Report for Colchester Hospital University NHS Foundation Trust

Review into the Quality of Care & Treatment provided by 14 Hospital Trusts in England

RAPID RESPONSIVE REVIEW REPORT FOR RISK SUMMIT

July 2013

Contents

Introduction

This section of the report provides background to the review process and details of the key stages of the review.

Overview of review process

On 6 February 2013, the Prime Minister asked Professor Sir Bruce Keogh, NHS England Medical Director, to review the quality of the care and treatment being provided by those hospital trusts in England that have been persistent outliers on mortality statistics. The 14 NHS trusts which fall within the scope of this review were selected on the basis that they have been outliers for the last two consecutive years on either the Summary Hospital level Mortality Indicator (SHMI) or the Hospital Standardised Mortality Ratio (HSMR). Definitions of SHMI and HSMR are included at Appendix I.

These two measures are intended to be used in the context of this review as a 'smoke alarm' for identifying potential problems affecting the quality of patient care and treatment at the trusts which warrant further review. It was also intended that these measures should not be reviewed in isolation and no judgements were made at the start of the review about the actual quality of care being provided to patients at the trusts.

Key principles of the review

The review process applied to all 14 NHS trusts was designed to embed the following principles:

1) **Patient and public participation** – these individuals have a key role and worked in partnership with clinicians on the reviewing panel. The panel sought the views of the patients in each of the hospitals and also considered independent feedback from stakeholders, related to the Trust, which had been received through the Keogh review website. These themes have been reflected in the reports.

2) **Listening to the views of staff** – staff were supported to provide frank and honest opinions about the quality of care provided to hospital patients.

3) **Openness and transparency** – all possible information and intelligence relating to the review and individual investigations will be made publicly available.

4) **Cooperation between organisations** – each review was built around strong cooperation between different organisations that make up the health system, placing the interest of patients first at all times.

Terms of reference of the review

The review process was designed by a team of clinicians and other key stakeholders identified by NHS England, based on the NHS National Quality Board which provides guidance on rapid responsive reviews and risk summits. The process was designed to:

- Determine whether there are any sustained failings in the quality of care and treatment being provided to patients at these Trusts.

- Identify:
    - Whether existing action by these Trusts to improve quality is adequate and whether any additional steps should be taken.
    - Any additional external support that should be made available to these Trusts to help them improve.
    - Any areas that may require regulatory action in order to protect patients.

The review follows a three stage process:

- **Stage 1** – **Information gathering and analysis**

This stage used information and data held across the NHS and other public bodies to prepare analysis in relation to clinical quality and outcomes as well as patient and staff views and feedback. The indicators for each trust were compared to appropriate benchmarks to identify any outliers for further investigation in the rapid responsive review stage as Key Lines of Enquiry (KLOEs). The data pack for each trust reviewed is published at http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/trust-data-packs/data-pack-Colchester.pdf.

- **Stage 2 – Rapid Responsive Review (RRR)**

A team of experienced clinicians, patients, managers and regulators (see Appendix II for panel composition), following training, visited each of the 14 hospitals and observed the hospital in action. This involved walking the wards and interviewing patients, trainees, staff and the senior executive team. The report from this stage will be considered at the risk summit.

- **Stage 3** – **Risk summit**

This will bring together a separate group of experts from across health organisations, including the regulatory bodies. They will consider the report from the RRR, alongside other hard and soft intelligence, in order to make judgements about the quality of care being provided and agree any necessary actions, including offers of support to the hospitals concerned. A report following each risk summit will be made publically available.

Methods of Investigation

The two day announced RRR visit took place on Tuesday 4 and Wednesday 5 June 2013. A variety of review methods were used to investigate the KLOEs and enable the panel to consider evidence from multiple sources in making their judgements.

The visit included the following methods of investigation:

- **Listening events**

Public listening events give the public an opportunity to share their personal experiences with the hospital and to voice their opinion on what they feel works well or needs improving at the Trust. Two listening events for the public and patients were held on the evening of 4 June 2013 at the Colchester Hospital site and another at Princes Theatre, Clacton. This was an open event, publicised locally, and attended by approximately 35 (Colchester Hospital) and 15 (Princes Theatre) members of the public, patients and staff.

The panel would like to thank all those who attended the listening event and were open with the sharing of their experiences and balanced in their perceptions of the quality of care and treatment at the Trust. The panel found the listening event extremely useful as it identified a number of positive themes around patient experiences, along with highlighting a number of areas for further investigation.

Information obtained about the quality of care and treatment at the Trust from the listening event was used to drive the panel's agenda for the second day of the announced site visit and for the unannounced site visit. Relevant areas emerging have been included within this report.

- **Interviews**

18 interviews took place with key members of the executive team, non executive directors and selected members of staff based on the KLOEs during the visits. See Appendix III for details of the interviews undertaken.

- **Observations**

Ward observations enabled the panel to see the Trust undergo its day to day operations. They allowed the panel to talk to current patients and their families, where observations took place during visiting hours. They allowed the panel to speak with a range of staff and enabled the panel to analyse observed handover processes within wards, to ensure that the staff that are coming on duty are appropriately briefed on patients.

During the RRR announced visit, observations took place in 17 areas of Colchester Hospital. See Appendix IV for details of the observations undertaken.

- **Focus Groups**

Focus groups provide an opportunity to talk to staff groups individually, and to ask each area of staff what they feel is the contributing factor to the Trust's high mortality scores. They enable staff to speak up if they feel there is a barrier that is preventing them from providing quality care to patients.

Focus groups were held with seven prearranged staff groups. Two drop-in sessions open to all staff were also held during the announced site visit. See Appendix V for details of the focus groups held.

The panel would like to thank all those staff who attended the focus groups. They were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the Trust.

- **Review of documentation**

A number of documents were provided to the panellists. Whilst not all the documents were reviewed in detail, they were available to the panellists to validate findings. See Appendix VI for details of the documents available to the panel.

- **Unannounced visit**

The unannounced site visit took place on the evening of Tuesday 11 June 2013 from 19.00 – 22.30. This focused observations in a number of areas that had been identified as a result of the announced site visit, see Appendix VII.

Next steps

This report has been produced by Liz Redfern, Panel Chair with the full support and input of panel members. It has been shared with the Trust for a factual accuracy check. This report was issued to attendees at the risk summit, which focussed on supporting Colchester Hospital University NHS Foundation Trust ("the Trust") in addressing the actions identified to improve the quality of care and treatment.

Following the risk summit the agreed action plan will be published alongside this report on the Keogh review website. A report summarising the findings and actions arising from the 14 investigations will also be published 16 July 2013.

Background to the Trust

This section of the report provides background information on the Trust.

Introduction

The Trust became a Foundation Trust in 2008 and has a total of 644 beds. The Trust owns two hospital sites (Colchester General Hospital and Essex County Hospital) and provides outreach services in three community hospitals (Clacton, Harwich, and Halstead). These community hospital sites are owned and run by the local community providers. The Trust is a medium sized trust for inpatient activity, relative to the rest of England. However, the Trust is in the upper quartile nationally for outpatient activity. General Surgery and Clinical Oncology are the largest inpatient specialties while Allied Health Professional Episodes and Nursing Episodes are the largest for outpatients.

Essex, in which Colchester is situated, is not a particularly deprived region of England. The age distribution in Colchester is largely similar to that of England as a whole, where there are significantly more women and men in their 20s. 8% of Colchester's population belong to non-White minorities, particularly Chinese and other Asians. Smoking during pregnancy is a particular health concern in Colchester and statutory homelessness is also much more common than in England as a whole. Disease and poor health indicators highlight acute sexually transmitted infections as being above the national average.

The district of Tendring in Essex is classed as a slightly deprived local authority of England. The population of Tendring is old compared to the population of England as a whole and has a significantly larger proportion of people aged 60 and above. 2.5% of Tendring's population belongs to non-White ethnic minorities, with the largest minority of 0.4% being White and Black Caribbean. Lack of adult physical activity is a particular health concern in Tendring, where education levels are also relatively low compared to England as a whole. The number of people diagnosed with diabetes is above the national average. Tendering has a higher number of obese children and smoking during pregnancy is a particular health concern. The Trust's SHMI level has been above the expected level for the last two years and was therefore selected for this review.

Key messages from the data analysis

The Trust data pack identified a number of key concerns that were used to inform the KLOEs, which are outlined below[1]

Mortality

The Trust has a SHMI level for the period December 2011 to November 2012 of 118, meaning that the number of actual deaths is higher than the expected level. Non-elective admissions are seen to be contributing primarily to the overall Trust SHMI. Specialty-level analysis of SHMI results highlight some key diagnostic groups within General Medicine for review, including: Pneumonia, Urinary tract infections and Acute cerebrovascular disease (stroke). The Trust's HSMR was within the expected range for the same period.

The KLOEs for the RRR targeted the panel's observations and interviews to review the identified specialities in the Trust with higher mortality indicators.

Governance and leadership

The Trust Board is comprised of primarily substantive appointees (except the Director of Nursing and the Director of Human Resources), and has been relatively stable for the past two years. The Chair took up position in July 2010 following removal of the previous Chair in 2009 as a result of Monitor intervention. This related to concerns that the Trust was failing to demonstrate enough progress and sustained improvement across a number of performance areas, reflecting failures in governance. The present Chief

[1] For further information and explanations on the data analysis used please see the published data packs please at http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/trust-data-packs/colchester-data-packs-PUBLISH.pdf

Executive was appointed by the new Chair, Sally Irvine in August 2010 following the retirement of the previous Chief Executive in summer 2010 (the current CEO had been a non-executive director at the Trust for four months prior to his appointment).

Key risks identified by the Trust in the data pack relate to mortality (in particular, mortality in babies just before or after birth), end of life provision across the community, serious incidents in obstetrics, surgical site infections, learning from experience, staffing levels and the emergency assessment unit.

A high level review of the effectiveness of the Trust's quality governance arrangements was a standard KLOE for the review.

Clinical and operating effectiveness

The Trust sees 96.6% of A&E patients within 4 hours which is above the 95% target level. The percentage of patients seen within 4 hours was relatively consistent during 2012. 93.8% of patients start treatment within the 18 week target time which is above the target level. This has been a consistent trend from April 2012 to March 2013. The Trust's crude readmission rate is lower than the national average, at 10.9%. Similarly, their standardised readmission rate shows a level of performance that is statistically below what is expected. The Trust's average length of stay is shorter than that of the national average. All of these measures indicated that the Trust is relatively efficient in its operations and raises no specific risks to investigate in the review.

The Patient Reported Outcome Measures (PROMs) dashboard shows that the Trust was an average performer overall. None of the indicators fell outside the control limits for the three years shown in the dashboard.

High level reviews of clinical and operating effectiveness measures were standard KLOEs.

Patient experience

The Trust scores reasonably well on patient surveys, with some concerns about consistency of information provided by staff, the quality of hospital food, information provided on post-discharge danger signals, and waiting times. The Trust's performance in relation to the Friends & Family Test is consistently in the upper quartile in the Midlands & East.

The Ombudsman rates the Trust as C-rated which indicates high risk of non-compliance with their recommendations. The Ombudsman investigates complaints escalated to it by complainants who are not satisfied with the Trust's response. It rates Trusts on whether they have implemented the recommendations made at the end of an investigation in a satisfactorily and timely manner, helping to ensure that Trusts learn from mistakes. The Ombudsman rates each Trust's compliance with recommendations and focuses on monitoring organisations whose compliance history indicates that they present a risk of non-compliance.

KLOEs were included in the review focusing on what patients say about the quality of care and treatment and what the Trust was doing in response to this feedback.

Workforce and safety

The Trust has reported fewer patient safety incidents than similar trusts recorded. The Trust reported 158 incidents between April 2011 and March 2012. Since 2009, two 'never events' have occurred at the Trust, classified as that because they are incidents that are so serious they should never happen.

The Trust's overall sickness rate is below the national and regional average. However, sickness rates for medical staff are above the national mean rate. The Trust spends more on agency staff than the median within the region. The Trust has relatively good staff turnover with a joining rate double the national average whilst the leaving rate is below the national average.

KLOEs were included in the review focusing on workforce and safety measures and staff views about the quality of care and treatment.

Key Lines of Enquiry

The Key Lines of Enquiry (KLOEs) were drafted using the following key inputs:

- The Trust data pack produced at Stage 1 and made publicly available to tailor the KLOEs to address any areas the Trust was an outlier in.
- Insights from the Trust's lead Clinical Commissioning Group (CCG), North East Essex CCG.
- Review of the patient voice feedback received via the Keogh review website, specific to the Trust and prior to the site visit.

These were agreed by the panellists at the panel briefing session prior to the RRR visit.

The KLOEs identified for the Trust were as follows:

Theme	Key Line of Enquiry
Governance and leadership	1. Can Trust staff clearly articulate the governance process for escalation of issues, risks and assurance over quality of care?
	2. How does the Trust use quality and performance information to support good governance?
Clinical and operational effectiveness	3. What governance arrangements does the Trust have to monitor and address clinical and operational performance data?
	4. What does the Trust do to develop and strengthen clinical engagement and leadership?
Patient experience	5. How does the Trust engage with patients and ensure it learns from complaints, compliments, survey results and other patient experience intelligence?
Workforce and safety	6. How does the Trust engage with its workforce and other stakeholders?
	7. How is the Trust assured that it has the necessary workforce deployed to deliver safe care?
	8. What assurance does the Trust have that the organisation is safe?
	9. How does the Trust support staff development?

Review findings

Introduction

The following section provides a detailed analysis of the Panel's findings and prioritisation of recommendations based on the evidence received in the Trust data pack, interviews, observation visits, staff focus groups and patient listening events. There are six key areas that the Trust should focus on to improve patient safety and these are summarised below. The findings and supporting evidence to underpin the key messages is contained in more detail in the following tables.

Key Messages

1. The Trust needs to rapidly update its quality strategy

The Trust will need to consider how it develops a clearer focus on quality improvement rapidly which is based on transparent performance information and a tone from the top. The Trust has a quality strategy, but it is out of date. The Medical Director told the panel that a new strategy was being worked on but still some way from completion, being partially delayed by the review.

The Trust needs to develop a comprehensive and clear quality strategy and ensure it is consistently applied throughout the organisation, so that staff can articulate the main priorities. The strategy should pull together the numerous actions underway at the Trust relating to quality improvement and mortality, and focus on priority areas identified in this review such sepsis, managing deteriorating patients and surgical site infections. An integrated action plan should be put in place and supporting performance information developed to provide assurance to the Board that quality improvements are being made.

2. The Trust needs to move rapidly to fully implement stated aspiration to be a clinically led organisation

The next stage of organisational development, since the appointment of the Chief Executive in 2010, is a stated aspiration to become a clinically led organisation. There has been organic progress in working towards this and now it needs a clear strategy and implementation plan that:

- Is unambiguous about the roles and accountabilities of the Board and especially the Nursing and Medical Director for patient safety, experience and outcomes;
- Gives clear accountability to the four clinical directors for the delivery of all aspects of their directorates;
- Supports the clinical leaders with the necessary personal development to undertake these new roles and allows them to define priorities and plans for delivery;
- Provides them with the right information and resource at directorate level to be successful in delivering a safe service with a high quality patient experience and patient outcomes;
- Provides them with an appropriate resource to support any necessary improvements.

3. Introduce regular staffing and skill mix reviews that are reported to the Board to ensure safe care against a changing patient acuity case load

The panel heard a number of examples where additional permanent nursing staff were being recruited or had already arrived in order to increase the number of registered nurses in some areas following a skill mix review. It was not possible during the visit to get all the detailed information on this and to understand the overall increased investment that had been approved by the Board. However the panel would strongly encourage that a staffing and skill mix review becomes a regular process, probably twice a year, to ensure staff remain in the right place with the right skills to ensure a high quality service is delivered. A medical staffing review should also take place to ensure that everything is being done to reduce the use of locum medical staff.

4. Continue to build on good staff relationships to enable them to maintain their confidence, understand the overall Trust clinical strategy and to continue to adopt and spread good practice

We met a large number of committed and enthusiastic staff who were keen to give their best for patients. We heard on numerous occasions from many sources how the announcement of the review had severely knocked the confidence of the staff. The panel was impressed by the staff they met and would want this review report and the recommendations it holds to enable continuous improvement for them as individuals to benefit the quality of care for patients.

There were a number of areas where the staff felt they were not being listened to by their managers and that there was an apparent lack of response to escalated patient safety concerns. Important areas identified by the panel included the process for managing deteriorating patients and radiology escorts, which staff identified as needing urgent action but had not seen this addressed. Further improvements in the amount of meaningful staff appraisal rates and finding a way to rapidly feed back to staff how their concerns have been heard and addressed should be a priority.

5. Continue to develop the process for handing complaints

The Trust should continue to develop the process for handling complaints by working with patients and staff. Many of the patient stories we heard had common threads about the poor handling of the complaints process, which the Trust have been acting to improve. Some of the stories were historical in nature, but not all. There have been changes to the complaints process and ownership for complaints is now with the clinical divisions. This needs to be further reviewed in the light of patient feedback.

6. Continue to work with local partners to find solutions for patients who could appropriately be dying in their normal place of residence

The panel heard that the Trust has identified that a high proportion of deaths occur in patients admitted at the end of their life. We heard from Trust managers that there is a complex system, with limited joined up working. The Trust has been working with partner organisations including the CCG and has developed a Joint Mortality Action Plan in the summer of 2012 which includes End of Life provision. All partners need to progress at pace.

The following definitions are used for the rating of recommendations in this review:

Rating	Definition
Urgent	The Trust should take immediate action to respond to these recommendations and ensure improvement in the quality of care
High	The Trust should develop a response and action plan for these recommendations to ensure improvement in the quality of care
Medium	The Trust should implement these recommendations to ensure ongoing improvement in the quality of care

Governance and leadership

Overview

The review into governance and leadership focused on the articulation and understanding of the governance processes for assuring the quality of treatment of care at all levels of the organisation. Through staff interviews, focus groups and review of governance documentation, the panel tested whether staff at all levels could describe the key elements of the quality governance processes, i.e. policies and procedures, escalation, incident reporting and risk management.

References to the Executive Team in the sections below refer to interviews held with the Chief Executive, Acting Director of Nursing, Directors of Operations and Medical Director.

The following good practice was identified:

- During interviews the Trust Chief Executive noted that the previous governance processes had not been fit for purpose and that changes were required. Work has been undertaken over the last three years to restructure the organisation including the identification of a clinical lead for each of the divisions since 2011.
- Recognition by the Trust that it needs to improve quality of care and treatment.
- The visibility and positive impact of the Chief Executive with staff.
- A good working relationship between the Chief Executive and the Chair of the Board.
- Examples were provided that demonstrated the use of performance information to improve the quality of patient care at ward level.
- A good working relationship between the Trust and the CCG.

The following areas of concern were identified:

- A clear focus on quality with associated clinical accountability, which is still being developed.
- There is lack of clear prioritisation and integration of actions in response to improvement plans from external reviews.
- There is a lack of clarity of the governance arrangements over quality.
- There is a gap between ward level and Board level in terms of understanding the quality governance arrangements and listening to staff concerns and an effective feedback loop to them about action.
- Performance reporting to the Board and Executive Team did not focus on quality indicators in sufficient depth to allow the Board to scrutinise fully the Trust's performance.
- The absence of a senior nurse post within the governance structure at divisional level.

For all the above areas of concern the panel identified a number of improvements already underway at the Trust or planned improvements demonstrating the Trust's continued progress and improvement. Many of these are in the process of implementation and therefore are not yet embedded.

Detailed Findings

KLOE 1: Can Trust staff clearly articulate the governance process for escalation of issues and risks and assurance over quality of care?

Good practice identified
During interviews the Trust Chief Executive noted that the previous governance processes had not been fit for purpose and that changes were required. Work has been undertaken over the last three years to restructure the organisation including the identification of a clinical lead for each of the divisions since 2011.
Throughout the visit during focus groups, one to one interviews and ward observations, the staff throughout the Trust noted the visibility and positive impact of the Chief Executive.
The panel observed a good working relationship between the Chair and the Chief Executive.
Patients, staff and the Trust Board consistently spoke of a changing culture at the Trust, albeit slowly, to one of improvement and forward planning. The Trust recognises the significant amount of work still to be done.
The Trust Board is made up of primarily substantive appointments and has been relatively stable for the past two years.

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
Quality focus still being developed It was clear from our interviews with the Chief Executive, Medical Director, the Acting Director of Nursing and Chair that they recognised the need for a quality and safety focus to be further developed at the Trust. We noted the following issues: • The current Chair and Chief Executive inherited an organisation with significant challenges. The Panel heard that historically the Trust had challenging external relationships with local commissioners and low staff morale reflected in below average staff survey results. • The current executive team and Board have developed the new clinically led divisional structure over the last three years, however there is still work to do to embed the governance and accountability	The Chair and Chief Executive recognised the need to further decentralise and embed the quality assurance process throughout the Trust. Work in relation to the quality planning, although commenced, has not progressed at the desired pace. This has partially been delayed due to the work required to prepare for the Keogh review.	The Trust will need to consider how it develops a clearer focus on quality, based on transparent information and a tone from the top. This should include implementation of the planned improvements and recommended actions in this report. The Trust must increase the pace of planned change in order to develop a safe and mature organisation that provides high quality patient care. The Trust needs to develop a	Urgent Urgent Urgent

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
arrangements for quality governance within the new structure. • The Acting Director of Nursing and Medical Director could not clearly articulate the quality strategy and how it is consistently applied throughout the organisation. • The panel reviewed a Quality strategy for 2010-2012. This was extended to early 2013 without revision and is therefore currently out of date, for example it does not respond to the Francis report findings. The Medical Director confirmed a new strategy was being worked on but still some way from completion, being partially delayed by the review. • Staff at all levels including the Acting Director of Nursing, were unable to clearly articulate the key quality priorities for the Trust. • During the interview with the Medical Director, the panel understood the Quality Hub was an initiative intended to be both a resource centre to promote the development of quality themes in the Trust. It is also a mechanism for performance managing the implementation of quality related programmes. The Acting Director of Nursing, who is responsible for the Hub, recognised that the programme has only managed limited progress in the first year in terms of engagement or outputs. The panel considered this needed further review to ensure it has the desired impact.		comprehensive and clear quality strategy and ensure it is consistently applied throughout the organisation. This must include areas of priority with defined action plans in place. The role of the Quality Hub needs to be reviewed.	High
Clinical leadership structure The Trust needs to review its organisation structure to empower clinical leadership more effectively and clarify accountability for quality. This includes clarifying executive responsibility and reporting lines to address the following issues. The panel heard from numerous interviews, observations and focus groups concerns regarding the lack of nurse representation at a divisional level. There is no senior nurse leadership other than the Acting Director of Nursing and Matrons on the wards. The panel considered that this lack of the 'nurse voice' at a senior level contributed to the issues with two way communication between ward level and Executive level that was	The non-executive directors and governors spoke positively of the improvement in relationships between Trust management and the Board and more joined up working since 2010. The Chair confirmed that a more direct relationship between the clinical divisions and the Board is needed.	The Trust should review the management structure in place to ensure it is robust enough to support consistent leadership and management at divisional level. The management structure should be reviewed to show a single reporting line for both of the Divisional Managers reporting into the Divisional Directors. The Trust should review the organisational structure and consider the benefits of including a nursing representation at a senior level to ensure that there is clinical	Urgent High

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
reported during interviews and observations. During interviews with the Clinical Directors, the panel noted that the management structure is not consistent with the structure publicised on the Trust's website. The panel was concerned that divisional clinical directors were reporting to the Medical Director and the Chief Executive whilst the Associate Directors report to the Director of Operations, which may lead to an inconsistent approach for performance management and governance arrangements. The panel considered that there was also a risk of the two leaders of each division having conflicting directions and priorities and unclear ownership of quality.		leadership and accountability for patient safety throughout the Trust. The Trust should review the reporting lines for the clinical and associate directors and consider whether the current arrangements allow the Executive team to achieve a joined up approach to performance management.	Medium
Committee Structure and Reporting During interviews with the Executive team, the panel noted that there was confusion over the Trust's committee structure and where accountability for patient safety sits. For example, it was unclear from talking to the Non-Executive Directors who chairs the committees, how the Quality and Patient Safety Committee communicates with the Audit and Risk Committee. The Chair confirmed that the current committee structure relies on individual Chairs to communicate with each other committees rather than using a systematic approach to reporting.	The Trust recognised that this is an issue and that a systematic approach to reporting should be developed.	The Trust should review the committee structure to ensure to ensure there are clear lines of reporting and accountability for patient safety.	High
Communication between ward level and Board level – escalation of issues and risks The panel considered that the processes for escalation of issues and feedback of outcomes to ward level which were articulated by the Board members were not consistently understood by the ward level staff interviewed. The panel noted that whilst staff could articulate well the processes in	At the next Board meeting a detailed plan for staff engagement is scheduled to be discussed.	The Trust should ensure that there are robust governance mechanisms embedded within the divisional structure that allow front line staff to escalate risks and concerns in relation to quality of patient care in a consistent manner. The Trust Board should ensure that there	High High

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
place at ward level, there was a lack of understanding of the governance processes in place to escalate and learn from issues and risks above Matron level. In particular, there were limited examples of learning from Datex and staff could not articulate how learning is used across the Trust in a systematic and consistent manner. Frontline staff consistently reported not being aware of the outcomes of clinical audits that had taken place. Frontline staff were consistent in stating that the Chief Executive was approachable and visible and they felt he was making a difference. A number of staff interviewed spoke positively of being able to escalate risks and issues to the Chief Executive although comments were made that this was seen as an open door to more senior staff rather than all staff. Frontline staff were unclear about the strategy for improving quality at ward level. Staff spoke of concerns with individual issues for example, the quality of medical appraisals and handovers, however could not articulate a clear and credible approach to the improvement of quality. Feedback to the panel from focus groups reported that the Quality Hub had a low profile at the Trust and there was no clear policy or strategy in place for its use. Those staff the panel asked about the Quality Hub knew of its name but could not describe what it was, how it was accessed and stated that it was under development. The Acting Director of Nursing, recognised that the Quality Hub programme has managed limited progress in the first year in terms of engagement or outputs but the Trust hope to develop a clear strategy on how to take it to the level required.		is a systematic approach in place for the collection, reporting and acting upon information on the quality of services. This review should include patient and clinician insights and should ensure that the processes include feedback and engagement of staff in learning and service improvement. The Trust Board and management, wider than the Chief Executive, should consider how it can strengthen their visibility, accessibility and listening mechanisms with frontline staff. This could include visiting areas of the hospital, including at night and during weekends, to understand the current position and any concerns and should include feedback to the wards on observations. The Trust should review the role of the Quality Hub to ensure that it is fit for purpose and is focussed on outcomes in addition to process review and supports planned improvements. The Trust should consider how information produced by the Quality Hub can be used by staff throughout the organisation.	Medium High

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
The role of the governors The panel noted during interviews that governors do not attend Board committees but they do have a mechanism of assurance through regular scheduled meetings with Board subcommittee chairs and lead executives whereby they report their findings to the Council of Governors. It was recognised that the Governors had decided to work in this way for a particular reason as a stage in their development, however we also understood from the Chair that this was likely to be reviewed and the panel would urge this to happen soon. The panel considered that Governors should be more active in their role of holding the Board to account on all aspects of quality.	None noted	The Trust should consider attendance of the governors at Board committees so they can undertake their role more effectively.	Medium

KLOE 2: How does the Trust use quality and performance information to support good governance?

Good practice identified
Monitor finance rating level 4. Amended in November 2012 from level three to four due to an improvement in the Trust's financial position.
The panel noted examples of the use of quality and performance information at ward level to improve the quality of patient care. Specific examples include • The use of patient safety crosses to visually show compliance with key initiatives for example, falls, WHO checklist. • Following an external review compliance with fluid charts/balance improved from 60% to 90% over a four month period.
The panel heard that the Trust had previously had a challenging relationship with commissioners but has developed a positive working relationship with the CCG, driven by the Chief Executive. This was confirmed by the CCG.

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
Absence of clear prioritisation and pace of change The Chief Executive has commissioned a number of external reviews to gain an in-depth understanding of the issues at the Trust. Recent reviews include ECIST review of emergency and urgent care provision, Dr Foster Group to reconcile the variances between HSMR and SHMI and Health Protection Agency to support on surgical site infection. Members of staff in focus groups spoke of the Trust being a reactive organisation rather than a proactive one when dealing with issues and concerns. An example provided was lack of development of a medical devices policy, despite an external review recommending this three years ago. The panel considered that the governance arrangements for ensuring that action plans in response to external reports were implemented in a timely basis were not clear. A number of staff members talked of the number of reviews that the Trust has undergone in recent years. Staff members spoke of the impact of external reviews on staff morale and a lack of involvement in the outcomes. Staff expressed concern that they did not know whether initiatives had been completed. Reporting of serious incidents and dissemination of lessons learned are included in KLOE 8. Whilst the Executive team interviewed referred us to a number of action plans in place, we observed an absence of prioritisation of the actions. The panel considered that the lack of clinical strategy referred to in KLOE 1 meant that the Trust had not yet embedded a real structure for planning the way ahead.	The Chief Executive and Chair recognised that the Trust has improved governance and assurance processes for quality over the past three years but there is further work to do to embed the quality processes throughout the Trust. Work in relation to the quality strategy, although commenced, has not progressed at the desired pace, this has partially been delayed due to the work required to prepare for the Keogh review.	Following the update of the quality strategy, the Board should approve a single, prioritised action plan for the Trust showing clearly the priorities by time period, e.g. for the next six months, six months to a year and so on. This should be clearly communicated to staff and progress against the plan monitored.	Urgent

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
Performance reporting The Panel reviewed the performance reports received by the Board and observed that there was a high volume of operational data reported. However, there was a lack of quality reporting in sufficient depth to allow the Board to fully scrutinise Trust performance. The non-executive directors when interviewed noted that they receive too great a volume of information. They noted that the information was not clear enough for them to drive change quickly enough. The non-executive directors were clear that they were working to improve this but were not clear precisely how this would happen. They noted that they are making progress in understanding how the data can be used and that data staff are available to support them. This CCG reported to the panel that on more than one occasion there have been delays in 45 day quality reporting. The CCG also reported that the lack of detailed quality reporting on key priorities to the Board contributed to the CCG raising contract queries relating to complaints and reporting of serious untoward incidents.	None noted	The Trust should review the information received by the Board and the Executive committees to ensure that members receive the correct information at a sufficient level of depth to scrutinise and challenge performance.	High
Ward level performance reporting The panel observed that many wards were using notice boards to be open and transparent about performance information, for example through the use of safety crosses for falls and complaints. The panel observed the use of audit information on Juno Suite to illustrate the frequency of checks on the resuscitation equipment, however where performance was below expectation it was not clear what action was being taken to improve performance.	None noted	The ward level information published on notice boards should be displayed in a consistent and standardised way and include steps taken to improve where performance is below expectation.	Medium

Clinical and operational effectiveness

Overview

The two KLOEs in the clinical and operational effectiveness area focused on the following:

- The governance arrangements in place to monitor and address clinical and operational performance data
- Strengthening clinical leadership

The following good practice was identified:

- Good levels of compliance with national targets such as four hour waits and 18 weeks referral to treatment times
- Good participation and challenge at Executive Mortality Review Meeting
- Examples of performance improvement on individual wards

The following areas of concern were identified:

- Issues with the escalation of deteriorating patients
- Bed management and patient flow in accident emergency and EAU
- Issues with the provision of end of life care across the health economy
- Issues addressing surgical site infection rates
- Communication between front line staff and management and perceived effectiveness of the management team
- Lack of clear tracking of actions at EMRM meetings

For the majority of the areas of concern, above, we identified a number of improvements planned or already underway at the Trust evidencing continued progress.

Detailed Findings

KLOE 3: What governance arrangements does the Trust have to monitor and address clinical and operational performance data?

Good practice identified
Good performance was noted on key operational performance targets, as described in the background section of this report
The panel attended the executive mortality review group and observed that there was good MDT and Executive team attendance with high levels of participation and challenge

Good practice identified
The panel observed on Lexdon ward evidence of changes in practice following a peri-natal mortality review through the use of CTG indication checking stickers
Nursing staff spoke positively about the reenablement service at the Trust. Changes have been made linking a social worker to the ward who is available seven days a week until 11pm with a two hour response time. Nursing staff felt they had seen an improvements in patient flow since the changes had been made
Nursing staff spoke positively about the patient care co-ordinators in EAU who worked with clinical colleagues to assess individuals patient needs and ensure they received good quality care, for example linking with the wards to communicate any specific patient needs.
The panel noted examples of good practice in response to mortality data in the stroke unit. They have investigated mortality through performance reviews. Dr Foster alerts were investigated last year. From audit data the ward recognised there was a high rate of aspiration pneumonia and now they have specific machinery to help work around this problem area.

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
Deteriorating patients During interviews, nursing staff spoke of concerns that deteriorating patients were not escalated correctly. During the drop in session, a consultant expressed a lack of confidence in recognising and escalating deteriorating patients if symptoms change through the night. The Executive team confirmed that there is a 24/7 nurse led outreach team in place, however nursing staff reported that the team was small and patients were not always escalated to the outreach team. There were numerous reports from wards that patients were transferred from EAU with Patient At Risk (PAR) scores completed but patients had not been escalated. Nursing staff and junior doctors reported a lack of support from senior	The Executive team confirmed that they are aware of the issues surrounding escalation of the deteriorating patients however further work is needed to understand the causes. The Trust had commenced a programme to revise the escalation processes and move to the use of the National Early Warning Score (NEWS) to improve consistency of escalation procedures across the organisation including a staff training programme. This is expected to be implemented by December 2013.	The Executive team should engage with clinical leadership and frontline staff including nurses and junior doctors to understand the reasons for the inconsistent escalation of deteriorating patients. Immediate action should be taken to address the issues identified relating to deteriorating patients. A clear action plan should be developed which should be monitored regularly by the Board in order to seek assurance that the issues are being addressed.	Urgent

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
doctors during out of hours working to enable them to escalate deteriorating patients. During observations of EAU the panel noted that templates used for documentation in patient notes was incomplete in a number of cases. PAR scores were completed but it was not clear from documentation the meaning of the score and action required. The patient board in triage used magnets to indicate a patient with a high PAR score however there was no indication of the score itself. The panel considered that the incomplete documentation and the template used to document PAR scores increased the risk of failure to escalate the deteriorating patient.		The use of National Early Warning Score (NEWS) is being implemented and should be expedited with a clear training programme for staff, a policy in relation to EWS and escalation and regular audit of the tool and triggers	
End of life provision across the health community The panel were told during an interview with Trust management and nursing staff on wards that there is a lack of joined up working with GPs for patients discharged from the Trust requiring end of life planning in the community, in particular relating to oncology patients and respiratory patients. It was reported to the panel that there is no advanced end of life care planning in nursing homes. This was raised as the main driver for the Trust's high mortality indicators. The CCG confirmed that discussions with the Trust have begun, however the leads raised that there were difficulties in engaging with the consultant group regarding service redesign.	Working with the CCG and other providers the Trust has developed a Joint Mortality Action Plan which includes care pathways for End of Life Care.	The Trust should continue to work with the CCG and community health providers to develop care pathways for end of life care. A strategy should be developed through joint engagement with the CCG to review wider health system engagement to make better use of hospital beds including using out of hospital care, preventative strategies and community care and to improve end of life provision for patients.	High

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
Surgical Site Infections The Executive team confirmed that the incidence of surgical site infections are an ongoing issue and that current responses are not satisfactory. During observations and interviews the panel noted incomplete documentation of surgical checklists. Nursing staff spoke of incomplete documentation completed on transfer from EAU and inconsistencies in working practices between consultants which made it difficult to provide consistently high quality care to patients. The panel observed the use of cefuroxime and metronidazole as routine use of antibiotic prophylaxis in theatres (avoidance of cephalosporins is recommended to reduce the incidence of c. difficile diarrhoea).	The Trust is working with the clinical teams to develop an improvement plan and has set up a surveillance group to provide assurance on progress against the plan to deliver the improvements.	The Trust should continue to meet with the consultant body to monitor the plans to reduce the rates of surgical site infection. The Trust should continue to monitor the use of surgical safety checklists to ensure that they are filled in correctly and consistently by all consultants and their teams across all the Trust settings where this is required. The Trust should review the use of prophylactic antibiotics by surgical teams.	High
Sepsis Several members of staff spoke of a delay of several years in the roll out of sepsis management care bundles across the Trust. A sepsis screening tool, which won national awards has been developed by the outreach nurses but is not embedded or supported by the Trust. Interviews with nursing staff on surgical wards raised concerns that wound care management is handed over between nursing shifts without being completed. During observations at EAU the panel noted that there was confusion amongst nursing staff regarding the sepsis bundle and that although a policy exists, staff were not able to access it quickly.	The Trust will continue to review prophylactic antibiotics by surgical teams.	The Trust should ensure that management of sepsis using a care bundle approach is embedded throughout the Trust and regularly reviewed to make sure it is consistent.	High

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
Escalation Procedures Nursing staff and junior doctors spoke at focus groups of concerns relating to escalation management. Procedures are clearly defined and risk assessments have been performed, however staff reported a lack of leadership for escalation management. At times staff felt unable to escalate concerns or request consultations because they feel that they cannot ask more senior staff for support. The escalation procedures in place are not consistently used across the Trust. Concerns were raised around lack of action following escalation of issues such as insufficient staffing levels and staff working outside their competency area, some of whom had not worked in an active nursing role for over 12 months. A member of staff spoke of an example where resuscitation equipment had not been available on an escalation ward to treat a patient with an elevated PAR score. Following interviews with the Director of Operations, Medical Director and Acting Director of Nursing, the panel considered that there was a lack of ownership at a senior level for the risks that had arisen during this period.	None noted	The Trust should consult with front line staff to understand why the policy for escalation is not being used consistently and why where staff have previously raised concerns no action has been taken in response. The Trust should review their plans and protocols and then ensure they are followed when there is a need to open additional beds at times of increased activity. These plans should include forward planning for staffing the ward as well as equipping it. The Executive team should clearly understand the lines of accountability for the quality of care on escalation wards and ensure the governance structure and reporting of risks are appropriately managed. The escalation plan should be audited for compliance with review at Board level.	High
Patient flow and management between A&E and EAU Throughout our visit the panel heard from numerous staff who spoke of poor bed management and flows at peak times of activity including the following:	The Trust has plans in place to redesign A&E with a rebuild at a later date.	The Trust should improve bed flows and patient management through: • Reviewing systems to enable	High

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
• Transition from A&E to EAU during periods of high activity can be problematic due to difficulty in moving patients from EAU to wards. Staff on EAU at the unannounced visits reported that patients can sometimes be in EAU for several days. • A number of reports from surgical admissions of patients being transferred from A&E and EAU with PAR scores completed identifying deteriorating patients but escalation had not occurred. • Reports from nursing staff of inappropriate transfer of patients from A&E to EAU to meet the 4 hour A&E target when patient not medically suitable for transfer to EAU. The panel did not find evidence of this during the visit. • Patients placed in EAU rather than HDU/ITU due to lack of beds. • The CCG and staff members spoke of the layout A&E and EAU impacting on patient flow and being a large area for nurses to cover. Nurses reported that the EAU layout made it more difficult to observe patient acuity. • Concerns were raised about staffing levels in EAU and an over reliance on staff overtime and bank nurses as the Trust are unable to fill nursing vacancies. At the unannounced visit staff said that more staff had been recruited since February and that staffing levels were considered to be safe. Nursing staff spoke positively about patient care co-ordinators who were in place on EAU to support medical and nursing staff in assessing individual patient needs. • Reports from Nayland Ward that patients are discharged prematurely from EAU. • The outreach team only has one member of staff leading to issues with availability. • Overnight medical cover has been expanded in the last 12 months and was reported to the panel as a consultant available to 10pm, two 'twilight' SHOs, two SHOs overnight and a registrar overnight. There is variable cover (dependent on locum bookings) by a "safety registrar" out of hours. In comparison surgical out of hours cover is	The Trust has increased staffing levels in A&E and EAU over the last several months and is continuing to recruit additional staff. The Trust has a clinical strategy to move to 24/7 working and currently has 600 staff who participate in 7/7 rotas in addition to the existing consultant cover in A&E department until midnight and EAU until 10pm,7 days week	best use of beds at all times, minimising the movement of inpatients over night and ensuring that EAU patients are admitted to the appropriate ward. • Progressing the move to 24/7 working, with senior doctors available out of hours. • Reviewing use of PAR score documentation and the escalation process to provide assurances that the Trust policy is being consistently applied. • Reviewing of the size and use of the outreach team • Continuing with recruitment plans to increase the staffing levels for A&E and EAU.	

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
limited to one SHO, one HO and one registrar available till midnight. Nursing staff of EAU and Brightlingsea ward reported difficulties in accessing surgical staff out of hours.			
Mortality Review The Trust has reviewed its mortality data and has a process in place to review its SHMI and 50% of medical and all surgical deaths in hospital. The panel attended the executive mortality review group and observed that there was good multi disciplinary team and Executive team attendance with high levels of participation and challenge. Whilst the panel observed minutes being taken and actions agreed at divisional level, the action taken is not reported back as completed at review group therefore there is no record of assurance that action has been taken. The panel also noted that there was no junior doctor presence at the executive mortality review group on this occasion. Management explained its SHMI outlier position as a reflection of the elderly population and the need to improve community provision of end of life care. The Chief Executive described how the Trust is working with the CCG and other providers and has developed a Joint Mortality Action Plan which includes care pathways for End of Life Care. It appears that the opportunity to improve quality of care across the health economy in its clinical pathways from these reviews is not being maximised.	The Trust actions being taken to improve mortality include the following: • Expansion of the executive mortality review group to include the patients named GP to support shared learning and improvement across the whole patient pathway. • Findings from mortality reviews being used to develop cross economy pathway improvement priorities, for example, working with community providers on antibiotic use in the community. • Reporting review findings and agreed actions through the monthly economy SHMI group.	The Trust should also ensure that actions required as a result of the executive mortality review group are systematically communicated to staff. The Trust should also consider whether staff members from a range of seniority and departments can attend these meetings to make this as open a process as possible and to share learning. The Trust should consider how it can more systematically use the mortality information it has to improve care pathways and provide assurance to the Board that actions agreed from reviews are being addressed.	High
Clinical coding The clinical coding team reported a historically underdeveloped and under resourced service which resulted in delays in coding.	Two additional staff have been recruited and the coding team are	The Trust should continue to develop the clinical coding team and	Medium

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
The team also reported that medical documentation was sometimes incomplete and difficult to interpret which may lead to coding errors. The coding team considered they were not resourced to perform internal validation which may reduce the error rate.	developing closer relationships with clinical staff.	develop relationships with clinical staff to reduce the coding error rate.	

KLOE 4: What does the Trust do to develop and strengthen clinical engagement and leadership?

Good practice identified
• Nursing staff on Brightlingsea ward reported to the panel good visibility of the Acting Director of Nursing and the Chief Executive.
• During some ward observations nursing staff reported strong leadership from Matrons.
• Student nurses when asked by the panel were all aware of the 'At Our Best' strategy and felt they were all encouraged to follow it.

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
Visibility of Executive Team Trust staff during ward observations reported visibility of the Acting Director of Nursing and Chief Executive but a lack of visibility of the rest of the Executive team. Staff confirmed that walkabouts take place occasionally but they do not receive feedback on the observations.	The Trust is developing an employee engagement plan which will be discussed at the next Board. The Trust is also undertaking a review of the Clinical Area Assessment Programme (CAAP) to identify the next stage of development to improve	The Trust should consider the need to formalise ward observations to increase the visibility of the Executive team with frontline staff and how findings of those observations are reported back at ward level.	Medium

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
	the wider clinical team engagement. This is scheduled to be presented at the next Executive Team Meeting.		
Effectiveness of clinical leaders and management at divisional level During interviews and focus groups with Trust staff the panel were told that clinical leadership at divisional level is perceived to be ineffective and therefore issues are escalated to the Executive team, in particular the Medical Director and the Chief Executive. There were numerous reports from staff on ward observations and focus groups who spoke of excellent leadership and approach by the Chief Executive however it was identified that there was a block in two way communication at middle management level. There were reports to the panel from nurses that the Trust had a culture that allowed bullying and harassment by managers. There were two examples reported to the panel where the behaviour had been reported to the Trust but the individual did not feel supported by the Trust. The issues raised under KLOE 1 relating to organisational structure and governance are also relevant to developing strong clinical leadership.	The Executive team reported work that is underway to unblock communication pathways between frontline staff and management.	The planned move to a clinically led organisation requires a strategy to achieve this and this should include a comprehensive development programme for those in or aspiring to be clinical leaders. This should apply to clinicians in the wider sense not simply the medical staff. The Trust should seek feedback from staff at all levels on how to improve two way communication between front line staff and management. The Trust should review the assurance process in place for bullying and harassment. The Trust should review any specific reports of bullying it has received to ensure that the response to this has been appropriate and that a proper investigation was undertaken.	High

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
Leadership from senior doctors Nursing and medical staff reported that the consultant group were slow to lead changes implemented at the Trust. Examples provided were as follows: • Medical staff do not support ALERT (acute life threatening events: recognition and treatment) training in terms of attendance or providing the training. ALERT courses for junior doctors are run by nurses as it is felt that senior medical staff are not willing to attend. • Junior doctors are not supported during out of hours working. In the past junior doctors had been expected to run sessions on their own despite feeling inexperienced; however they did report that this is being phased out and is happening less. • Junior doctors reported not being able to escalate concerns to senior staff, specifically surgical consultants. • The Executive team reported difficulties in getting senior surgical consultants to take ownership for increased surgical site infections. The Medical Director spoke positively of the Trust's aspiration to have a clinically led organisation but the implementation requires further planning with timescales for implementation.	The Executive team did recognise that the consultant group required more support to carry out their responsibilities.	The Trust should ensure that there is a clear strategy in place with timescales to implement the clinically led structure. Consultant staff support the ALERT training programme through the Intensive Care Consultants and one of the Nephrology Consultants. The Trust needs to understand from the nursing team why they that perceive senior consultants are not engaged or support them in a more consistent and effective manner The Trust should seek feedback from nursing staff and junior doctors on how senior medical staff can engage with and support them in a more consistent and effective manner. Divisional clinical leads and senior doctors require further development to fulfil their roles and their roles and responsibilities should be clarified. The Trust should be innovative in its engagement with the senior medical workforce.	Medium

Patient experience

Overview

The KLOE in the patient experience area focused on how the Trust engages with patients and ensures that it learns from complaints, compliments, survey results and other patient experience intelligence.

The following good practice was identified:

- Across a variety of wards, patients provided positive feedback and were pleased with the quality of care.
- There was a great feeling of loyalty to hospital from patients.
- The Trust recognises that there are issues to be resolved with the complaints process and is taking actions to resolve.

The following main areas of concern were identified for patient experience:

- Patients raised concerns related to communication issues with staff, discharge and nursing care.
- The complaints team is stretched and quality of complaints handling has not been good in the past.
- The Trust does not have clear processes in place for organisational wide learning from complaints.
- Systematic Board understanding of patient experience.
- Clarity over actions taken in response to concerns and complaints.

For the majority of the areas of concern above, we identified a number of improvements planned or already underway at the Trust evidencing continued progress.

Detailed Findings

KLOE 5: How does the Trust engage with patients and ensure it learns from complaints, compliments, survey results and other patient experience intelligence?

Good practice identified
• There were a higher number of positive experiences recorded by the patient voice feedback than negative experiences. At the time of reporting 277 comments have been received 165 of which were positive.
• Mersea ward mentioned specifically by numerous patients reporting staff as kind and compassionate.

Good practice identified
• ‘What is it like in your shoes’ workshop held in March 2013 to get patient feedback.
• Patient leaflet sent to patients prior to admission which sets out expectations of the Trust and patients.
• The panel noted good evidence of capturing and reporting patient experience on Brightlingsea Ward.
• A number of patients commented on the approachability and visibility of the Chief Executive.
• At the listening event patients reported speaking at staff induction events to discuss key themes for example: disability and dealing with difficult patients.

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
Complaints process The panel observed a number of issues related to the complaints process: • The handling of past complaints has not been good. This was acknowledged by the Executive team and Patient Advice and Liaison Service (PALS) team. There were also a number of complaints raised at the Patient and Public listening event where patients raised concerns that their complaint had not been responded to satisfactorily. • Patients fed back that the Trust had been slow to respond to the complaints. • Complaints team feel stretched. They do not feel there is enough staff to support the volume of complaints coming through. The complaints team also felt as though the governance arrangements around complaints could be improved by further embedding complaints into the governance structure of the clinical divisions and by moving complaint team to the Trust Secretary rather than the Acting Director of Nursing to maintain independence. • There is a perceived lack of visibility of complaints team by patients.	The Executive team and PALS acknowledged that there are shortfalls in the current processes and is currently reviewing these. The review is due to be completed in two months. Randomly selected complaints are now reviewed at each Board Responsibilities for complaints handling has recently been transferred to the clinical divisions where the Trust has improved the quality of complaints letters over the last six months.	The Acting Director of Nursing and the PALS manager should review the handling of complaints and the processes whereby complaints can be systematically fed back and used by staff teams to improve service delivery. This should include: • Improving understanding and visibility of complaints methods with staff and patients. • Continues to liaise with and meet patients to ensure their concerns are addressed. • Reviews size and structure of complaints team. • Reviews the governance arrangements at directorate level to improve ownership of complaints. • Reviews the process and person responsible for ensuring a complaint	Urgent

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
• It was not clear who really had control of the complaints process and therefore there was a lack of ownership. The Chief Executive confirmed that responsibility for complaints now sits within the clinical divisions. • Patients complained of receiving letters from Clinical Directors having written to the Chief Executive. • The panel heard from a large number of patients that responses to complaints from the Trust do not resolve the issues raised. • There were comments from a number of patients and from the Trust Executive team and Governors around the effectiveness and lack of authority from PALS. • The patients at the listening event and the Governors spoke of the need for PALS to escalate issues for resolution quickly rather than rely on the formal complaints process to be resolved. There were also reports from the listening event that the PALS team needed to be more open and transparent in their response to complaints. There were a large number of complaints from patients and staff where it was unclear what learning had taken place upon receipt of a complaint. It was also not clear that the Trust gets assurance action plans created in response to complaints that have been implemented.		is answered in a timely manner. • The Trust should develop a mechanism for learning lessons from complaints and communicating these across the organisation to ensure key messages are cascaded. For example, a panel could be established which meets regularly to identify lessons learned. The panel could include members of each Divisional leadership team in order to identify and disseminate lessons through the divisional governance structures down to departments and wards. The Trust should review the focus, culture and approach of PALS to be more patient experience focused, impartial and approachable	
Patient experience themes The review team held two public meetings in Colchester General Hospital and The Princes Theatre, Clacton. The Trust has not taken the opportunity to buy advertising space in the local press to widely inform the public these meetings were taking place, which was disappointing. However, the public meetings were advertised through local media, Facebook, the Trust's Website, via MPs and mailing to Trust membership in addition to the events being advertised on the NHS Choices	The panel heard from the Executive team that the Board committees routinely receive information on patient experience. Further In Your Shoes events are planned including feedback on previous	The Trust should undertake real patient communication and engagement through: • Reporting patient stories to the Board in a systematic way not just numbers and trends. • Communicating actions taken in response to patient feedback should	High

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
Website. The following themes were gathered through speaking to patients at the Patient and Public listening event and on the ward observations: • There were numerous complaints that the public events had not been widely advertised. • A number of patients complained of being cold on EAU. • There were a number of complaints about poor standard of food on more than one ward. • There were a number of patients who complained about poor access to staff at weekends. • Patients requested a patient group to help empower patients. • A number of patients reported that staff on more than one ward were not very good at breaking bad news • There were a number of patients who reported that nurses are not sufficiently trained to deal with elderly care patients, especially dementia patients. • Poor communication when patients transferred between wards. • A number of patients reported issues relating to falls. A recent example was provided where a patient fell whilst using a commode. • Patients left in corridors wearing gowns while waiting for x-ray. The Trust has provided evidence to demonstrate that steps have been taken to improve patient care including the introduction of intentional rounding, dementia assessment and the implementation of nutritional assessment on admission. There were a large number of patients who raised concerns with the Trust complaints process. These are included in the section '*complaints*' below.	sessions	be communicated to patients. • The Executive team should gain assurance that action plans in response to feedback are implemented. • Actively seeking feedback from patients and relatives wider than from the membership. • The Board should receive a summary of the substance of complaints, trends and themes as a minimum. This should be reviewed and an action plan agreed to respond to key themes. PALS information should be included as it can act as an early warning mechanism and evidence a wider problem to support a complaint. • The Trust should capture more real time patient experience data and report on it in a systematic way from ward to Board and back to the ward. • The Trust should develop an action plan to address the issues raised in the CQC patient survey. • The complaints received through the Keogh website referred to in the key themes relate to treatment received within the last two years. Therefore the Board should seek assurance that where action is taken the impact is triangulated with patient experience themes.	

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
The issues raised at the public listening events were reflective of the concerns raised through the patient voice feedback. At the time of reporting 277 comments have been received 165 of which were positive. Themes raised though the patient voice feedback were as follows: • Shortage of staff particularly out of hours • Poor communication during discharge process • Poor communication • Patients not being fed • Waiting times/delays securing appointments			

Workforce and safety

Overview

The four KLOEs in the workforce and safety area focused on staff views of the main barriers in the Trust to delivering high quality treatment and care for patients, staff engagement, workforce planning and staff development.

The following good practice was identified:

- Workforce is committed, loyal, passionate, caring and motivated.
- Examples of staff being supported in implementing innovation

The following areas of concern were identified within workforce and safety:

- Low levels of compliance with mandatory training
- Concerns over inaction following external reviews of staffing levels
- Poor uptake of the appraisal process at consultant level
- Dissatisfaction with the appraisal process
- Examples of insufficient clinical supervision
- Concerns over staffing level and mix particularly during winter pressures.

Detailed Findings

KLOE 6: How does the Trust engage with its workforce and other stakeholders?

Good practice identified
The panel observed on D'Arcy ward a notice board in the staff room which listed the concerns of the ward staff and the action taken in response to those concerns. The notice board was clearly visible to all staff and was positively received by staff interviewed.

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
Engagement with Trust staff There were a number of concerns raised during staff focus groups regarding engagement with staff, mostly relating to communication with middle management and a lack of feedback received when issues are escalated upwards. Examples provided were as follows: • Staff reported the perception that the Trust does not act on information gained from exit interviews • A number of staff commented that they would not recommend the hospital to friends and family • Concerns relating to staff development (KLOE 9) • Issues with a lack of clinical leadership (KLOE4) • A communication gap between ward level and Board level (KLOE 1) • A lack of nursing voice at divisional level (KLOE 1)	The Executive team noted the need to work hard on engagement with staff. The non executive directors specifically mentioned the complexity of issues dealt with by the Trust staff. The Executive team felt that the 'In Our Shoes' programme had led to improvements in staff engagement over the last 18 months. The Board reported to the panel that they receive comprehensive reports on staff feedback. The Board noted that 'At Our Best' would be used going forward to engage with staff and drive innovation.	There appears to be an issue with the flow of information between staff and managers at the Trust that is not visible to the Trust Board. The Trust should ensure it uses systematic processes to gather feedback from Trust staff, for example focus groups, including ways to gather feedback confidentially. The Trust should also consider how it uses the information collected to act on concerns raised by staff and how it feeds back actions taken as a result to all staff in a consistent manner.	High

KLOE 7: How is the Trust assured that it has the necessary workforce deployed to deliver safe care?

Good practice identified
The Trust has identified the need for providing appropriate staffing levels across the Trust at all times and has moved 600 staff to 7 day rotas to improve staffing levels at the weekend. The Trust is continuing to recruit extra nurses and aspires to implement 24/7 rotas in time.

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
Radiology Escorts The panel heard at the public event concerns that patients are taken to radiology without an appropriately qualified escort when required. At the unannounced visit the panel observed a high risk patient waiting unescorted for X-ray. This issue was escalated to the Trust using the formal escalation process. The CQC have requested that the Trust provides them assurance that action has been taken on this issue. The radiographers reported to the panel that the issue of unescorted high risk patients in X-ray awaiting assessment and diagnosis from A&E and EAU has been raised with management on several occasions but no action had been taken.	The Trust has confirmed that this is being investigated and the existing policy would be reinforced.	The Board should obtain urgent assurance that the policy is being applied consistently. This should include working with the CQC to provide them with assurance that action has been taken and Trust staff are compliant with the policy.	Urgent
Staffing levels and skill mix A number of issues were noted by the panel with staffing levels and skill mix: Following interviews with the Director of Nursing the panel were concerned about the governance around nurse staffing. It appears that the Trust are unable to provide any evidence of the 2011 Capita review going to the Board and therefore provide assurance to show the recommendations have been implemented. Examples of low staffing levels noted by the panel were as follows: • During observations, patients spoke of insufficient nursing staff on Brightlingsea ward at the weekend to respond to patient needs. • At the unannounced visit nursing staff on Brightlingsea reported staffing levels of 4 registered nurses and 2 HCAs or 3 registered and 3 HCA's with 2 registered nurses and 2 HCA at night. The panel did not feel 3 registered and 3 HCA's was sufficient for a ward of this size (34 beds) • During observations, the panel evidenced that D'Arcy Ward had 2 registered nurses plus 1 bank nurse at overnight. The panel did not feel	The Executive team reported that skill mix guidelines are followed however it is the responsibility of the ward nurse to make a judgement of staff staffing levels on the wards. Capita has been working with the Trust since February 2013 to review nursing staffing levels. Phase 1 of this work has focused on Stroke care and care of the elderly services. Phase 2 of this work has been a review of nursing	The Board should urgently review staffing levels on the following wards to assure themselves that staffing levels are safe, particularly out of hours: • Brightlingsea, • D'Arcy, • Fordham, and • Nayland The panel heard from the Executive that staffing reviews have taken place and additional nursing and medical staff have been and continue to be recruited, however the panel felt they did not see a comprehensive strategy for assessing and addressing staffing issues at the	Urgent High

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
2 registered and 2 HCA's was sufficient for a ward of this size (29 beds) • During the listening event, patients spoke of insufficient levels of staff at night on Fordham Ward to assist with toileting. Nursing staff reported to the panel staffing levels on the early shift was 3 registered nurses and 3 unregistered nurses for a ward where there was a high number of women with broken neck of femurs. These patients require intensive support in dressing, washing and breakfast in the early morning so this may not be sufficient. • During ward observations the panel identified a number of areas where the ward skill mix was not appropriate considering the dependency and number of patients on the ward at that time. Nayland Ward had one band 5 and 1 student nurse to care for 16/18 patients. Staffing levels issues specific to EAU and A&E are included as part of KLOE 3. The evidence observed by the panel during the unannounced and announced visits are supported by evidence in the data pack which shows the Trust has an above average spend on agency staff, a below average WTE per bed day (December 2012) and a below average ratio of Nurse Staff to Qualified Staff Ratio (January 2012-March 2012). During focus groups, nursing staff raised other concerns with the panel as follows: • Nursing staff reported that research nurses had been working on wards during periods of high activity. • Discussions with staff during focus groups identified numerous concerns regarding the use of specialist nurses on wards opened to support winter pressures without proper orientation or training, in addition to causing staff level issues in other divisions. • Student nurses reported working as HCA's on the isolation ward and Nayland ward. Student nurses also reported not having time to meet	requirements across all clinical areas and the finding of this work is in the process of being implemented. The Trust has informed the panel that an action plan is in place to recruit paediatric emergency nurses and there are currently 4.1 WTE paediatric trained nurses in A&E. The Trust informed the panel that it is working to provide paediatric consultant input for accident and emergency however did not confirm the date this is due for completion.	Trust. The Trust should develop a clear and credible plan for staffing levels which sets out how it will ensure staffing levels and mix are safe The Board should assure itself that investment in additional medical and nursing staff is impacting in high risk areas. Information should be reported to the Board that clearly triangulates staffing levels, qualified to unqualified nurses, incident rates e.g. falls, complaints and staff feedback so that the Board can measure the impact of additional investment in staffing levels and ensure that staffing levels are consistently safe.	

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
patients' emotional needs due to low staffing levels. • Nursing staff reported increased staffing levels on the wards and a temporary increase in use of agency staff during the announced visit. When the panel attended for the unannounced visit nursing staff reported that this increased use of agency staff had stopped. The Chief Executive has confirmed that the Trust did not increase nursing staff specifically for the announced or unannounced visit. The Trust has reviewed work shifts for the days in question and can confirm that they either filled to template or where there were minor gaps in the rota due to sickness and vacancies were noted, agency and bank nurses were used to fill those gaps where possible. • Nurses spoke of the insufficient number of Paediatric trained nurses in accident and emergency, although they did recognise that this is on the Trust risk register and action is being taken to recruit. There were also concerns that there was has been no Consultant with interest in paediatrics in accident and emergency since November. • There were mixed views on the level of seven day consultant cover for the delivery suite and the Trust may wish to seek their own assurance that the current level are adequate.			
Support for junior doctors Panellists particularly noted concerns around support from registrars for junior doctors at handover and during night-time and weekend working. The ownership among medical staff for deteriorating patients overnight was unclear and PAR escalation was not effective. One example, escalated to the Executive team was that the junior doctors did not have bleeps and therefore there was no way to contact the juniors when off of the ward. The junior doctors felt this had been known for several months but no action taken.	The Trust has implemented a clinically led medical rota task group to improve rota management within the medical specialties which includes agreeing, following recommendations from the task group and the appointment of a new band 6 rota coordinator (the position is currently out to advert).	The Trust should review the staffing levels and support for junior doctors, including addressing concerns about bleeps, inappropriate delegation and escalation processes.	High

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
Sickness absence and vacancies The sickness absence figure for medical staff is higher than the average for all trusts in England. The panel were told from the Executive team when interviewed that medical sickness reporting could be incorrectly reported.	None noted	The Trust should review the reporting for medical sickness. If sickness levels are accurate the Trust should investigate reasons for this and develop clear actions to address the issues.	Medium
Availability of hospital porters Junior doctors reported that porters do not consistently respond to bleeps, which causes delays in patient care. Staff reported that they often feel pressured to do the job of the porter themselves. There were reports that on more than one occasion a code red for major haemorrhages has been used to simply to get the porter to come to the ward.	The problem with porters has been highlighted to the night team and is also being looked at in the internal "Basing Review"	The Trust need to ensure that there are sufficient porters available to prevent 'code red' calls being used inappropriately.	Medium

KLOE 8: What assurance does the Trust have that the organisation is safe?

Good practice identified
• The Trust has reduced the rate of total pressure ulcers for The Trust to below the national average.

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
Quality of handovers	None noted	The Trust should ensure that all members of the handover team	High

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
<u>Medical</u> A medical handover was observed at the announced visit by the panel at which the junior doctors reported that they were not clear of the handover process. The panel noted that the handover did not follow the standard operating procedures that were posted on the wall. A second handover was observed at the unannounced visit by the panel. The panel felt that the handover was adequate but could have been improved. See recommendations. <u>Surgical</u> The handovers attended by the panel were medical handovers. There are separately conducted handovers for surgery and the other specialties. The quality of these was reported to be poor by the junior doctors at the focus group, with no involvement of other staff or the Hospital @ Night team which they felt had a negative impact on getting these patients seen by the Outreach team.		understand and follow the standard operating procedures in place. The observed handover could have been improved by: • more emphasis on physiology by patients with the highest PAR scores and acutely sick patients being prioritised and highlighted during the handover process • clear allocation of tasks • greater detail in the description of patients for example through the use of the SBAR (Situation, Background, Assessment, Recommendation) framework. Surgical and other speciality handover arrangements should to be formalised and attended by senior nursing staff.	
Reporting of serious incidents The Trust has reported fewer patient safety incidents than similar Trusts (5.3 patient safety incidents reporting per 100 admissions).The most regular occurrences of patient incident are ‘patient accident’ and ‘medication’. During staff interviews and ward observations, nursing staff reported an open culture relating to incident reporting at ward level, however they were unclear on how the incidents reported were escalated above Matron level and fed into Board reporting.	The Trust has recognised the need to improve incident reporting and learning from incidents. The Trust has informed the panel that an improvement plan has been developed and is monitored through the Trust Quality and Patient Safety Committee and	The Trust should clarify the process for escalation of Serious Incidents and communicate this to all staff. The Trust should ensure that the learning from incident reporting happens at all levels throughout the Trust. The Trust must assure itself that lessons learned from events, themes and cases are visibly used in Trust-wide events in a systematic manner to alert the relevant	High

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
Whilst serious incidents are reported, staff interviewed felt that the outcome of this reporting was not communicated back to them. Examples were provided to the panel on EAU and Mersea Ward of where Datex had been used to report the outcome to the feedback provider, however this was not consistent across the Trust. Radiology staff reported to the panel that they had verbally raised concerns regarding unescorted patients numerous times with no acknowledgement or action taken. Junior doctors reported to the panel at a focus group that responses to incidents entered into Datex which can take several months to get a response and no visible action had been taken.	the economy Clinical Quality Review Group. The improvement plan has been submitted to the CCG and the CQC.	staff to that issue. The Trust should make it easier for frontline staff to escalate quality issues such as a trigger form (other than Datex which is for incident reporting) that requires a response back.	
Dissemination of lessons learnt There non-executive directors were able to articulate the process in place for implementing learning for example through internal audit, Clinical Area Assessment Programme (CAAP) and follow up of action plans, however there was limited evidence of lessons being learnt from complaints and incidents and dissemination of these themes across the whole Trust. Nursing staff during interviews reported that they did not receive feedback on complaints or incidents routinely and were unclear what action had been taken on concerns that had been escalated. The panel heard from staff focus groups that Learning from Experience Action Plans (LEAPs) are in place however they are not routinely implemented in a timely manner and cascaded throughout the Trust. The Executive team confirmed that there is no formal process in place for reporting on the implementation of lessons learned or to triangulate common themes between divisions.	The Trust currently has 225 staff trained in root cause analysis who are staff appropriate to undertake key investigations and are reviewing how it disseminates information across the Trust.	The Trust should consider further investment in learning from reviews and ensure that lessons learnt and key themes are clearly disseminated throughout the organisation and progress against action plans monitored. The Trust should introduce regular Trust wide risk newsletters highlighting lessons learnt and improved outcomes for patients The Board should assure itself that staff trained in root cause analysis have responsibility for monitoring of action plans and embedding lessons learnt throughout the organisation, supported by risk managers and reporting to the	High

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
		clinical effectiveness group. The Trust should put in place an implementation and audit/reporting process to ensure learning from action plans are embedded throughout the Trust as part of its quality strategy. Necessary support should be made available to staff to achieve this.	

KLOE 9: How does the Trust support staff development?

Good practice identified
• During observations the panel heard examples where staff felt the Trust supported in implementing ideas, for example band 5 nurses had been supported in introducing 'nursing indicators' at Accident and Emergency.
• Non-Executive directors and governors spoke positively of the training programme and induction programme in place.

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
Clinical supervision Student nurses during ward observations on Brightlingsea Ward reported being without a mentor for two weeks and not receiving orientation before performing tasks for the first time.	The Executive team outlined the support programme for newly qualified student nurses through the preceptorship support programme and the induction programme.	The Trust needs to ensure that there is sufficient clinical supervision for student nurses and newly qualified nurses.	High

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
Staff appraisals and development During interviews with health care assistants (HCA), the panel heard that training needs identified as a result of appraisals had not taken place. There was confusion around HCA roles and responsibilities and they wanted a more 'joined-up' MDT education programme. The Executive team confirmed during interviews that they had received a mixed response from staff when asked about their experience of the appraisal process. Consultant appraisal rates at the Trust were reported at 55.6%, which is the lowest of the trusts under review. The Executive team reported to the panel there are two consultants who are still to complete an appraisal. Uptake had previously been was low as consultants were unhappy with the appraisal process as it did not result in the desired outcomes for example, access to training.	The Trust has confirmed that development plans have been reviewed and improved and are now linked to gateways as per the agenda for change programme. Plans to improve succession planning are underway. The Trust has implemented a new appraisal system and has recruited additional band 6 resource to focus solely on clinical appraisals.	The Trust needs to ensure that all consultants complete the appraisal process in a timely manner. The Trust needs to review the appraisal process for staff to ensure that appropriate development needs are identified and ensure that progress against development plans is monitored.	High Medium
Compliance with mandatory training requirements Interviews with nursing staff identified that although mandatory training was provided, it was often cancelled due to staffing shortages, particularly in A&E. The panel confirmed through interviews with the Executive team, that mandatory training had been cancelled on a number of occasions during the winter period but were unable to confirm how frequently. The uptake level for mandatory training reported to the panel by the Executive team was 55%.	The Executive team reported that a review of the training programme has been carried out. A 'Fitness to Practice' model is being developed that will be supported by E-learning and is to be rolled out in September 2013. The training will cover the key requirements as set out in the service level agreement with commissioners. Senior Executives will be briefed after which the model will be rolled out throughout the organisation. The responsibility to build sufficient	The Trust must assure itself that there are adequate staffing levels to allow protected time for completion of mandatory training. The Trust may need to use innovative solutions to address this issue for example by offering staff payment to attend outside of normal working hours of planning cover for mandatory training	Medium

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
	training time into staffing rotas will sit with individual Matrons supported by divisional managers.	attendance with bank in advance.	

Conclusions and support required

The review identified a number of good areas of practice across the Trust, with some great examples of excellent care being delivered to patients. Some staff groups and particular individuals at the Trust also received praise. The review also identified a number of areas of outstanding concerns across all nine key lines of enquiry which will require urgent or high priority action to address as identified in the detailed findings section. The Trust recognises that there are steps it needs to take to address the concerns raised by the review. Some improvement plans are already in motion, and the review team thinks that these should be expedited. Other things may be areas that the Trust has not yet considered and the panel recommends that the Trust quickly develops action plans to address these concerns. A number of these areas are recommended for discussion at the risk summit to consider what support may be required for the Trust to address these concerns.

Urgent and high priority actions for consideration at the risk summit

Problem identified	Recommended action for discussion	Priority	Support required by the Trust
1. Quality focus in the Trust needs further development and an underpinning strategy (Page 13)	The Trust will need to consider how it develops a clearer focus on quality, based on transparent performance information and a tone from the top. This should include implementation of the planned improvements and recommended actions in this report. The Trust must increase the pace of planned change in order to develop a safe, mature organisation that provides high quality patient care. The role of the Quality Hub needs to be reviewed to support this. The Trust needs to develop a comprehensive and clear quality strategy and ensure it is consistently applied throughout the organisation. This must include areas of priority with defined action plans in place.	Urgent Urgent Urgent	To be discussed at the risk summit
2. The Trust needs to empower clinical leadership through an improved governance and organisational structure, and leadership development (Page 14)	The Trust should review the management structure in place to ensure it is robust enough to support consistent clinical leadership (both medical and nursing) and management at divisional level. The Trust should ensure there is clinical leadership and accountability for patient safety throughout the Trust.	Urgent	To be discussed at the risk summit

Problem identified	Recommended action for discussion	Priority	Support required by the Trust
3. Processes to recognise and escalate deteriorating patients are not operating effectively (Page 21)	The Trust should develop an action plan to improve its escalation approach for deteriorating patients. This should include engagement with clinical leadership and frontline staff including nurses and junior doctors to understand the reasons for the inconsistent escalation of deteriorating patients and improve related documentation. The action plan should be monitored regularly by the Board in order to seek assurance that the issues are being addressed.	Urgent	To be discussed at the risk summit
4. The Trust's policy on radiology escorts is not being consistently applied (Page 37)	The Board should obtain urgent assurance that the policy is being applied consistently. This should include working with the CQC to provide them with assurance that action has been taken and Trust staff are compliant with the policy	Urgent	To be discussed at the risk summit
5. The Trust needs to improve its engagement and communication with staff (Page 34)	The Trust should ensure it uses systematic processes to gather feedback from staff, for example focus groups, including ways to gather feedback confidentially. The Trust should also consider how it uses the information collected to act on concerns raised by staff and how it feeds back actions taken as a result to all staff in a consistent manner.	High	To be discussed at the risk summit
6. Staffing levels and skill mix need review (Page 37)	The Trust should urgently review staffing levels on the following wards: • Brightlingsea • D'Arcy • Fordham • Nayland. The Trust should develop a clear and credible plan for staffing levels which sets out how the Board will ensure staffing levels and mix are safe, particularly out of hours. The Board should assure itself that investment in additional medical and nursing staff is impacting in high risk areas. Information should be reported to the Board that clearly triangulates staffing levels, qualified to unqualified nurses, incident rates e.g. falls, complaints and staff feedback so that it can measure the impact of additional investment in staffing levels and ensure that staffing levels are consistently safe.	Urgent	To be discussed at the risk summit

Problem identified	Recommended action for discussion	Priority	Support required by the Trust
7. Complaints management processes need urgent improvement (Page 31)	The Acting Director of Nursing and the PALS manager should review the handling of complaints and the processes whereby complaints can be systematically fed back and used by staff teams to improve service delivery. This should respond to the issues identified in this report.	Urgent	To be discussed at the risk summit
8. End of life provision across the health community needs review (Page 22)	The Trust should work with the CCG and community health providers to develop care pathways for end of life care. A strategy should be developed through joint engagement with the CCG to review wider health system engagement to make better use of hospital beds including using out of hospital care, preventative strategies and community care and to improve end of life provision for patients.	High	To be discussed at the risk summit

Appendices

Appendix I: SHMI and HSMR definitions

HSMR definition

What is the Hospital Standardised Mortality Ratio?

The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the mortality rate at a hospital is higher or lower than you would expect. Like all statistical indicators, HSMR is not perfect. If a hospital has a high HSMR, it cannot be said for certain that this reflects failings in the care provided by the hospital. However, it can be a warning sign that things are going wrong.

How does HSMR work?

The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 specific groups (CCS groups); in a specified patient group. The expected deaths are calculated from logistic regression models taking into account and adjusting for a case-mix of: age band, sex, deprivation, interaction between age band and co-morbidities, month of admission, admission method, source of admission, the presence of palliative care, number of previous emergency admissions and financial year of discharge.

How should HSMR be interpreted?

Care is needed in interpreting these results. Although a score of 100 indicates that the observed number of deaths matched the expected number; in order to identify if variation from this is significant confidence intervals are calculated. A Poisson distribution model is used to calculate 95% and 99.9% confidence intervals and only when these have been crossed is performance classed as higher or lower than expected.

SHMI definition

What is the Summary Hospital-level Mortality Indicator?

The Summary level Hospital Mortality Indicator (SHMI) is a high level hospital mortality indicator that is published by the Department of Health on a quarterly basis. The SHMI follows a similar principle to the general standardised mortality ratio; a measure based upon a nationally expected value. SHMI can be used as a potential smoke alarm for potential deviations away from regular practice.

How does SHMI work?

1) Deaths up to 30 days post acute trust discharge are considered in the mortality indicator, utilising ONS data
2) The SHMI is the ratio of the Observed number of deaths in a Trust vs. Expected number of deaths over a period of time

3) The Indicator will utilise 5 factors to adjust mortality rates by
    a. The primary admitting diagnosis
    b. The type of admission
    c. A calculation of co-morbid complexity (Charlson Index of co-morbidities)
    d. Age
    e. Sex
4) All inpatient mortalities that occur within a Hospital are considered in the indicator

How should SHMI be interpreted?

Due to the complexities of hospital care and the high variation in the statistical models all deviations from the expected are highlighted using a Random Effects funnel plot

Some key differences between SHMI and HSMR

Indicator	HSMR	SHMI
Are all hospital deaths included?	No, around 80% of in hospital deaths are included, which varies significantly dependent upon the services provided by each hospital	Yes all deaths are included
When a patient dies how many times is this counted?	If a patient is transferred between hospitals within 2 days the death is counted multiple times	1 death is counted once, and if the patient is transferred the death is attached to the last acute/secondary care provider
Does the use of the palliative care code reduce the relative impact of a death on the indicator?	Yes	No
Does the indicator consider where deaths occur?	Only considers in hospital deaths	Considers in hospital deaths but also those up to 30 days post discharge anywhere too.
Is this applied to all health care providers?	Yes	No, does not apply to specialist hospitals

Appendix II: Panel composition

Panel role	Name
Panel Chair	Liz Redfern
Deputy Panel Chair	Chris Gordon
Lay Representative	Neeta Meeta
Lay Representative	Trevor Begg
Lay Representative	Margaret Ogden
Junior Doctor	Shelley Griffiths
Doctor	James Bristol
Doctor	Andrew Phillips
Doctor	Colette Marshall
Student Nurse	Sian Ball
Student Nurse	Amy Burgin
Board Level Nurse	Brigid Stacey
Senior Nurse	Paul Webb
Senior Nurse	Julie Orr
CQC Compliance Manager	Sue Fraser-Betts
Senior Trust Manager	Patricia Miller
Senior Regional Support	Gareth Harry
Senior Regional Support	Lyn McIntyre

Panel role	Name
Observer, Area Team representative	Pol Toner
Observer, CCG Nominee	Lisa Llewelyn
Observer, Area Team representative	Christine Macleod

Appendix III: Interviews held

Interviewee	Date held
Gordon Coutts, Chief Executive	4 June
Sean MacDonnell, Medical Director	4 June
Kathy French, Acting Director of Nursing & Patient Experience	4 June
Governors	4 June
Lead Governor	4 June
Acting Director of HR	5 June
Deputy Medical Director, Director ofTraining, Education and Appraisal	5 June
Associate Medical Director for Audit and Effectiveness	5 June
Associate Director forService Improvement	5 June
Chair of Quality and Patient Safety Board Assurance Committee	5 June
Non Executive Directors	5 June
Chair, Dr Sally Irvine	5 June
Divisional Clinical Directors	5 June
Deputy Head of Clinical Coding	5 June
Director of Finance	5 June
Complaints and Litigation Services Manager/Nurse responsible for complaints	5 June
Fiona Crump, Service Manager for General and Specialist Medicine	5 June
Members of Parliament	20 June

Appendix IV: Observations undertaken

Observation area	Date of observation
Birch Ward	4 June
Mersea Ward	4 June
Peldon Ward	4 June
Brightlingsea Ward	4 June
Emergency Admissions Unit	4 June
Accident and Emergency	4 June
Wivenhoe ward	4 June
Lexden Ward – Obs and Gynae	4 June
Stanway Ward – gynaecology	4 June
Special Care Baby Unit – paediatrics	4 June
Fordham Ward	5 June
D'Arcy Ward	5 June
Dedham Ward	5 June
Stroke Unit	5 June
Emergency Admissions Unit	5 June
Accident and Emergency	5 June
Nayland Ward	5 June
Layer Marney Ward	5 June
Tiptree Ward	5 June

Further observations were undertaken as part of the unannounced site visit, see Appendix VII.

Appendix V: Focus groups held

Focus group invitees	Date held
Student Nurses	4 June
Health Care Assistants	4 June
Non-clinical staff and Allied Health Professionals	4 June
Registered Nurses	4 June
Consultants and Registrars	4 June
Junior Doctors	5 June
Essex County Hospital	5 June

Appendix VI: Information available to the RRR panel

Clinical Strategy 2008-13	Patient Safety Strategy	Board Assurance Framework 2012/13 Quarter 2
Board Assurance Framework 2012/13 Quarter 3	Trust Risk Register	Mandatory Clinical Audit Plan 2013/14
Trust Clinical Audit Plan 2013/14	Clinical Audit Annual Report 2011/12	Cost Improvement Programme Index for 2012/13 and 2013/14
Cost Improvement Programme assessment process Diagram	Monitor Self-Assessment for Quarter 2 & Quarter 3	Organisational Structure
CVs of Executive Directors	Organisational Governance Structure	Board & Assurance Committee Terms of Reference
Executive Groups Terms of Reference	Private (informal) & Public Board of Directors Papers for November 2012 (quarterly meetings)	Private (informal) & Public Board of Directors Papers for February 2013 (quarterly meetings)
Draft Minutes of Private (informal) & Public Board of Directors Meeting held on 14 February 2013 (not yet approved)	Quality & Patient Safety Assurance Committee Papers – November 2012	Quality & Patient Safety Assurance Committee Papers – January 2013
Mortality Review Group Papers & Minutes March 2013	Mortality Review Group Papers & Minutes April 2013	2012/13 Quarter 1, 2, 3 & 4 Performance Framework
2012/13 Quarter 1, 2 & 3 Monitor Feedback Letter	Annual Plan Submission to Monitor 2012/13	Annual Plan Financial Templates 2013-15
Draft Key Priority Areas for 2013/14	Complex Elderly with a Respiratory System Primary Diagnos	Intestinal Obstruction without Hernia
Diabetes Mellitus	Royal College of Obstetrics & Gynaecology Review Report	Dr Foster Report into HSMR/SHMI
Professor Draper's Report on Perinatal Mortality	HPAs Report on Surgical Site Infections	Deloitte Internal Audit Report on Serious Incident Process

Trust's Initial Response to Audit Recommendations	St Helena Hospice	Harmoni Out of Hours
Anglia Community Enterprise (ACE)	East of England Ambulance	Essex County Council
North Essex Partnership NHS Foundation Trust	North East Essex Clinical Commissioning Group	Trust analysis of mortality including any detailed analysis
Complaints and incidents policy and latest report	Escalation policies	Operational policies for surgery
Patient feedback surveys	World Health Organisation (WHO) Checklist	Template referral form
Template handover form	Quality Impact Assessment process and reporting for Cost Improvement Plans	Patient experience and engagement strategy
Safeguarding policies (adults and children)	Whistle blowing policy	C Difficile Trajectory
Monthly SHMI Review Minutes (January-April 2013)	Weekly Mortality Review Meeting Notes (April, May 2013)	Friends and Family Test Results
CQC Patient Survey Report	Mandatory Training Report	Serious Incident Action Plan
Lines of reporting up to Executive Directors	Structure of the Quality Hub	CEO Briefing 31 May 2013
Executive Patient Group Minutes – March 2013	Investigation Reports for Never Events	Community Midwifery Ratios
East of England Supervising Authority – Annual Report to the Nursing and Midwifery Council – April 2011 – March 2012	2011 AUKUH report	Nurse in Post Changes
Report from Governors Assigned to Assurance Committees	Outcome of PAR audit	Datex: October – February relating to escalation
Meridian Track Results by Ward	Bed occupancy rates	Action Plans relating to Staffing Levels to in March Incident Report

Patient Safety Strategy	Essential Skills Training Report	Serious Harm Panel for Falls
Policy for escalation – winter pressures	Risk Assessment of Winter Pressure Escalation	Nursing Skill Mix Review

Appendix VII: Unannounced site visit

Agenda item
Panel pre-meet
Entry into Colchester Hospital and announced arrival to site manager
Observations undertaken of the following: • Accident and Emergency • Emergency Admissions Unit • Brightlingsea Ward • D'Arcy Ward • Maternity Suite • Juno Suite
Meeting held with site manager to understand current staffing and patient levels
Panel left Trust and announced exit