AGENDA ITEM 7

# HOSC/47/16

**Committee** Health Overview and Scrutiny

**Date** 27 July 2016

**Report by:** Graham Hughes, Scrutiny Officer

**Colchester Hospital University NHS Foundation Trust (CHUFT) and the North East Essex and Suffolk Sustainability and Transformation Plan**

**Recommended actions:**

(i) To consider the Care Quality Commission report and the issues raised;

(ii) To finalise future approach, level of oversight and scrutiny towards the proposed partnership between CHUFT and Ipswich Hospital, and the development of the local Sustainability and Transformation Plan.

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Background – Colchester Hospital

On 15 July 2016 the Care Quality Commission (CQC) released the latest of a number of highly critical inspection reports on CHUFT based on inspections in early and mid-April. The CQC's overall rating for the Trust remains as Inadequate.

The full 15 July 2016 CQC inspection report was circulated by email to HOSC members on the day of publication. The summary of findings from the main report is reproduced in an Appendix to this report.

On 28 April 2016 it was announced that the Trust would be entering into a partnership with Ipswich Hospital. Subsequently, the Colchester Chairman and Chief Executive left their posts and Colchester Hospital now has shared Chairman and Chief Executive with Ipswich Hospital.

Background – Sustainability and Transformation Plans

Sustainability and Transformation Plans (STPs) are to be established across the country. STPs are five-year local plans that will set out a sustainable approach to addressing the health needs of local populations, and accelerate the implementation of the NHS five year forward view vision of better health, better patient care and improved NHS efficiency.

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To develop and deliver these plans, NHS providers, CCGs, Local Authorities and other health and care services have come together to form 44 local STP "footprints" across the country, taking the following factors into account:

a) Geography (including patient flow, travel links and how people use services);

b) Scale (the ability to generate solutions which will deliver sustainable, transformed health and care which is clinically and financially sound);

c) Fit with footprints of existing change programmes and relationships;

d) The financial sustainability of organisations in an area; and

e) Leadership capacity and capability to support change.

One such STP (or footprint) is Suffolk and North East Essex (900,000 people and 3 CCGs).

Approach

In previous consultation with the HOSC Chairman and Vice Chairmen, the suggested HOSC future approach towards CHUFT has been to look more strategically at their partnership with Ipswich, probably as part of the development of the Sustainability and Transformation Plan (STP) for the north east Essex and Suffolk area.

It is likely that the HOSC will be invited to join Suffolk HOSC to scrutinise the STP proposal for North East Essex and Suffolk.

**Appendix**

## CARE QUALITY COMMISSION – INSPECTION REPORT 15 JULY 2016

SUMMARY OF FINDINGS (pages 2-6 of the report)

The Care Quality Commission (CQC) carried out an unannounced inspection of Colchester General Hospital on the 4th and 5th April 2016. The purpose was to look specifically at safety and caring elements of the surgery, medical care and end of life care services, which were some of the key areas of concern from the September2015 inspection. These areas were reflected in the section 29A warning notice served on the trust on 30th December 2015; the trust was required to have complied with the warning notice by 18th February 2016. This focused inspection was to assess if significant improvements had been made. The areas inspected in April 2016 included a selection of wards/departments that were identified as a concern in the September 2015 inspection, as well as areas where concerns were not identified during the previous inspection but local intelligence suggested that risks may have increased in those areas. This included concerns regarding risks of patients deteriorating without appropriate monitoring or escalation. The local inspection team had also received six complaints specifically regarding end of life care in the previous six months, which was a higher number than would be expected. An inspection of the emergency department was also included due to an increased number of complaints from the public, poor performance on the trust's quality metrics dashboard and an increased rate of serious incidents with four deteriorating patient deaths and five reported misdiagnosis incidents.

The inspection team also undertook a further announced inspection on 13th April 2016. During this inspection they met and interviewed members of the board and trust executive management team. The purpose of this announced inspection was to assess whether improvements had been made to the overall governance systems and processes within the trust. We also needed to assess whether any improvements were sustainable or had been sustained since our previous inspection.

Colchester Hospital University NHS Foundation Trust is comprised of two main hospital sites which are Colchester General Hospital and Essex County Hospital. Essex County Hospital is scheduled to close during 2017 and the only services currently provided on site are outpatient services and ophthalmic eye surgery under local anaesthesia. Colchester General hospital has 560 beds and provides district general hospital care to 370,000 people in North Essex. For this inspection The local inspection team focused on a selection of inpatient wards and the emergency department only.

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Colchester Hospital University NHS Foundation Trust and the Colchester General Hospital location were rated as inadequate at our last inspection in 2015. Following the publication of our inspection report in January 2016 I informed the trust they were required to make significant improvements, or a further decision would be taken with regards to the future of services at the Trust.

I will not be providing a rating to Colchester Hospital University NHS Foundation Trust or Colchester General Hospital for this inspection. The reason for not providing a rating was because this was a very focused inspection carried out to assess whether the trust had made significant improvement to services within the prescribed time frame.

In **medical care** our key findings were:

• The inspection team noted that on the Emergency Assessment Unit the conditions imposed on them on 29 January 2015 were being met.

• The inspection team identified significant concerns regarding the nursing leadership on Peldon ward with concerns raised to us regarding the bullying culture of the ward. Nurses on this ward were treated as either “English” or “Foreign” nurses with staff raising examples of unfair treatment by service leads.

• Patients spoken to on Peldon Ward were aware of the poor culture of the ward and reported to us that they were aware staff could be “sharp at times”.

• Two members of staff formally raised concerns to the inspection team using the whistleblowing policy. One of these concerns was of such a serious nature they were escalated to the director of nursing and medical director for immediate action and support for those involved.

• Poor culture for safeguarding patients were noted on Peldon ward, with practices noted to prevent or limit the movement of people with dementia on the ward who were referred to as ‘wanderers’. The practice involved placing a patient in bed and tilting the head back and feet up to prevent them from getting out of bed. We subsequently raised two safeguarding alerts to the local safeguarding authority following this inspection.

• The inspection team were concerned about the care provided to patients on Peldon ward and requested that the trust take immediate action to ensure that patients were protected from the risk of harm or abuse.

• The culture and levels of staff support in endoscopy had improved. However the disrepair of endoscopy equipment resulted in delays and cancellations to patient care and treatment due to the equipment being out of service.

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• There were observed improvements in how patients on Birch ward were cared for, with more positive staff interactions with patients. However the quality and recording of patient care in the records of patients on Birch ward was identified as a concern.

In **surgery** our key findings were:

• The inspection team noted improvements in previous wards of concern including Aldham ward and the allocated staffing on Mersea Ward. However, due to high rates of sickness this improved level of staffing could not be achieved.

• There was a notable decline in the care and safety of Brightlingsea ward where there was poor record keeping, care planning, medicines management and risk assessment. This ward has been raised as a concern by CQC on previous inspections, and the concerns about the ward's deterioration were raised to the executive team again on this inspection.

• Poor practice with safer surgery checklists was found on the previous inspection in 2015. A review was undertaken to see if improvements had been made. Serious concerns with the completion of the safer surgery checklist were noted. Staff do not routinely complete the 5th step by undertaking a debrief. Staff were observed to have completed post operation checklists prior to procedures commencing. Staff were also not routinely checking anaesthetic machines.

• The audit rates show 100% compliance for previous three months yet several incidents had been recorded where the checklist were not completed.

The inspection team checked the audit data and incident reporting but these did not correlate, therefore the data for the audits was not accurate.

In **end of life care service** our key findings were:

• The inspection team found that awareness amongst the staff regarding end of life care had improved, e-learning training had been provided, though not all staff had completed it.

• Staff were more engaged in end of life care and were responsive to concerns identified by the inspection team. However, there remained a lack of awareness of when to place a patient on the individual care records for last days of life. The inspection team identified three patients during the first day of inspection who were not on the care plan who should have been.

• The inspection team also found that where the individual care record for last days of life was in use, the completion of this record was not consistent.

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• There was a lack of recording of discussions with family and patients. There was a lack of evidence that information was provided about what they might expect which had reportedly caused some anxiety.

• The completion of DNACPR forms had not improved with the many reviewed being completed poorly or incorrectly. Several were seen with reasons for DNACPR given as ‘Dementia’.

• Use of the Mental Capacity Act was poor in relation to end of life care. The majority of staff in the trust, according to the training matrix, have received training in MCA. However, this is not well reflected in the care being provided.

• There was a notable lack of syringe drivers available. Staff were reverting to the use of sub cutaneous ports for use when equipment not available. One patient, who died the day prior to inspection, was reviewed post inspection by the trustwide team following concerns about a potential overdose of

PRN (as prescribed) medication. We raised our continued serious concerns regarding the care for patients at the end of their life, and those nearing the end of their life to the trust executive team.

In the **Emergency Department** our key findings were:

• The inspection team observed that the nursing staff were working more cohesively. However there was a lack of integration with the medical staff.

• In December 2014 we imposed a condition on the trust’s registration to ensure that streaming occurred within the department. The inspection team noted at our inspection in September 2015 that this was working well and appeared to be embedded in the department. However at this inspection we noted that at times of peak activity this process was abandoned. This impacted upon the risk of harm to patients.

• There was a noticeable lack of clinical leadership. Nursing leadership was good and was much improved and they were working to manage risks.

However the doctors were disengaged in the delivery of a safe, effective and responsive service.

• The streaming process did not function effectively due to staff shortages. There was there was no contingency plan in place for the event that there was a shortage of staff.

• The inspection team saw that first assessment of patients was taking up to 50 minutes. However, the 15 minute assessment times were showing at over 95%. This gave rise to concerns that the data provided by the department was not accurate.

• There were many patients in the corridor area near the ambulance bay, and still in ambulances due to the department being full. There was a lack of

clinical oversight in this area from an experienced nurse and a lack of doctors reviewing patients.

• There was a lack of mobile rapid assessment and treatment process (RAT) leading to a lack of escalation/ recognition of the acutely unwell patient.

• The inspection team identified and escalated five patients who were not well. These patients had incorrectly calculated NEWS scores. Two further patients were escalated due to a lack of care, hydration and pain relief.

Our key findings from our **interviews with the executive management team and trust board** were:

• Whilst improvements had been made in some areas, there remained a lack of robust grip and proactive identification of risk.

• There was insufficient pace to address the wide range of significant improvements required.

• There was a lack of action and response by the board on key issues such as A&E performance and safer surgery checks, despite knowing the risks were there and presenting an immediate risk to patient safety.

• The senior team stated that they felt that there had been significant improvement. However, they also acknowledged that the trust in the longer term would not continue to be able to provide services without the support of an external organisation.

Based on the findings of this inspection I authorised that urgent enforcement action be taken against the trust in respect of the emergency department streaming process and patients' being cared for in the corridor area. I also authorised for enforcement action to be taken on the surgery service in respect of ensuring that safer surgery checklists are completed and patients are protected from the immediate risk of harm. The trust has been in special measures for more than two years and subsequently based on the inspection findings I cannot recommend a further extension to special measures.

I have recommended to the secretary of state that a solution needs to be found, and a partnership agreement with Ipswich Hospital NHS Trust is being established. CQC will continue to monitor this trust closely to ensure that patients receive safe, effective, responsive and well led care.

**Professor Sir Mike Richards - Chief Inspector of Hospitals**