for hospital cancellations showed that 19.4% were due to rescheduled clinics, 12.1% were booking errors and 6% were when patients were offered an earlier appointment. We were concerned to see that 42.8% of hospital cancellations were due to consultant requests, the data showed that this was due to consultant requests for unknown reasons, study leave, illness, consultant being on-call.
- One of the senior nurses we spoke with had recognised this issue, but it had not been addressed, they told us that occasionally, nursing staff and patients had arrived to clinic, but no consultant had turned up and they were not always informed that clinic had been cancelled.
- We spoke with two consultants in the outpatient department about this. Neither consultant had looked at the data however both reported that they followed the trust clinic cancellation policy giving at least six weeks' notice when cancelling clinics. Both consultants had cover from registrars, one consultant recognised that if they had to attend to an on-call emergency, the clinic would get cancelled on the day.
- Patient cancellation rates were also high: 14.63%, 14.73% and 15.53% for February, March and April 2014, respectively. However, there was no data to explain this.

Environment

- We also found a faulty door that was later fixed during our inspection. Reception staff told us that both issues had been reported several times to the maintenance department the previous week, but that nothing had been done.
- There was a quiet room patients could use for privacy or when extra support was required and Macmillan Cancer Support volunteers within the trust to provide support and information for all patients and relatives.
- During our inspection, we saw four patients on beds, unchaperoned and waiting for x-rays, close to the outpatient waiting area. This did not protect patient privacy and dignity and left them vulnerable.

- In the EEG area, staff reported that tests for bedbound inpatients were conducted in the waiting area as the clinic doors were too narrow to accommodate the width of the bed. This meant that the privacy and dignity of the patient was not protected.

Meeting people's individual needs

- We saw patient records in two clinic rooms stored on window sills, with patient names on view to people passing by outside. We found one room unlocked opposite a patient waiting area with over 30 patient records stored. This meant that confidentiality was compromised.
- We were told by a volunteer working for Macmillan Cancer Support based at County Hospital that they provided support and information for all patients and relatives within the trust. The service relied upon volunteers and ran Monday to Friday, 9am to 5pm.
- Reception staff told us that lunch packs were available for patients with diabetes or vulnerable patients who may have missed lunch due to their appointment or transport issues. We witnessed a receptionist give a cardiology patient a lunch pack, as they had missed their lunch due to transport delays. There was also a water dispenser in the main reception.
- We saw patients being weighed and having their blood pressure taken before going into clinic, there was a curtain around the scales to protect their privacy and dignity.
- There were leaflets and posters throughout outpatient services that provided information about diagnoses, treatments and the support available for patients and relatives. This meant that the service provided patients with appropriate information and support in relation to their care and treatment.
- In the main hospital and Gainsborough Wing receptions, there was a volunteer coffee shop with a range of snacks, drinks and magazines. There were also refreshments available from vending machines for patients and visitors to use.
- In the main reception, there was a receptionist at an information point, directing people to their required destinations and providing hospital maps, where needed. They told us that this service was currently only available Monday to Friday, 8am to 8pm, as the staff member covering weekends was off sick and no alternative covering arrangements had been implemented.
- In the Gainsborough Wing reception area, there was an electronic information stand that was out of order.
- In the main outpatient reception area, there were magazines and a large television screen available for entertainment while patients waited. There were comfortable seats for patients to wait.
- We noticed that there was limited parking for patients at the hospital. There were visitor discount permits for up to seven days for regular visitors. One patient told us that they had waited 20 minutes for a disabled parking space and that there were no wheelchairs nearby to get from the car park to the hospital. They commented: "Parking is horrendous." Another patient commented, "We always have to arrive early to get a disabled parking space." Two other patients commented, "It was a nightmare parking," and, "Parking was so stressful." Receptionists in the EEG department highlighted a lack of disabled parking spaces close to the department and that this made getting to the department difficult for patients.

Learning from complaints and concerns

- Within outpatient services, we saw written information about the complaints procedure and the Patient Advice and Liaison Service.
- None of the 13 patients we asked had been given any information about complaints or knew how to make a complaint.
- Senior outpatient staff told us that there was a trend of delayed waiting times in recent complaints. A sister reported that when they received a complaint and had replied on behalf of the service, there was no feedback from the Patient Advice and Liaison Service about the outcome.

Are outpatients services well-led?

Requires improvement

We found senior staff each had visions for the service at local-level, yet there seemed to be a lack of combined objectives and strategy to achieve an improved service. Issues had been identified within the service, but there were delays in resolving these. We were provided with minutes from divisional governance meetings which appeared to demonstrate that outpatient services were discussed in relevant speciality meetings rather than as a

separate service and within these outpatients was discussed at any length. There was no discussions minuted relating to delays in appointments or cancellations. Staff we spoke with were not aware of key performance indicator targets or results for the service and therefore were not proactively managing the situation at clinic-level.

Vision and strategy for this service

- Senior staff told us what each of their visions for the service was at local-level, yet there was a lack of shared objectives and strategy to achieve an improved service.
- None of the staff we spoke with acknowledged the trust vision or objectives.
- One receptionist told us that there was a trust weekly newsletter sent out via email to keep staff informed.

Governance, risk management and quality measurement

- We were concerned throughout outpatient services about the delays in waiting times. A sister told us that one of the main challenges in the service was regular delays for patients waiting time and the overbooking of clinics, as patients were allocated five minute appointment slots. They reported that they had no control over this. We spoke to three senior staff in outpatient services who had all recognised the issue. One had recently found that approximately 900 different staff could make changes to appointment templates and, therefore, clinics were easily overbooked, this had been a hidden problem and was not being investigated. They reported that service managers were not aware and not managing the problem. This indicated poor management of bookings across the service.
- We were also concerned that the matron for outpatient services told us that there had been no outpatient services patient survey or questionnaire since 2011. The service had trialled a Meridian patient experience tracker service to gain patient feedback, but this had been unsuccessful. The matron reported that the plan was to target two clinics per week to complete the NHS Friends and Family Test, and to investigate a text message feedback survey. This meant that the service did not consider the views of patients, restricting learning and improvement.
- We were told by senior radiologists that there were a range of quality assurance and governance meetings within the trust to discuss issues at ground and board-level, including a divisional board and governance meeting, a joint accident and emergency meeting and an Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) committee meeting. We saw evidence of clinical audits, incidents, complaints and the risk register being discussed at monthly radiology governance meetings attended by senior staff. We were not provided with the same assurance for general outpatient services.
- The trust had a referral to treatment (RTT) work stream and work plan monitoring the efficiency of outpatient booking. We saw evidence of a draft Patient Access Policy to define the management of the 18 week RTT and cancer waiting times, to achieve national objectives in reducing waiting times and improving patient care. This policy identified that patient waits for treatment was a significant quality and clinical governance issue and everyone had a responsibility, including the patient, to aim to achieve these targets.
- We were concerned that staff we spoke with, including a consultant, nursing staff and administrative staff working within outpatient services were not aware of key performance indicator targets or results for the service and, therefore, were unable to proactively manage the situation at clinic-level. Only the outpatient physiotherapy lead could tell us how physiotherapy was performing and how they were managing waiting times and DNA rates.

Leadership of service

- We spoke with three senior managers within outpatient services, none of them reported having recent management or leadership training. One told us that they had no NHS management training.

Culture within the service

- We spoke with a several nursing staff who reported working in a bureaucratic environment.
- We spoke with the newly appointed deputy service manager for outpatient services, who told us that one of the challenges was to change culture within the service and embed consistent processes.
- We spoke with staff working in radiology, who told us that, “We are not supported by management,” and, “It’s a target culture that has increased our caseload and has become very stressful,” and, “Career progression is limited.” They also said, “This place is rubbish to work.” This reflected the findings of the 2013 NHS Staff Survey that found increased stress levels, poor motivation and

job satisfaction amongst staff. They told us that they did have team meetings but these were in their unpaid lunch break and prevented them from having a clear break.

- Despite this, all the managers we spoke with told us that they were proud of the staff working in the various services across outpatient services and of their commitment to the service.

Innovation, improvement and sustainability

- We spoke with one healthcare assistant, who told us that they had study time included within their shift pattern and we saw evidence to support this. They told us that they felt supported by the sister.
- The matron for outpatient services told us that the service had introduced associate practitioner posts and that there were competencies for staff to work towards. However, outside of these posts, they reported the practice development team focused on training for inpatient staff and that outpatient development was limited. They commented that outpatient nursing staff had little study leave, as it was "difficult to release staff" and that there was "no clear career progression".
- Senior outpatient nursing staff could identify recent issues amongst staff within the service, such as the punctuality of staff, housekeeping and the use of mobile phones. They reported no equipment issues or the storing of patient records prior to what we found. There was an overall lack of recognition of some issues and neglect to solve local-level issues that had been identified.
- The radiology practitioner for Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER 2000) and quality assurance told us that radiology provided IRMER training for clinical staff such as nurses and physiotherapists, so that they could request diagnostic tests. This meant that requests could be completed earlier rather than waiting for the authorisation of a medic. This was an example of good practice.
- In radiology, we were told that a voice recognition system had reduced the production time of radiology reports and, as a result, the system was more effective. This meant that the service was being led to improve efficiency.
- In the EEG department, they had introduced equipment for video telemetry tests. This meant that local patients could now attend Colchester General Hospital rather than going to a London-based hospital for the test. This demonstrated improvement within the service.
- The head of speech and language therapy showed us the props they used to explain patient diagnosis and treatment, including an iPad and models. This illustrated how the department was using innovative ways to deliver care.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure that there is a robust incident and accident reporting system in place; including reporting staff shortages and that lessons learnt from investigations of reports are shared with staff to improve patient safety and experience.
- Ensure that all equipment has safety and service checks in accordance with policy and manufacturer's instructions and that the identified frequency is adhered to, including emergency equipment requiring daily checks, portable appliance testing and regular maintenance.
- Ensure that all patients' records are kept up to date and appropriately maintained to ensure that patients receive appropriate and timely treatment.
- Review the process for referring safeguarding concerns to the local authority to ensure that these are undertaken appropriately for the safety and wellbeing of patients.
- Ensure that there are sufficient numbers of qualified, skilled and experienced staff at all times, particularly in A&E, medical wards and children's services including the high dependency unit.
- Review handover arrangements to ensure that they are effective and the necessary information is passed to the next responsible staff team so that patients receive appropriate treatment in a timely manner.
- Ensure that staff complete their mandatory training and have access to necessary training, especially safeguarding and resuscitation, and development to ensure they maintain the appropriate skills for their role.
- Ensure that patients are assessed by appropriately trained and experienced staff within the A&E department.
- Ensure all staff, particularly medical staff have received an appraisal.
- Review the recording of necessary information such as arrival and discharge times in the A&E department to ensure that the information on performance is robust and correct.
- Review the patient flow from the A&E department to ensure that patients are assessed to meet their needs and there are no unnecessary delays.
- Review the complaints process to ensure that appropriate lessons can be learned and improvements made in service delivery.
- Ensure all staff adhere to the infection prevention and control of infection policy and procedures, particularly with regard to hand washing and cleaning procedures on the maternity unit.
- Ensure that all sterile fluids and medicines are stored in accordance with manufacturers and legislative guidance and that expiry dates are adhered to.
- Review the arrangements for dealing with controlled drugs to ensure that they comply with national standards and legislation and that these are implemented and adhered to by staff.
- Ensure that patients' records are appropriately stored in accordance with legislation at all times.
- Ensure that a patient's mental capacity is assessed appropriately and that records are up dated and maintained in accordance with national guidance and recommendations.
- Ensure that the assessment for a do not attempt cardio-pulmonary resuscitation complies with best practice and national guidance, involves the patients or their representatives and that these discussions are recorded, including when discussions have been deemed inappropriate.
- Review the arrangements for internal transfer of patients in the night and ensure that this is kept to a minimum, particularly for frail and elderly patients.
- Review the involvement of staff in trust-wide issues to ensure that staff are fully conversant with the trust vision, strategies and objectives and can contribute to the development of services.
- Review the cancellation of outpatient appointments and take the necessary steps to ensure that issues identified are addressed and cancellations are kept to a minimum.
- Review waiting times in outpatients' clinics and take the necessary steps to ensure that issues identified are addressed.

Action the hospital SHOULD take to improve

- Review the blood testing processes in the A&E department to ensure that they are efficient and timely.

Outstanding practice and areas for improvement

- Review information given to patients on why they are waiting in the A&E department to allay anxieties.
- Review the information following clinical audits and ensure that any actions and learning are shared with staff.
- Review the training available to staff on caring for people living with dementia or with a learning disability and provide training to ensure that staff have the appropriate skills for their role.
- Review staff communication and engagement to ensure that they are aware of the trust strategies and vision, including new initiatives such as the clinical care strategy for end of life care.