This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

The Ipswich hospital NHS Trust has one general hospital, which was first built around 1910, and has been expanded to cover 45 acres. The private finance initiative (PFI) wing, opened in 2007. The hospital serves around 385,000 people from Ipswich and East Suffolk. Community hospitals and specialist community services were taken on by the Trust in October 2015.

The trust provides acute, maternity and community health services across the following locations; Ipswich hospital, Gilchrist birthing unit, Foot and Ankle Surgery centre, Aldeburgh community hospital, Bluebird Lodge community hospital and Felixstowe community hospital.

Acute services are provided at Ipswich Hospital and encompass urgent and emergency care, planned medical and surgical care, critical care, consultant and midwifery-led maternity, neonatal and paediatric care, end of life care and diagnostic and therapy services. The hospital has a total number of 650 beds) that includes 594 general and acute beds, 38 maternity beds and 15 critical care beds (commissioned for 12).

As of June 2017, the trust employed 3650 WTE staff across all locations. In Ipswich, 11% of the population identify as Black and Minority Ethnic (BME) origin. The trust’s overall BME workforce is 14.6%. BME response rates in the NHS staff survey 2016 were lower than the minimum recommended (45.6%). There are no BME board members on the Trust's executive board, or BME staff appointed above band 9.

Between February 2016 and January 2017 there were:

- 88,196 inpatient admissions. This was an increase of 4% from the same period 2015/16.
648,305 outpatient attendances. This was an increase of 7% from the same period 2015/16.

88,547 accident and emergency attendances. This was an increase of 5% from the same period 2015/16.

3,454 births. This was a decrease of 3% from the same period 2015/16

1,374 deaths. This was an increase of 4% from the same period 2015/16.

The trust was last inspected in January 2015 as part of our comprehensive inspection programme. At the 2015 inspection we rated the Trust good overall. Safe and responsive were rated as requires improvement with caring, responsive and well led rated as good.

In January 2015, we rated medical care, surgery, critical care, maternity and gynaecology, end of life care and outpatients and diagnostics good overall. Urgent and emergency services were rated outstanding overall and services for children and young people were rated as requires improvement.

Following the 2015 inspection we undertook enforcement action and told the trust it must take action to improve. CQC served two Requirement Notices; one in relation to Regulation 9, Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services. The other was in relation to Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control.

During this inspection we found the trust had taken action to ensure that the issues in the Regulation 9 requirement notice had been met. Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control related to Outpatients, which we did not inspect during this service but have continued to monitor through regular engagement.

Ipswich hospital NHS Trust is a part of the Suffolk and North Essex STP. In May 2016, The Ipswich Hospital NHS Trust (IHT) and Colchester Hospital University NHS Foundation Trust (CHUFT) committed to entering a long-term partnership. An outline business case was developed to consider the following merger options:

a) A merger of the two Trusts with full integration of clinical services,

b) A merger of the two Trusts with some integration of clinical services,

c) An acquisition of one Trust by another and as a comparison, the scenario of ‘no change’ is also being considered.

A merger or acquisition would not necessarily require clinical services to move, but may mean that services would work together more closely, for example, sharing best practice in delivering high quality care. This sees the trusts developing working arrangements in line with the STP, with Nick Hulme as overall CEO for both trusts.

The recommendation from the outline business case, announced on 17 August 2017, was to form a single combined organisation with fully integrated clinical services. We have been advised that subject to the boards approving the case, the Trusts will go on to develop detailed plans for the combined organisation. A final decision to form a single organisation will then be taken by both Trust boards around June 2018.

Is this organisation well-led?
Leadership

There were clear processes in place to ensure that the trust board and senior leadership team had the skills, knowledge, integrity and experience that they needed on appointment and throughout their employment.

The trust board consisted of five voting executive directors and six non-executive directors (NEDs). In addition to this, there are four further executive directors and one associate non-executive director. The Chief Executive Officer (CEO) was an established leader and had been appointed as interim CEO for the trust in May 2012 and this became a substantive appointment in April 2014. The managing director had been in post since October 2016 having previously been chief operating officer at the trust from July 2013. The medical director was newly appointed in August 2017 and was an established clinician and educator. The director of nursing had been in post from December 2016 having previously been deputy DoN at Ipswich hospital for two years.

The trusts CEO and chair had been appointed to these roles at a neighbouring trust in May 2016. Despite managing two trusts they continued to have an effective presence at Ipswich Hospital NHS Trust. There was a genuine concern from all board members that this dual role would not impact upon Ipswich Hospital NHS Trust. The CEO remained visible to staff and ensured that they were communicated effectively with. The rest of the board members ensured that they had a variety of strategies in place to ensure that they were visible and open to staff engagement. We found no impact on the services provided at Ipswich Hospital following this dual role appointment. All board members were aware of the issues within the trust, had plans in place to address them and understood the challenges the trust faced.

The trust had a comprehensive Fit and Proper Persons Requirement (FPPR) process in place to ensure that directors were fit to carry out their responsible roles in accordance with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The process included comprehensive pre-employment checks that included enhanced Disclosure and Barring Service (DBS) checks, insolvency and bankruptcy checks, disqualified director register checks and occupational health checks. There were further checks on appointment through self-declaration and previous employment checks and on-going assurance through an annual declaration process.

The trust had embarked on a leadership training programme and there were talent management and succession planning processes in place. Some members of the senior management team had developed into their roles through the trust’s succession planning processes; for example, the director of nursing and managing director had both progressed through this programme. These processes were inclusive of staff at all levels as the trust recognised the need to encourage and develop staff from within the organisation along with recruiting externally to introduce new perspectives. For example, the trust had a consultant development programme whereby newly appointed consultants were nominated by their divisional senior teams for leadership development. The trust also conducted leadership conferences for clinical and non-clinical leaders within the organisation where they discussed challenges such as managing change.

The trust leadership team had a comprehensive knowledge of current priorities and challenges and took action to address them. For example, the trust had developed a comprehensive strategy based on the results of the ‘Carter review’ and in line with ‘Personalised care in health 2020: framework for action’ (Department of Health, 2016), in anticipation of integrating systems with other providers within a prescribed network. The strategy entitled ‘ICT Enabling strategy 2017-2022’ had been aligned with the trust’s overall strategy and described the steps needed to
strengthen the ICT infrastructures and minimise the risk of unauthorised access. We found that the leaders worked together to make improvements and ensure patient safety. For example, during our unannounced core service inspections we identified some concerns relating to the recording of venous thromboembolism (VTE) assessments in the medicine core service. We raised our concerns with the senior management team and when we returned for the Well-led inspection we spoke with the Director of Nursing and the Medical Director and found that they had worked together with local leaders to develop a plan to strengthen the VTE assessment process.

During our interview with the CEO, we asked them how they were able to maintain oversight of the two trusts that they were responsible for and lead the STP and be assured that matters that they needed to be aware of had been appropriately escalated to them. The CEO told us that they had focussed on developing a cohesive leadership team through succession planning and adopting a culture of openness and constructive challenge which encouraged staff at all levels to recognise and escalate concerns appropriately. Our subsequent interviews with members of the senior leadership team confirmed that they understood the unique qualities and needs of their team.

Senior leaders were visible and approachable. Members of the board visited different areas of the trust throughout the year to increase visibility and engage with staff at all levels. Leaders undertook clinical and operational shifts, visited other trusts and attended networking events and national conferences on a regular basis to ensure that they were current with their knowledge and utilising the most relevant evidence-based care and treatment in delivery of quality care. For example, the trust was working with academic partners to introduce training programmes at all levels in quality improvement processes and methodology. This meant that staff at different levels would have the skills and knowledge necessary to affect change in the areas that they had identified for improvement.

There were clear priorities for ensuring sustainable, compassion, inclusive and effective leadership. The trust had developed a ‘People, Organisation and Development Strategy’ with equality, inclusion and diversity forming an integral part of the plan to develop leaders and ensure that training and support was provided to promote caring and effective leaders.

At the time of our inspection, the trust had appointed an interim equality and diversity advisor to conduct a review of the current practice and work with leaders to develop and implement an improvement plan. Senior managers and members of the non-executive director team acknowledged that the trust board was not representative of the workforce or the local population and they were working with the equality and diversity advisor to understand what was needed to address this. There was no non-executive director with responsibility for equality and diversity.

**Vision and strategy**

The trust had a clear vision and set of values with quality and sustainability as the top priorities. The trust’s vision was ‘To be an outstanding provider of health services for our population’, the vision was underpinned by four strategic goals, which were to:

- Deliver a great care experience;
- Be recognised as a leading innovator in healthcare nationally;
- Be financially secure;
- Improve the experience of working in healthcare.
The values had been developed through a series of engagement exercises with staff and they were: respect, kindness, listen and involve, professional, efficient and improving together. Our conversations with staff during the unannounced core service inspections confirmed that staff at all levels were aware of the vision and values and how achievement of the strategy applied to the work of their teams.

There was a comprehensive and realistic strategy for achieving the priorities and developing good quality, sustainable care. The strategy had been developed using a structured planning process in collaboration with staff, people who used the services and other external partners and stakeholders. An outline of the five year strategy to achieve the vision was published on the trust's public website entitled ‘Writing the next chapter…’ and had been developed with staff and other stakeholders. The trust had conducted a number of workshops and briefing sessions for 30 different stakeholder groups from September 2016 to November 2016 to receive feedback and suggestions regarding the proposed strategy. This was followed up by a series of strategy briefings held monthly with key representatives from each stakeholder group. The stakeholder groups included staff, carers, patients and external partners who were all given the opportunity to contribute to discussions about the strategy and the plans to change the services. For example, one of the local community groups had commented that the text in the draft strategy document did not reflect the trust's goal to empower people in caring for themselves and the text had been updated to reflect this. Another group had commented that they felt that the text should be more explicit in relation to acknowledging diversity within the local population.

The trust’s strategy was aligned to local plans in the wider health and social care economy and had been developed to take into account the needs of the local population. The trust had strong links to the STP and there were clear working relationships with other stakeholders to develop services. The trust was working as part of Suffolk wide group including local commissioners, community groups, and local authorities to improve community services for people experiencing mental health illness. There were also plans in place to effectively monitor health inequalities and develop pathways for access for all through the Equality delivery System (EDS2) and local plans. For example, the trust was working with external stakeholders to increase awareness amongst the travelling community about accessing the right services.

The trust had a comprehensive estates strategy which took into account the needs of the trust and the local environment. For example, one of the aims of the estates strategy was to meet the targets for carbon reduction, the trust had installed their own bio-fuel system, this meant that they were able to supply up to 80% of their own electricity which enhanced sustainability and was better for the environment.

Most staff that we spoke with knew and understood the trust’s vision, values and strategy and how achievement of these applied to the work of their team. Our review of corporate information received by teams confirmed that the trust embedded the vision, values and strategy in policies and communications.

The leadership team had developed reporting and monitoring processes to measure progress for the key deliverables of the strategy. Our review of evidence such as quality accounts, annual reports, business plans and committee meeting minutes confirmed that progress against the strategy was monitored from the ward to the board.

The senior team all articulated that the merger with Colchester Hospital University NHS Foundation Trust (CHUFT) secures longevity for the trust. All of the senior team displayed a serious commitment to deliver patient improvement through a joined up integrated approach,
rather than a separate site approach, with interaction from all staff and patient groups essential to develop the direction of the partnership and clinical strategy. As such there had been a series of reference and advisory groups set up to engage and gain views. These included a patient advisory group, stakeholder advisory group and staff reference group. During our inspection collaborative working and discussions were beginning across various clinical areas on both sites.

Culture

The majority of staff we spoke with described an open culture where concerns were listened to and they felt valued and respected in their roles. However, we found that in some areas staff felt that their voices were not always heard. This was communicated to the senior management team, who took immediate actions to understand the issues and developed plans to address the concerns. For example, we found that four months prior to our first unannounced inspection on 29 and 30 August; concerns had been raised by staff members regarding the environment and processes in the Electro-Medical Engineering (EME) department. We saw that senior managers had formulated a local plan to address the issues; however this had not been effectively communicated to staff involved, which meant that they were not confident that their concerns were being listened to. The director of estates and facilities acknowledged that communications with the team could have been better and we were told that with the addition of extra supervisory staff communications would be improved. On our second unannounced visit (19 and 20 September) we found that some improvements had been made in line with the action plan. Whilst communication with staff had taken place there was still some disconnect between information from the senior staff and the team and effort needed to continue to ensure communications were improved.

The trust had developed a rapid action plan in response to the NHS staff survey 2016. The survey identified four key areas for improvement, these included health and wellbeing and, bullying and harassment and communication between senior management and staff. The action plan had been implemented in June 2017 and involved a series of workshops and planned events to discuss the issues with different staff groups and develop ways to improve. The workshops were completed at the end of September 2017 and the senior leadership team made a commitment to staff to work with them to make improvements. One suggested improvement by the senior leaders, relating to appraisals, was that they would make this protected time and only cancel appraisal appointments if clinical pressures were such that there was a potential risk to patient safety

The trust target for appraisal completion was 85%; data supplied by the trust showed that as of March 2017 completion rate for appraisals for nursing staff was 89% and 96% for medical staff. The results of the NHS staff survey 2016 and internal feedback mechanisms indicated that staff did not always have the opportunity to have a meaningful discussion about learning and development opportunities through appraisal. The trust had developed the ‘Improving Together’ programme which provided a structured framework for staff to explore areas of development with their line managers.

NHS Staff Survey (2016) Performance on questions relating to bullying, harassment and equal opportunities

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between white and black and minority ethnic (BME) staff, as required for the Workforce Race Equality Standard.
Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key Finding and question numbers have changed since 2014.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

<table>
<thead>
<tr>
<th>Question</th>
<th>Staff group</th>
<th>Trust 2016</th>
<th>Average (median) for acute trusts</th>
<th>Trust 2015</th>
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<td>White</td>
<td>30%</td>
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<td>30%</td>
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<td></td>
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<td>39%</td>
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<td>43%</td>
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<td>88%</td>
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<td></td>
<td>BME</td>
<td>13%</td>
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(Source: NHS Staff Survey 2016)

Senior staff told us that it was a priority for them to understand what support staff needed to empower them to voice their concerns in a safe environment. The trust had appointed a ‘Freedom to Speak Up Guardian’ and there was information available throughout the hospital and on the internal trust website encouraging staff to raise concerns openly or anonymously. The trust had a comprehensive whistle-blowing policy, that had been approved through the Workforce Assurance Committee, and we saw that whistle-blowing concerns were treated sensitively and monitored to identify trends. From March 2016 to April 2017, the trust recorded four anonymous whistle blowing concerns, we saw that changes to practice and protocols were made as a result of whistle-blowing concerns.

Most staff we spoke with were positive about the trust and proud of the work that they did as individuals and within their teams. The trust had an awards and recognition scheme called the ‘Ipswich Hospital Commendation’. Nominations were made by staff and patients on an annual basis and judged by a panel which involved colleagues and patients. Examples of the nominations and award winners were published in the trust’s annual ‘Quality Account’ and available on their public website.
In order to achieve the trust’s overall strategy there were a number of divisional and departmental strategies aligned to the overall strategy. Each of the strategies linked to the overall strategy and clearly evidenced the trust’s commitment to planning and provision of care that was patient-centred and listed this as one of the key priorities. For example, the trust’s Quality Improvement Plan (QIP) 2017 – 2022 had a focus on ‘improving the patient and carer experience’ and was based on feedback from patients and national evidence based guidance such as ‘A promise to learn – a commitment to act: improving the safety of patients in England’ (Don Berwick, Department of Health, 2013). The QIP included aims and objectives for ensuring patient centred care this included patients experiencing care that was fair, inclusive and respectful of their individual needs.

During our Well-led inspection, we spoke with representatives of the trade unions who described a positive, but limited, working relationship with the leadership team. There were concerns raised that the role was undertaken outside their own clinical or primary role commitments.

Staff had access to support for their own physical and emotional health needs through various support networks including occupational health and employee assistance programmes. A key priority in the trust’s people and organisational development strategy was establishing and maintaining a healthy workplace. For example, the trust was working with a local charity which supported people experiencing mental health illness to conduct an audit of staff needs in this area and implement the recommendations.

**Sickness levels**

The trust’s sickness levels between June 2016 and May 2017 were consistently either in line with or lower than the England average, and followed the same trend of variation over time.

**Sickness absence rate, June 2016 to May 2017**

![Sickness Absence Rate Graph](image)

(Source: NHS Digital)
Staff networks were in place to promote the diversity of staff. There were equality and diversity champions throughout the trust. These were individual members of staff who had a particular interest in equality and diversity issues. The trust had developed a single network that encompassed all protected characteristics as outlined in Equality Act, 2010. The role of the diversity champions included promoting awareness of equality and diversity issues, developing knowledge in equality and diversity practices and issues and sharing the knowledge throughout the trust.

Throughout our recent inspection, we saw examples of positive relationships between teams and they worked well together to address issues and resolve conflict appropriately.

**Governance**

The trust had effective structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees and team meetings. Leaders regularly reviewed these structures. At the time of our inspection, the trust was in the process of reviewing their corporate governance framework to meet the needs of the changing services by incorporating the community services into the governance strategy. The trust had developed an ‘Accountability Framework (AF)’ which was used to monitor quality and performance at local, divisional and board level. By local we mean ward and teams and there were four divisions; medicine and therapies, surgery, women, children and cancer services and executive support

There was a separate AF for each level which was used as a focus of discussion at the various levels and types of meetings, which then allowed for the information to flow from ward to board in both directions. The local level AF fed into the divisional AF which fed into the AF that was presented to sub-committees which fed into the board. The accountability framework itself was divided into four areas which were safe, caring, responsive and well-led. Each area had data relating to key performance indicators KPIs which included rates of health care associated infections, compliance to professional standards, national KPIs such as ‘referral to treatment’ times and staff well-being. The AFs also contained data relating to incidents, application of duty of candour and complaints, this allowed managers to share essential information such as learning from incidents and take action as needed. Our conversations with leaders at all levels and our review of minutes from various meetings at divisional and board level confirmed that the AF was integral in challenging poor performance and holding those responsible for service delivery accountable in line with local and statutory requirements. Papers and reports for board meetings and other committees were of a reasonable standard and contained appropriate information.

Non-executive and executive directors were clear about their areas of responsibility. Areas of responsibility were detailed in the trust’s corporate governance framework. The framework also had a Scheme of Delegation which highlighted who was responsible for making decisions at an executive level in matters related to areas including finance and workforce.

Staff that we spoke with at all levels of the organisation understood their roles and responsibilities and what to escalate to a more senior person. Key trust policies such as the equal opportunities policy and escalation policies clearly outlined the responsibilities of individual staff members at various levels.

The trust had introduced a “Your team Ipswich Passport” for temporary workers. This included a welcome note to temporary workers and outlined the trust values and behaviours. It included specific induction checklists and a record of skills and preferences alongside training and competencies. The information included in the passport allowed the senior staff on the placement ward to ensure the temporary member of staff had the appropriate skills and training required. The
temporary staff keep the passport and were required to show this, along with identification, to the senior nurse on every shift.

The trust worked with external partners to develop governance arrangements to promote effective patient care. For example, the trust had worked with two local trusts to provide community services as an alliance (this was due to end 1 October 2017 when Ipswich hospital was to become the sole provider of community services). The trust had also developed arrangements with a third party to provide psychiatric liaison services.

Management of risk, issues and performance

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. The governance team regularly reviewed the systems. We interviewed the director of governance who was in the process of implementing a risk management process which focussed equally on embedding processes for identifying risk and taking steps to achieve quality improvement. Most staff that we spoke with told us about the ‘big risk’ form. When risks were identified through channels such as learning from incidents, audits, patient safety alerts, complaints and patient and staff feedback, leaders responsible for monitoring and managing the risks were encouraged to use the form to consider the immediate, long-term and potential risks and ways to mitigate the risk as low as possible.

The trust used the accountability frameworks to form a basis for an integrated divisional performance report which was used for discussion and review at committee and board meetings. Our review of minutes from public and private trust board meetings confirmed that the integrated performance reports were used to manage current and future performance. For example, the trust had a comprehensive cost improvement programme (CIP) which was monitored through the local and divisional AFs and included in the integrated performance report. This metric was discussed at various meetings including the quality and safety committees to ensure that CIPs were not impacting on patient care and informed the board if the trust was meeting financial targets.

Leaders were satisfied, in the main, that clinical and internal audits were sufficient to provide assurance. Teams acted on results where needed. The trust had an audit committee which was chaired by one of the non-executive directors. The committee met bi-monthly and reviewed all audit activity to ensure that audits were delivered on time and recommendations from audits were acted upon. For example, minutes from a meeting held in February 2017 showed that the audit committee had discussed the ‘nerve centre’. The trust ‘nerve centre’ was an electronic system used to record patient observations that was introduced in 2016. Concerns were raised in relation to the accuracy and timeliness of the data that was entered and whether or not it was in line with the trust’s deteriorating patient policy. It was established that an audit would be undertaken in March 2017 to test the system. The results were reported to the committee in April 2017 and showed that there was some room for improvement as not all medical staff were using the system in line with the policy. This did not present an immediate risk to patient safety as all patient observations were being recorded on nursing documentation and monitored through local audits and the AF. It was decided that the issue would be referred to the quality committee to ensure that the use of financial resources to maintain the ‘nerve centre’ was in the best interest to enhance patient care.

The trust had performed badly in the End of Life Care Audit: Dying in Hospital”, published in March 2016 by the Royal College of Physicians and had taken action in response. Monitoring against the actions identified was through the End of Life Programme Board. However we found that there remained a lack of clarity around how quality improvement measures were monitored for End of Life Care (EOLC), how local audits were being utilised to make improvements and how incidents specific to EoLC were highlighted to identify learning and areas for improvement. The executive
lead for end of life care confirmed that the hospital did not audit preferred place of death or care (PPD/PPC). This meant there was no way to measure how many patients had received care and died in their preferred place.

Concerns had been raised to the trust by Healthwatch Suffolk in April 2017 with regard to professional understanding of how to implement and practice the Mental Capacity Act to which the trust formally responded. We found that there were established safeguarding clinical leads within the trust that worked in partnership alongside a dementia and learning disability lead. All were passionate about their roles and safeguarding patients from abuse. There were established processes in place, with updated policies and good access to lead staff and a reporting and assurance structure to the board. However we also found that staff knowledge, understanding and ownership around Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) and safeguarding concerns was inconsistent. Staff were not confident about their own responsibility with the onus being on referral to the safeguarding leads to raise appropriate concerns and take action. We raised our concerns during inspection and were informed that the trust were beginning to introduce a number of safeguarding link staff in various departments to provide additional support and embed processes. Staff knowledge of MCA and DoLS varied across the services. The dementia lead provided training however take up was variable and they were aware of issues with capacity assessments linked to DNACPR orders, specifically for vulnerable patients. Evidencing patient capacity and documentation was not robust. It was felt that staff, including doctors, were frightened of making the decisions.

The trust had reviewed their risk management processes to move from a risk management policy approach to a risk management strategy approach. This included replacing their risk management system to align with the new approach. This meant that staff with responsibility for monitoring risks had a full risk profile for their area and would escalate as appropriate. This meant that divisional and trust governance focused on emergent risks that were escalated and required mitigation and a controls assurance focus for known risks and mitigations already in place.

Arrangements were in place for identifying, recording and managing risks, highlighting issues and implementing mitigating actions. Recorded risks were aligned with what staff told us, during the core service inspections, was on their ‘worry list’. The trust board had sight of the most significant risks and mitigating actions were clear through the accountability framework. Divisional boards fed into trust wide groups and monthly divisional oversight meetings that in turn fed into the trust wide quality committees, into executive management committee and then trust board. However we found there was a lack of senior oversight and risk assessment for both the discharge lounge and the Electrical and Biomedical Engineering (EBME) department. Concerns in the discharge lounge centred around a lack of emergency resuscitation equipment, lone working and impact this may have on managing the deteriorating patient. and no formalised admission criteria outlined. The environment within EBME department did not appear fit for purpose with restricted environment and a leaking roof. Staff we spoke with stated they had raised concerns however the issues remained unaddressed. We raised this during inspection and the trust took action to address the concerns.

Staffing in the EBME department had reduced due to vacancies and retirement and this was having an impact on the capacity to repair equipment in a timely manner. There was a process for equipment service and repairs in place. Referrals to the Electrical and Biomedical Engineering (EBME) team were tracked through the software system. Repairs were categorised according to priority. Faults and planned maintenance were recorded via the accountability framework scorecard. Information provided post inspection demonstrated that for priority one repairs (that
required to be rectified within one day) the trust performance had declined from 100% in May to July 2017 to 91.7%, 92%, 97% and 94.9% in August to November 2017 respectively however this remained above the compliance target of 80%. This meant the trust continued to respond to the most urgent equipment repairs. The trust also achieved consistently above the 70% target for both priority 2 repairs (faults rectified within three days) and priority 3 repairs (faults rectified within seven days) over the same time period. Where there was a notable decline was in the performance of the lower priority 4 repairs (faults rectified within 14 days) where the target of 70% was met in four of the eight months between April and November 2017. In June, July, September and October 2017 performance was 60.7%, 47.5%, 55% and 53.6% in those months respectively. However in November this had significantly improved to 84.8%.

During episodes of increased capacity the trust undertook a ‘red to green’ approach to access and flow in the hospital. This is a more formal approach to capacity that encompasses identifying empty beds, planned and potential discharges and review of elective patients. This can make a real difference to patients’ experience of care by reducing unnecessary delays. Red to green was in operation during inspection. The red to green meeting had representation from all divisions, clinical and operations staff, the patient flow team and complex discharge team along with wider network staff such as social worker and hospice representation. The meeting was structured and organised with supportive challenge given and proactive support across the teams to address any issues that may be cause for delay such as diagnostics, referrals, repatriation (from or to another trust) and pending clinical review. Examples included one patient that had been declined admission to a nursing home due to a funding issue for bariatric equipment required for discharge. The patient had been in the trust for 120 days, there was a decision made to complete an exceptional funding form and a nominated person identified to undertake this and liaise with the director of contracts at the appropriate clinical commissioning group (CCG). Another example was identification of a patient that required a multiagency review. Similarly there was one patient, post stroke, awaiting repatriation to another trust (nearer to where they lived). However that trust were currently under bed pressures and so plans were identified to assess therapy and home requirements to enable discharge straight to home should this be appropriate.

At the time of inspection the finance director had been in post as an interim for eight days however they had been deputy finance director for the previous four years which meant continuity was maintained. The finance and performance committee is a sub board of the Trust board. In addition the finance manager sat on the workforce committee but did not sit on the quality committee. We were informed that there was an established quality assessment process through the divisions, Director of Nursing and Medical Director to ensure all cost improvement ideas did not negatively impact patient care. Staff were aware of their contribution to cost improvement objectives and there was support and training provided to middle managers to enable ownership and responsibility for cost improvement. Finance managers supported each of the divisions. The trust has a good relationship with the Clinical Commissioning Groups (CCG) and had negotiated a Guaranteed Income Contract (GIC) with the lead commissioner which was being continued this year 2017/18. This approach was helping to underpin the system financial position and support the focus across all organisations to the system-wide costs of providing healthcare. The Trust board reviewed the financial projection for 2017/18 and believe it to be a credible and appropriate plan, whilst recognising that there is an increased risk profile to the plan linked to a challenging requirement to identify and deliver efficiencies. The Trust financial plan is aligned intrinsically to the Trust Strategy ‘Writing the Next Chapter’.

The Director of Nursing confirmed that sepsis remained high on the trust agenda. Two specialist nurses (one for sepsis and one for acute kidney injury - AKI) had recently been appointed. There was monthly reporting via a sepsis CQUIN and whilst better care was embedded for neutropenic...
patients and in the emergency department the trust were working on improvements elsewhere. Just prior to the inspection the trust had recently celebrated sepsis awareness week. There was an electronic system for observations in use for early warning scores and the trust were building a business case to add into it the sepsis module that will also then pull in data from the hospital laboratories.

There were plans in place for emergencies. For example adverse weather, a flu outbreak or a disruption to business continuity. The trust had a comprehensive major incident and business continuity plan which met national legislation.

**Information management**

Through the accountability framework (AF), committee reports and integrated performance reports the board was able to receive holistic information on quality and sustainability. Leaders used meeting agendas to address quality and sustainability sufficiently at all levels across the trust. Staff said they had access to all necessary information and were encouraged to challenge its reliability.

Data quality was discussed at board level through the clinical quality report and data quality improvement plan which was developed to ensure that the trust met national standards related to data validation and quality. Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. The information was available through the AF which was displayed in staff communal areas and local leaders were able to discuss the information at team and divisional meetings.

The board and senior staff expressed confidence in the quality of the data and welcomed challenge. The trust had commissioned external reviews to provide assurances to all stakeholders that data quality and validation processes were effective and the trust sought to make improvements where required.

The Trust ICT enabling strategy outlined the strategy for ‘Digitising the Next Chapter’ to support the delivery of the Trust Strategy 2017-2022, aimed at providing a strategic framework for IC&T developments within the Trust. Five priorities are outlined in the strategy with the first being integrated clinical system Support, with the aim to have single sign and security access for clinical teams accessible at the point of care irrespective of organisation boundaries. The electronic tool ‘nerve centre’, used within the childrens and young peoples service, records paediatric early warning scores which then sends an automatic alert if the score is too high so that the patient can be promptly reviewed.

The Trust was aware that the existing clinical systems used were disparate and the level of information available was often limited by the location of the care or by the infrastructure and devices provided to staff and were taking steps to make improvements. For example there was a target date of October 2017 for staff in the community services to be able to access the trust intranet.

The trust had recently introduced an electronic staffing tool that had been in place for four weeks at the time of inspection. The tool was based on patient acuity and required staff on the wards to enter an acuity score for patients three times a day. The system provided a percentage of shifts where staffing matched patient acuity for early, late and night shifts and indicated a level for each ward. This is then utilised at the bed meetings to allocate staff and mitigate gaps. There were plans to build in red flags from National Institute for Health and Care Excellence (NICE) guidance into the system. At the time of inspection the tool did not interact with the electronic rostering tool.
directly but there were plans to try to integrate the two systems to enable review in advance, possibly one week ahead. Once data base was established it would also be utilised for trend analysis.

There were arrangements to ensure the availability and integrity of identifiable data, records and data management systems in line with data security standards. However, notes trolleys were not fully secure but were stored in areas where staff were present, such as behind nursing desks. In the majors area of the emergency department notes were left in pigeon holes. These were not in view of patients and were not easily accessible to patients but were accessible to staff. Within the pigeon holes (numbered for each bay) there was a confidentiality sheet in front of the notes as an extra precaution.

The medical director was the appointed Caldecott guardian and the trust had identified that a current information governance risk was delivering on the General Data Protection Regulation (GDPR) standards. In January 2012, the European Commission proposed a comprehensive reform of data protection rules in the EU. While the regulation entered into force on 24 May 2016, it shall apply from 25 May 2018. To prepare for this the trust had in plan an internal and external audit to determine their readiness.

Staff raised concerns during the inspection about the administrative process surrounding the issuing of death certificates and cremation documentation. This had direct impact on families and loved ones experiencing delays in making funeral arrangements. An audit and analysis had been undertaken and plans had been devised to improve the efficiency of the system. Timely completion of death certificates was included as an objective in the end of life care strategy and meeting minutes showed this was discussed at the end of life programme board on 22 August 2017.

Generally, data or notifications were consistently submitted to external organisations as required.

Engagement

The trust had a structured and systematic approach to engaging with patients, those close to them and their representatives. A full and diverse range of people’s views and concerns was encouraged, heard and acted on to shape services and culture. There was an established, nationally recognised, ‘patient leader’ network in place where 14 user groups met regularly with trust leads to feed into the Ipswich Hospital User Group (IHUG). IHUG provided a strong user voice on various committees such as charity, nutrition, infection prevention and control, art project, quality improvement and end of life care work streams. IHUG met with directors and non-executive directors (NED) every six weeks to ensure ongoing monitoring of views and issues raised alongside engagement with service and strategic developments. The main objective of IHUG is to improve the patient experience by working together with staff. ‘Adopt A Ward’ informal ward visits take place to talk to patients, carers, visitors and elicit ‘soft intelligence’ and provide real-time feedback to ward staff to highlight issues, make improvements and provide praise as appropriate. The chair of IHUG also attends and prepares a report for each public board meeting and also co-chairs the CCG’s community engagement partnership. Public consultation took place in different areas of the community to develop the strategy and then consult on it.

Wards, teams and divisions had access to feedback from patients, carers and staff and were using these to make improvements. Patients were invited to provide feedback and comments through comment cards or electronically with a hand held device, we saw that adaptations were in place for children. The trust also participated in national patient surveys, for example the friends and family test and the CQC inpatient survey.
The trust had an active volunteer network with a carer’s cabin-coffee shop on site that is run by Suffolk Family carers and is open Monday to Friday. The trust works collaboratively by providing initial training when volunteers start. Volunteers are provided with free parking, a lunch allowance and can claim mileage expenses. The trust has a substantive member of staff whose role is to support and provide information to carers such as registration, information about carers’ assessments and help with applications for ongoing care.

Healthwatch Suffolk report identified that the majority of patients that shared experience with Healthwatch were positive about the care provided at the Trust. Ratings recorded onto the Healthwatch feedback centre were four stars based on 726 comments, including 354 five star reviews between September 2016 and August 2017. Cleanliness, staff attitude, waiting time, treatment explanation and quality of care all received ratings of four stars or above. The trust has regular engagement meetings with Healthwatch to discuss any issues and Healthwatch Suffolk attended key events and activities at the hospital. There was evidence that the trust responded to concerns raised by Healthwatch, for example with regard to discharge to care homes and poor communication, the trust outlined actions that included increased collaboration and investigation into time spent on hospital transport and spot check on nursing documentation amongst others. The Trust held an open day for local care homes to continue engagement and improve service.

The trust had a structured and systematic approach to staff engagement. All members of the senior team were visible throughout the trust, undertaking walk rounds and engaging with patients, relatives and staff. These were not just limited to ward areas and included others such as administration offices, finance and the central sterilising services department (CSSD).

The trust was in line with the national average for staff engagement and had the ambition to be in the top 20% for staff satisfaction and engagement by 2022. From surveys the trust had identified four key areas to address, appraisal and development support, communication between senior management and staff, errors and incidents (bullying and harassment) and health and well-being. The staff engagement ‘Rapid Action Plan’ June to September 2017 outline a programme of work over 16 weeks to gain divisional and staff input into devising changes by engaging in ‘what matters to you’ plan whereby each of the four key areas would be addressed. This included focus groups, drop in sessions, individual and team workshops culminating in a review and communication of findings and agreed commitments.

**NHS staff survey performance**

In the NHS Staff Survey 2016, the trust performed “better than” other trusts for six questions, “about the same” as other trusts for five questions and “worse than” other trusts for 21 questions.

The questions for which the trust performed “better than” other trusts were:

- Percentage of staff believing the organisation provides equal opportunities for career progression / promotion (89% compared to the England average score of 86%).
- Percentage of staff reporting errors, near misses or incidents witnessed in last month (91% compared to the England average score of 90%).
- Percentage of staff feeling unwell due to work related stress in last 12 months (33% compared to the England average score of 35%).
- Percentage of staff agreeing that their role makes a difference to patients / service users (92% compared to the England average score of 90%).
- Percentage of staff experiencing physical violence from staff in last 12 months (1% compared to the England average score of 2%).
• Percentage of staff reporting most recent experience of violence (71% compared to the England average score of 67%).

The questions for which the trust performed “worse than” other trusts were:

• Percentage of staff appraised in last 12 months (84% compared to the England average score of 87%).
• Quality of appraisals (2.87 compared to the England average score of 3.11).
• Quality of non-mandatory training, learning or development (3.98 compared to the England average score of 4.05).
• Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month (32% compared to the England average score of 31%).
• Fairness and effectiveness of procedures for reporting errors, near misses and incidents (3.67 compared to the England average score of 3.72).
• Staff confidence and security in reporting unsafe clinical practice (3.57 compared to the England average score of 3.66).
• Percentage of staff attending work in last 3 months despite feeling unwell because they felt pressure (58% compared to the England average score of 56%).
• Organisation and management interest in and action on health and wellbeing (3.52 compared to the England average score of 3.62).
• Percentage of staff satisfied with the opportunities for flexible working patterns (48% compared to the England average score of 51%).
• Percentage of staff working extra hours (76% compared to the England average score of 71%).

The engagement score for this trust was 3.81, which was the same as the England overall figure.

(Source: NHS Staff Survey 2016)

Health promotion

Supporting patients to achieve healthier lives was identified as a key work stream in the Quality Improvement Plan. As part of this the trust was working with public health to embed Making Every Contact Count (MECC) and Health coaching across the workforce to support staff to have a different conversation with patients. Preoperative assessment provided an opportunity for discussions with patients around what changes they could make to improve their own health and outcomes.

The trust had recently become a tobacco free site and all patients could access smoking cessation support. Signposting leaflets for visitors and staff were in place to access smoking cessation services.

Multidisciplinary specialist input supported and helped to provide patients and their carers with tools, education, support and encouragement to self-manage where appropriate. For example all inpatients at risk of malnutrition were seen by a dietitian and had a care plan devised. The trust also worked with system partners to develop a joint approach such as closely working with the local mental health provider through the psychiatric liaison service.

The trust also was actively seeking to encourage health promotion amongst staff. The staff engagement ‘Rapid Action Plan’ theme for September 2017 was health and wellbeing in response
to a key area of concern in the 2016 staff survey. Wellbeing sessions that were included in the plan were smoking cessation, weight management, exercise classes and personal resilience.

**Learning, continuous improvement and innovation**

There was a strong focus on continuous learning and improvement at all levels of the organisation. The senior executive team actively promoted quality improvement through responsibility, accountability and ownership at divisional and local levels. There had been improvement in several core services. Local teams were passionate about providing patient care and striving to improve. For example there had been a focus within medicine on improving the provision of elderly care that included integrated therapy work, implementation of a system wide frailty pathway and care home discharge to assess pathway. The Frailty Assessment Base won a patient experience network national award in March 2017 (PENNA) and received Health Service Journal’s (HSJ) Value in Healthcare Award in the ‘value and improvement in acute service redesign.’ The service prevents high numbers of admissions. In the first year 90% of patients returned home, 31% with additional support or review, 3% were stepped up into intermediate care beds and 7% were admitted to hospital. At 30 days 81% of those assessed had continued to remain at home.

The trust has a simulation training centre that opened in 2013, with dedicated simulation training facilitators. The centre provided bespoke and team driven scenarios as well as multiagency simulations. The simulations are recorded “live” and then watched with feedback given immediately that included candidates undertaking their own after action review (AAR). If trends are identified then the facilitator will escalate to the appropriate teams to ensure shared learning. The Ipswich hospital user group (IHUG) have also participated in scenarios to provide insight and perspective from a “relative’s role”. The centre achieved funding to provide human factors training that has been undertaken on two wards with 98% of nursing staff from these areas attending.

Responses indicated a positive impact with communication and team working. Following which the training will be continued in other areas of the trust. An example of the bespoke training scenario was a designed simulation of a dislodged tracheal tube for intensive care staff. An area being developed was mental health training that included deprivation of liberty safeguards (DoLS) with capacity and capability of patients. At the time of our inspection there was an application to the board for funding of two more mental health courses before the end of the financial year with the plan for these to be both hospital and regionally based by inviting other providers to apply for the training. The centre was also collaborating with the local NHS mental health trust to run a pre and post-natal training course in November 2017.

There were a number of forums used to share learning including the nursing and midwifery board, and mortality and morbidity (M&M) meetings. However we did find that junior doctors were not provided with the opportunity to attend M&M meetings which was fed back to the trust during the inspection. There was a system in clinical areas of “red folders” that detailed recent incidents and complaints along with the recommendations for improved practice. Executive summaries of incidents from other clinical areas was also captured and staff throughout the services utilised these. The nursing teams had also implemented a five minute huddle process where five topics a day were discussed in huddles, to ensure focused awareness on learning.

The trust was accredited in the following external schemes:
- Joint Advisory Group on Endoscopy (JAG) 2016
- Clinical Pathology Accreditation and it’s successor Medical Laboratories ISO 15189
- CHKS Accreditation for radiotherapy and oncology services
The contract for Community Services in Suffolk expired in September 2017 and the Ipswich and East Suffolk and West Suffolk CCG’s launched the multiscpecialty community provider (MCP) tendering process at the end of summer 2016. Ipswich Hospital developed an alliance for east Suffolk services with Suffolk County Council (SCC), Norfolk and Suffolk Foundation Trust (NSFT), and the Suffolk GP Federation to respond to the bid. The alliance was successful and Ipswich hospital trust take over the contract (including services subcontracted to the GP Federation) for service delivery of the services from 1st October 2017.

The Trust worked closely with commissioners to undertake wholesale service transformation through the development of Clinical Transformation Groups (CTG’s). These were clinically led by a hospital consultant chairing a steering group with system partners, including a GP lead. This approach delivered greatly improved collaboration between acute clinical services and primary care improving service provision for patients. The CTGs have engaged to deliver end-to-end pathways in a number of specialties including musculoskeletal (MSK), Ophthalmology, Gastroenterology, Audiology and Respiratory.

The trust had also developed standardised pre-referral guidance and implemented prior approval processes across a number of specialties to improve the quality and completeness of referrals. This has reduced inappropriate referrals, and has been educational for GP’s. The trust approach to the provision of Advice and Guidance to GP’s ‘ALL CAS’ (Advice Letter Listing Clinical Assessment System) influenced the redesign of the national e-referral system.

### Acute services

### Urgent and emergency care

#### Facts and data about this service

The emergency department (ED) at Ipswich Hospital is located within the Private Finance Initiative (PFI) wing of the hospital that was purpose built and opened in 2007. The ED at Ipswich Hospital provides a 24-hour, seven day a week service to the local area.

From April 2016 to March 2017, there were 87,970 Urgent and Emergency Care attendances at Ipswich Hospital NHS Trust. Of these attendances, 26.8% resulted in an admission, compared to the England average of 27.4%. The department had 19,745 attendances for children. The department also had 27,685 attendees arriving by ambulance during the same time period.

The ED provided care which was divided into different streaming areas from minor injuries to major trauma (the ED achieved major trauma unit status in 2013). The emergency department has a resuscitation area with five resuscitation bays, two of which were used for rapid assessment and treatment and a dedicated resuscitation bay for children. These are positioned next to the dedicated ambulance entrance. There are 12 cubicles for patient in the majors streaming area and four assessment and treatment rooms for patients in the ambulatory care stream (minors’ area). The department also had a dedicated x-ray room, low stimulation room, a relative’s room and a designated children’s ED.

The children’s ED was accessed from the main waiting room with swipe card access, patients and their parents had to be given access children’s waiting area by a member of staff. The department had three treatment and assessment rooms for children in a secure area.
Our inspection was unannounced (staff did not know we were coming) to ensure to observe routine activity. During our inspection we used a variety of methods to help gather evidence to assess and judge the urgent and emergency services at Ipswich Hospital Trust. We spoke to 31 staff, four adult patients and relatives. We examined 20 patient records six of which related to children. We interviewed the associate director of nursing and three consultants working within the emergency department. We spoke with professionally qualified and support staff. We observed the environment and the care provided to patients. We also looked at a wide range of documents including policies, meeting minutes, action plans and audit results.

Is the service safe?

Mandatory training

The trust had a programme of mandatory training that all staff had to complete. The modules that formed mandatory training included; basic life support, clinical fire safety, moving and handling, PREVENT, safeguarding children level two, safeguarding children level three, conflict resolution and blood awareness. The trust had a rolling mandatory training year.

Nursing staff were rostered into mandatory training on the duty rotas and the educational leads informed us that they avoid rostering training during peak holiday periods. The educational leads could additionally work clinically in any area of the emergency department to backfill and allow staff to attend training.

Nursing staff had a mandatory training handbook produced every year. A staff nurse showed the inspection team their handbook, which demonstrated they were up to date with their competencies and mandatory training. A staff member told us that there were many training opportunities within the department and that they were part of a band six preceptorship programme. The ED educational leads would log the completion of mandatory learning on a database that was Red Amber Green (RAG) rated to show what training was outstanding for which staff member. The department ran emergency department refresher training three times a year; it was mandatory for staff to attend at least one session per year. The table below shows the completion rate for each of the mandatory training core modules for staff in the emergency department.

The trust set a target of 95% for completion of mandatory training. A breakdown of compliance for mandatory courses between June 2016 and June 2017 in urgent and emergency care is shown below;

Note: The trust did not provide a staff group breakdown for medical & dental/nursing & midwifery staff therefore this is an overall staffing completion rate.
The trust only met the 95% target for the blood awareness training module. The trust did not meet the target for the remaining six modules; conflict resolution had the lowest completion rate with 60%.

(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training)

Information provided following inspection demonstrated that there was a higher compliance for mandatory training by nursing staff than medical staff however none met the trust’s target of 95%. For example nursing staff compliance was 90% (96 staff out of 106 had completed training) for basic life support, 78% (83 staff out of 106) had completed clinical fire safety and 70% (74 staff out of 106) had completed moving and handling training.

In contrast for the medical staff 36% (nine medical staff out of 25) had completed basic life support and 48% (12 medical staff out of 25) had completed clinical fire safety. The data provided stated that moving and handling training was not applicable for medical staff. Therefore staff were not up to date with mandatory training requirements for their roles. We were not assured that medical staff had appropriate training and skills for moving and handling patients in a way to protect both the patient and staff from injury.

There was a display in the staff room showing the emergency department’s performance with mandatory training. This reminded staff when they needed to book refresher training. The display showed that staff had not completed the mandatory training to meet the trust's target of 95% in all core modules.

We spoke with three members of staff about mandatory training. They told us they were able to access mandatory training and that training opportunities were good within the department.

Staff were required to complete statutory eLearning modules and this was supported with a training handbook. Modules included but were not limited to, dementia awareness, end of life care, leaning disabilities awareness and medicines optimisation.

Safeguarding

The department had processes in place to ensure that adults and children in vulnerable circumstances were safeguarded from abuse or harm. However we found that documentation
surrounding risk assessments were not always comprehensive and not all staff had the correct level of safeguarding training for their roles.

The ED met most of the Royal College of Emergency Medicine standards for safeguarding children with the exception of all medical and nursing staff receiving child protection level two.

The intercollegiate document ‘Safeguarding children – Roles and competencies for healthcare staff’ published by the Royal College of Paediatrics and Child Health (RCPCH) 2014 provides guidance on the level of safeguarding training required for different staff groups. The document states that ‘All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns’ should be trained in safeguarding for children levels one, two and three’.

Safeguarding children formed part of staff mandatory training for all clinical staff working within the ED. All clinical staff were expected to complete safeguarding children to level three. The training consisted of three modules, which were delivered face-to-face over a three-year rolling programme.

The ED had not met the 95% trust target for staff completing training for safeguarding children level two and level three.

The trust set a target of 95% for completion of safeguarding training. A breakdown of compliance for safeguarding courses between June 2016 and June 2017 in urgent and emergency care is shown below:

Note: The trust did not provide a staff group breakdown for medical & dental/nursing & midwifery staff therefore this is an overall staffing completion rate.

The trust did not meet the completion target of 95% for either the safeguarding children level 2 or safeguarding children level 3 modules.

(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training)

Information provided following inspection demonstrated that 81% (86 staff out of 106) of nursing staff had completed safeguarding children level 3 and 44% of medical staff (11 out of 25) had completed safeguarding children level 3.
The department had a notice board in the staff room dedicated to safeguarding. The display had information about female genital mutilation (FGM), a guide for making a safeguarding referral, safeguarding referral forms and a flowchart for assessment following sexual assault. The notice board also displayed contact numbers for the local safeguarding team and information about making safeguarding referral out of hours.

The electronic learning module for safeguarding level one included information related to FGM for both adults and children and covered topics such as child sexual exploitation.

Staff could clearly describe the procedure they should follow if there was a safeguarding concern about a child or an adult. We spoke with six members of staff about safeguarding and all of them were able to describe the procedure to raise concerns and were able to give clear examples of concerns they had raised in the past.

The emergency department (ED) had close links with the trust safeguarding team. The safeguarding children’s nurse collected data every morning from the department and staff could contact them directly if they had any concerns. Staff we spoke with were able to name the safeguarding lead and told us they felt comfortable to contact them if there were any safeguarding concerns.

The hospital used an electronic flagging system on their patient electronic record for safeguarding alerts. Staff in the ED had access to this system, as patients were booked into the department at either the main reception or the ambulance reception. The safeguarding team were alerted to patients with existing or new alerts when they presented at the department or the next day if they presented at night.

The emergency department had a safeguarding link nurse. The link nurse role had been re-introduced a short time before our inspection and was still in the process of being embedded in the department.

We reviewed both paediatric and adult patient records, which contained safeguarding flow charts. However, the flowcharts only related to physical injuries and there was no prompt for other factors of abuse for example societal and environmental factors. We raised these concerns with the senior leadership who advised us that the trust was in process of updating the ED patient records which included a flow chart for all types of abuse.

**Cleanliness, infection control and hygiene**

The emergency department was mostly clean and corridors and waiting areas were free from clutter. In addition, we saw the clean utility and storage areas were visibly clean and well organised.

There were hand hygiene stations within all of the cubicles in the department and wall mounted hand-sanitising dispensers in the corridors. We observed that staff sanitised their hands between contact with patients and when moving around the department. Staff actively encouraged patients and their relatives to engage in this process by reminding them to sanitise their hands.

All staff wore uniforms with short sleeves to ensure they followed the ‘arms bare below the elbows’ guidance.

Staff consistently demonstrated the effective use of personal protective equipment (PPE) such as gloves and aprons. We observed staff using and disposing of PPE items appropriately in clinical waste bins.
Clinical waste and domestic waste bins were available in all patient treatment areas and were clearly marked. We saw sharps bins were in all clinical areas, of the seven we checked all labels had been completed by the person who had assembled them with the date of assembly.

Staff told us that they cleaned all of the equipment after each patient transfer or discharge. We observed staff cleaning a patient assessment trolley and equipment in one of the cubicles thoroughly following a patient transfer. All surfaces were cleaned using an appropriate cleaning solution.

We found rusted and dusty equipment in two of the cubicles. In one of the cubicles, there was a dusty aged suction machine with rust to the surface and also rust and bubbling paint on the patient assessment trolley. In another cubicle we found a layer of dust to the base of the patient trolley. We were concerned that this posed an infection risk to patients. We escalated these concerns to a senior member of staff who told us that they would arrange for the items to be cleaned and assessed.

Domestic staff were visible within the ED and made regular checks to ensure the environment remained clean. We reviewed the cleaning audits from March 2017 to July 2017, which showed that the department scored between 98-100%.

The ED undertook monthly audit for urinary catheter insertion, peripheral intravenous care and hand hygiene. The department scored between 98 - 100% consistently from April 2017 to August 2017.

**Environment and equipment**

The design, maintenance and use of facilities and premises generally met all patients’ needs. There were not systems and processes in place to ensure that the maintenance and use of equipment kept people safe.

There was a dedicated children’s ED, which had secured entry from the adult waiting area. All doors in to the children’s ED were secured with swipe care entry and all visitors had to gain entry by the main reception or with a member of staff. There was also one bay in the resuscitation area specifically for children and had been decorated with child friendly wall art. In the event of a further child in the resuscitation area an adult bay was used.

The children’s department had a dedicated waiting area with age appropriate toys and distractions for patients under the age of 18 years. The waiting room was visible from the reception desk. There were four assessment rooms with appropriate equipment such as cardiac monitors, suction units and electronic weighing scales. All of the equipment we checked in children’s ED was up-to-date with electrical safety testing and daily checks had been completed according to the records.

The nurses’ station was central to the major streaming cubicles and the resuscitation bay. This gave staff good visibility of the most critically ill patients. This also enabled staff to assess the demands of the department. However, the minor streaming area was out of sight of the main staff desk and was not in direct sight of the waiting room. We were concerned that staff did not have oversight of patients in the main waiting area if their condition deteriorated.

The ED had x-ray facilities located in the ambulatory care area of the department, enabling good patient access. Computerised tomography (CT) facilities were located within the main radiology department of the hospital a short distance from the ED.
The adult’s waiting area was large with a reception desk positioned next to the security doors for the children’s emergency department. There was limited protection for receptionists who worked at the reception desk because there were no protective screens. The receptionists felt this would pose a risk to their security if a patient became agitated. We raised this concern with senior managers in the ED team and we were told that options were being considered in response to the concerns raised by staff, however, consideration was also being given to the patient experience and screens sometimes were considered as a barrier to patient-centred care. This was not highlighted as a risk on the departmental risk register.

The ED did not have a dedicated mental health assessment room within the department for patients with mental health support needs. From 7am to 7pm, adults and children who presented to the ED with mental health illness were referred to the mental health liaison team. The mental health liaison team were from an external provider and they had a dedicated room adjacent to the main waiting room in ED. Outside of these hours, the ED did not have access to this room and used bays within the majors’ area and a side room for patients presenting with acute mental health illness. These did not meet Royal College of Emergency Medicine guidance, as there were ligature points and a lack of security and visibility.

The department did not have a formalised risk assessment tool for the cubicles or the side room to assess the safety for patients with mental health needs. Staff used an informal risk assessment process and this was not documented. There had been 14 incidents between August 2016 and June 2017 that were described as incidents of self-harming behaviour. The lack of dedicated mental health room and formalised risk assessment was not highlighted as a risk on the departmental register. We brought this to the attention of the senior team who undertook a risk assessment that identified controls and actions to be taken to reduce the risk to patients. This included ensuring the bay utilised was closest to the nurses’ station for observation, adaptation of the environment to remove any potential self-harm items such as sharps and potential ligature cords, one to one care and 15-minute observations. The risk assessment provided stated that monitoring would occur through a documentation audit focused on completion of a patient mental health risk assessment and the mental health governance forum; however this was yet to be embedded. The patient mental health risk assessment for both children and adults was specific to the patient’s condition and did not include a record that the environment had been adapted or that the steps taken in the risk assessment had applied therefore it was unclear how the assurance would be provided that the steps had been taken to alter the environment appropriately via a documentation audit of these forms.

The department had a low stimulus room within the majors streaming area, this room was used to care for patients who required a quiet care environment. The room had no medical equipment and had a panic alarm. The staff we spoke with about the room told us the room had multiple uses for example to care for patients who were agitated and a quiet area for relatives to view deceased patients.

Nursing staff working in the area were required to check the equipment in the resuscitation bays daily. Staff had a check sheet to complete and they were able to list any missing equipment and out of date equipment or medicines. Staff working in the resuscitation area told us they raised any issues with the equipment checks to the floor co-ordinator immediately to ensure these items were replaced quickly.

There were three resuscitation trolleys within the adult emergency department and one in the children’s emergency department. Each trolley was sealed with a tag, which had a unique identification number. A member of the nursing staff was allocated the task to check the resus trolleys on a daily basis. Equipment on top of the trolley was to be checked daily and the contents of the locked draws were to be checked weekly or when the seal had been broken.
During our inspection, we looked at the frequency at which the resuscitation trolleys had been checked. Within the majors streaming area, the records showed checks had not been completed for 6, 9, 20 and 29 August 2017, and the records noted that the department was too busy to complete the checks. We raised this as a concern with the matron for the department who told us that staff had not followed the correct procedure. Information provided following inspection identified that there was a process in place for monitoring of daily checks such as fridge temperatures and resuscitation checks. It was part of the floor co-ordinators role to record that these checks had been completed on the shift log, which was then scanned and saved. The resuscitation trolley checking records had been removed for the other two trolleys in the department, to be audited by the resuscitation officers, because it was the end of the month. Data provided following inspection demonstrated that in August compliance checks for the resuscitation trolleys were as follows: 81% in resus one, 94% in resus two, 97% in resus three, 94% in majors and 97% in paediatrics. The ED resus bay in paediatrics had been completed every day between 18 and 31 August, however it was noted that the sheet for the beginning of the month (1-17 August was missing). Compliance had slightly improved in September, ranging between 90 and 100% across all areas.

There was a process for equipment service and repairs in place. Referrals to the Electrical and Biomedical Engineering (EBME) team were tracked through the software system. Repairs were categorised according to priority however not all equipment was up to date with routine electrical testing. We checked 36 items of electrical equipment, which included electro-cardiogram monitors, defibrillators and suction units; of these six were not up-to-date with electrical safety testing. We spoke to the EBME manager who reported that safety testing was completed on the electrical equipment that was available to test at the time the team were in the department, which meant those items in use would need to be rescheduled for testing. However, there was no clear system to ensure all outstanding items were tested.

**Assessing and responding to patient risk**

The emergency department used a rapid assessment and prioritisation tool called the Manchester triage system to stream presenting patients through the department. Patients were seen in priority dependent of their presenting condition. We tracked seven patients through the emergency department and of these five patients were triaged within 15 minutes of arrival.

Patients that arrived in the department as a priority (blue light) call were transferred to the resuscitation area immediately for rapid assessment and treatment. The department had two resuscitation bays set aside for the rapid assessment and treatment of patients. The resuscitation bays were positioned close to the ambulance entrance.

Nurses and doctors staffed the rapid assessment bays to ensure assessments were undertaken and diagnostic tests were done quickly.

Nursing staff triaged patients arriving in the department by their own means. Patients triaged as low risk of deterioration were directed to the main waiting area to await a full assessment. Patients triaged as medium or high risk of deterioration were seated within a smaller waiting area where nursing and medical staff were able to observe them for further deterioration.

We spoke with a receptionist in the main reception area who told us they were not trained to identify deteriorating patients. This area was not visible from the treatment area of the department. We were concerned that patients in the waiting room may be at increased risk deteriorating health, as reception staff may not identify deteriorating patients. The matron told us that plans were in place to have a registered nurse reviewing patients in the waiting room every 30 minutes and an emergency nurse practitioner stationed with in the waiting room identify patients appropriate for GP streaming. This was due to be rolled out in September 2017.
The emergency department used a modified early warning score (MEWS) assessment tool as part of the triage process. We reviewed 16 sets of patient records and found that three MEWS charts had not been completed fully as the scores were not recorded in the documentation. However, we saw these patients had been escalated appropriately to the medical team for a review.

We found that staff did not consistently record MEWS scores in the minors streaming area. We raised this as a concern to the senior consultant in charge of the department. The senior consultant reported that MEWS scoring was an issue raised with the nursing manager due to the inconsistent completion of the documents.

The department conducted monthly audits for early warning score documentation and escalation. The audits from April to August 2017 showed that the department scored between 90.6% and 95.4% against the trust’s target of 90%.

We reviewed the incident reporting data and found minimal impact to patients due to the inconsistent completion of MEWS scores or the reduced observation of patients within the main waiting room. We also saw that the lack of oversight of the main waiting room in the department was on the risk register and a consultant was allocated to the minors streaming area to help mitigate the risk.

The children’s emergency department used the paediatric early warning score (PEWS). The children’s emergency department had two registered children’s nurses on each shift to ensure there was always a children’s nurse available. The matron told us that in the event of staff sickness, an adult nurse who had completed paediatric competencies would cover the sickness but there must be a registered children’s nurse within the department.

The department had a completion rate of 100% for paediatric basic life support training. Information provided by the trust showed that compliance with paediatric intermediate and advanced life support training was 44% (this was for all staff, medical and nursing). Compliance with adult intermediate and advanced life support training was 38% (this was all staff, medical and nursing).

Staff had a good understanding of sepsis recognition and the protocols in place to manage patients arriving to the department with suspected sepsis. The emergency department used the sepsis six care bundles. The Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. Staff used stickers which were placed in the existing records to be completed for sepsis screening. We spoke to the clinical lead about sepsis audits and we were told that the department was no longer auditing sepsis response after the completion of the Royal College of Emergency Medicine (RCEM) audit had ended. The RCEM data for 2016/17 showed that the emergency department scored 53.6% for antibiotics administered within one hour of arrival. The department had performed better than the national aggregate of 44.4%.

The trust scored “about the same” as other trusts for all five questions in the CQC A&E Survey.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the A&amp;E staff?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q6. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>6.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q7. From the time you first arrived at the A&amp;E Department, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.2</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Q31. In your opinion, how clean was the A&E Department?  

9.0  

About the same as other trusts

Q32. While you were in the A&E Department, did you feel threatened by other patients or visitors?  

9.8  

About the same as other trusts

(Source: CQC - A&E Survey (1 January 2014 – 31 March 2014))

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust did not meet the standard over the entire 13 month period between 1 July 2016 and 30 June 2017.

Performance against this standard has shown a slight trend of improvement, though the trust is still not meeting the standard or performing better than the England average. The average time to treatment for the 13 month period was 87 minutes against the England average of 58 minutes. In the latest month, June 2017, the trust’s performance was worse than the England average; 92 minutes compared to 62 minutes.

The trust was in the process implementing changes advised during an external review to improve the patient flow through the emergency department. An example of this was a new GP service that was due to open in September 2017. The trust had other initiatives within the trust to improve the flow through the hospital such as ‘Red to Green’ which was fully embedded into routine operational practice.

All patients – Time to initial treatment between 1 July 2016 and 30 June 2017 at Ipswich Hospital NHS Trust

(Source: NHS DIGITAL: A&E quality indicators)

The trust’s median time from arrival to initial assessment (emergency ambulance cases only) was better than the overall England median over the 13 month period between 1 July 2016 and 30 June 2017.

The trust performance was at its best in October 2016, where the median time to assessment was four minutes compared to the England average of seven minutes. From November 2016 to June 2017 the trust had a steady rate of six minutes for median time from arrival to initial assessment.
Between August 2016 and July 2017 there was a relatively stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Ipswich Hospital. Performance ranged from 77% to 82% throughout the reporting period; April 2017 had the lowest percentage of turnaround times with 82%, and the latest month June 2017 showed ambulance turnaround times over 30 minutes at 81%.

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. Between June 2016 and May 2017 the trust reported 612 black breaches, with an upward trend over the period.

Performance remained relatively steady from June 2016 to December 2017. There was a large increase in January 2017, with the trust reporting 217 black breaches. In February 2017 the number of black breaches dropped to 80 and continued to decrease in the following months.
Nurse staffing

The trust has reported their staffing numbers below for June 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Actual staff – WTE</th>
<th>Actual staff – whole number / headcount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>130.7</td>
<td>147</td>
</tr>
</tbody>
</table>

At all times during our visit we found the skill mix of staff was suitable for the needs of the emergency department. We found that senior staff had oversight of the staff within the department and moved staff around to ensure all areas were safe and to ensure staff breaks were covered.

Between July 2016 and June 2017 the trust reported a vacancy rate of 14% in urgent and emergency care. A breakdown by location is as follows:

- Ipswich Emergency Department – 13%
- Ipswich Brantham – 17%

The emergency department had a vacancy for one for a shared lead nurse post, the other managerial post was filled just prior to our inspection. The Matron for the emergency department was identified as the department manager by staff during the inspection.

The emergency department used a combination of the BEST tool and the NICE emergency department staffing recommendations to ensure the department was staffed appropriately. The staff acuity assessment undertaken in early 2017 had shown a deficit of 11 registered nurses and deficiencies in the skill mix. The department has taken a staggered approach to recruitment to ensure staff had time to complete competencies and were integrated into the team in smaller groups. The department had recruited three band five and three band six registered nurses. The department was on track to recruit the five registered nurses needed to complete their establishment.

Between April 2016 and March 2017 the trust reported a turnover rate of 2% in urgent and
emergency care. This meant there was a stable staff group within the department. For the same reporting period the trust reported a sickness rate of 10.5%.

There was a recognised shortage of nursing staff employed in the department. Between June 2016 and May 2017 the trust reported for nursing staff an average bank usage rate of 10.5% an average agency usage rate of 3.9% and an average unfilled shift rate of 3.21%.

Below is a monthly breakdown of bank and agency staff usage;

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

The emergency department had regular board rounds throughout the day which were led by a consultant or registrar. All staff working within the major’s streaming were included in the round.

Medical staffing

The trust has reported their staffing numbers below for June 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Actual staff – WTE</th>
<th>Actual staff – whole number / headcount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental Staff -</td>
<td>63.06</td>
<td>65</td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

The emergency department employed nine whole time equivalent consultants. Three of the consultants did not undertake on-call shifts and the other permanently employed consultants covered the on-call rota. We spoke with two consultants working in the department who told us this arrangement worked well as it meant the department retained experienced consultants that might otherwise leave.

The emergency department had two consultants on shift from 9am to 9pm seven day a week. Regular locum consultants covered the weekend shifts. The clinical lead told us that in the event of regular locum consultants being unavailable to cover weekend shifts one of the consultant team would fill the shift. Medical staffing rotas requested and post-dated the inspection.

National guidelines for emergency departments seeing 16000+ children a year state that there should be at least one consultant with sub-specialist training in children’s emergency medicine. The emergency department did not have a paediatrician but did have a lead consultant responsible for paediatric care. The department had access to a paediatric consultant from the children’s department.

Consultants worked to an on-call rota to provide out of hours support to the junior doctors. The clinical lead told us that consultants would often remain in the department after 9pm to ensure patients were safe. Consultant handovers were conducted by telephone between the duty consultant and the on-call consultant. The handover gave a report of the department and a discussion about any complex patients in the department at the time of the handover.
The registrars had regular handovers throughout the day with board rounds for all staff. The evening registrar was responsible for providing a comprehensive handover to the night registrar. The clinical lead reported that the evening handover was not at a set time but took place between 10pm and 12am.

Between July 2016 and June 2017 the trust reported a medical vacancy rate of 6% and a 5% turnover rate in urgent and emergency care. The trust reported a sickness rate of 14% in the same period. Data provided by the trust demonstrated that bank and locum medical staff were utilised where there were shortfalls.

Between 1 May 2017 and 31 May 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was also marginally higher.

**Staffing skill mix for the 46 whole time equivalent staff working in Urgent and Emergency Care at Ipswich Hospital NHS Trust.**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>33%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career</td>
<td>20%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>21%</td>
<td>32%</td>
</tr>
<tr>
<td>Junior</td>
<td>26%</td>
<td>25%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital Workforce Statistics)

**Records**

The emergency department operated a paper based notes system in addition to adding admission information into the department’s computer system. Staff informed us that the department would be moving to an electronic system within the next 18 months.

Staff completed paper based patient records contemporaneously and there was clear evidence of the care provided and decision making processes. We reviewed 16 sets of patient records which demonstrated clinical history, examination and clinical decision making for each patient. The records showed a clear timeline of care and treatment given within the emergency department. However there was inconsistent completion of the modified early warning scores (MEWS). We reviewed nine MEWS records and of these three had not been completed fully.

Records could not be accessed from archiving out of hours but we were informed that basic information about the previous admission would be on the current online system including the patient’s discharge letter.
When a patient was admitted to the hospital the paper notes would be scanned onto the hospital's electronic system so that the relevant department could access the patient's documentation. Staff could view x-rays and test results online.

Staff kept records in organised in pigeonhole staff areas within the major streaming area and in a notes trolley within the minor streaming area. The pigeonholes were behind the nurses' station. These were not in view of patients and were not easily accessible to patients but were accessible to staff. Within the pigeonholes (numbered for each bay) there was a confidentiality sheet in front of the notes as an extra precaution to protect confidentiality.

Staff in the emergency department archived notes and kept them in a secure storage area. Adult records were kept in the department for one month and child records were kept for six months before being sent to the trusts main archive.

**Medicines**

The trust had medicines policy for healthcare professionals. We saw that the policy was up-to-date with version control and referenced national guidance and legislation.

The clean utility rooms had swipe card access and were well organised with medications including intravenous fluids stored correctly. Cupboards used to store medicines were locked and controlled drugs were stored in line with legislation and trust policy.

Staff completed controlled drug reconciliation daily. We checked the stock, which matched reconciliation records, and we could see that the controlled drugs were checked daily without any gap in the records.

Staff correctly completed medicine charts. We reviewed nine prescription records for both adults and children and we saw that the patient's name, date of birth and allergies documented on the prescription record. The medication doses were appropriate for the patients they had been prescribed.

Staff checked medicine fridge temperatures daily. We reviewed temperature records for the medicine fridges within the department and saw there were no gaps for August 2017 and any concerns had been escalated.

One of the medication fridges had been above the maximum temperature for three days during our inspection. The medication fridge has exceeded the maximum temperature on 28, 29 and 30 August 2017. We raised this with pharmacist from the trust who reported that the medicines that were in the fridge had been quarantined. The department had another fridge which was being used in the department to store refrigerated medicines.

Staff checked patient details before administering medicines. We observed staff administering medicines to patients and they asked the patients questions such as name and date of birth to ascertain they were administering medicines to the correct patient. Staff practice was in line with trust policy.

We found three prescription pads left in the controlled drug cupboard with records of prescription logs. We were concerned that the prescription pads may be used inappropriately as there was no way to log the serial numbers of prescription and reconciliation to the patient. We escalated our concerns to a senior member of staff who informed us that the prescription pads were no longer used due to the new pharmacy system in place. The senior member of staff contacted the pharmacy and asked for the prescription pads to be removed from the department.

**Incidents**
The emergency department reported a total of 1073 incidents from June 2016 to May 2017; of these 908 (84.6%) were classified as no harm, 148 (13.7%) were classified as low impact, five classified as moderate impact, two were severe, six were for death of a service user and four were for abuse.

There were clear processes in place for incident reporting, investigation and learning from incidents. Staff knew how to report incidents and they were able to give examples of recent incidents they had reported. We spoke to six members of staff about incident reporting all of these staff members were able to give examples of recent incidents. The staff members varied from consultants to healthcare assistants.

Staff reported incidents using an electronic reporting system. All of the staff we spoke to about incidents had access to the system and could demonstrate use of the system. The associate director of nursing and the matron for the emergency department had oversight of all incidents that were reported within the emergency department.

The nursing staff had a huddle at the start of each shift to discuss any updates and information such as incidents. This huddle had been named the ‘five topics’ delivered by one of the senior nurses.

Staff received feedback about incidents and learning about incidents. The emergency department had five topics during handovers where incidents were discussed. The department also had the red book of incidents which staff were encouraged to read and sign. We reviewed the red folder and could see learning from incidents and that staff had signed to show they had read the latest updates. The department also shared learning related to incidents that were identified by the wards following patient transfers to ensure all learning was captured.

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Between July 2016 and June 2017, the trust reported no incidents classified as never events for Urgent and Emergency Care. (Source: NHS Improvement - STEIS)

In accordance with the Serious Incident Framework 2015, the trust reported seven serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England between July 2016 and June 2017.

Of these, the most common types of serious incident reported were.

- Diagnostic incident including delay meeting SI criteria, including failure to act on test results (five SIs, 71% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria (one SI, 14% of total incidents).
- Treatment delay meeting SI criteria (one SI, 14% of total incidents).
We reviewed two root-cause analysis documents following serious incidents within the emergency department. Both of the documents identified the root-cause and had clear learning for staff. We saw completed action plans for both of the incidents.

The hospital held trust wide monthly mortality and morbidity meetings. We reviewed the meeting minutes which showed that Dr Foster alerts and complex cases were discussed.

The emergency department consultants held monthly mortality meetings. Two consultants told us that all staff were able to attend these meetings and reported that there was representation from the nursing staff. We reviewed the meeting minutes from March to July 2017, which showed that staff had discussed complex cases and with attached learning outcomes.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person. Not all staff were aware of the principles related to duty of candour. Senior staff knew the triggers for the duty of candour process but junior staff were unable to explain what the duty of candour was or the process for implementing duty of candour. We spoke with the associate director of nursing, two senior consultants and one band seven nurse who gave a clear explanation. We spoke with three junior members of staff who were unable to fully explain the duty of candour. However all of the staff we spoke with identified the need to be open and honest with patients.

The trust had a comprehensive major incident and business continuity plan in place. In the event of a major incident the trust’s senior leadership team co-ordinated staff and resource from the trust’s operations centre. We reviewed the policy, which defined staff roles and responsibilities. The policy was up-to-date, was version controlled and due for review in December 2017.

The emergency department had major incident provisions stored in secure areas inside the department and the decontamination equipment for the chemical, biological, radiological and nuclear (CBRN) was securely stored outside near the ambulance entrance of the department. The provision included appropriate personal protective equipment, instruction cards and a decontamination tent. Staff received regular major incident simulation training as well as table top exercises for preparation of a major incident. We spoke with the CBRN lead and the head of risk management who gave examples of the training provided and the comprehensive plans in place in the event of a major incident.

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering
harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm or new catheter acquired urinary tract infections between July 2016 and July 2017 within urgent and emergency care.

(Source: Safety thermometer - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

The care provided by staff within the emergency department (ED) was evidence based and in line with national guidance. The department had specialist pathways for patients based on national guidance, for example stroke and fractured neck of femur.

The stroke pathway coordinated communication between ambulance crews and ED prior to arrival, staff arranged for a stroke consultant and stroke nurse to assess the patient on their arrival to the department. Once assessed patients were referred for a Computerised Tomography (CT) scan and then to the hyper-acute stroke unit for thrombolysis. Medical and nursing staff told us this had significantly reduced patient’s time to treatment. This pathway was in line with National Institute of Health Care Excellence (NICE) guidance, which dictates that adults presenting at an accident and emergency department with suspected stroke are admitted to a specialist acute stroke unit within four hours of arrival. The pathway ran during working hours, the department were looking to implement the pathway out of hours. Out of hours stroke patients were assessed in the majors Rapid Assessment and Treatment area before being sent for a CT scan.

Department staff had access to trust policies via the trust’s intranet.

The trust had a NICE implementation and monitoring group, which had the responsibility to approve policies and guidelines. The group were also responsible for providing strategic direction in the improvement of patient care and public health by ensuring the co-ordinated application and audit of NICE guidance.

The care given within the emergency department was in line with the Royal College of Emergency Medicine (RCEM) Best Practice Guidance, 2017. For example, there were twiddle muffs available for patients with delirium. This was in line with standard 40. Patient feedback was sought and acted upon and clinical areas enabled patients to retain dignity and privacy. However the environment did not always meet the guidelines as the dedicated psychiatric assessment room did not conform to the Psychiatric Liaison Accreditation Network standards.

The operational lead for the department informed us that they worked alongside consultants in the department to develop leaflets, posters and information for patients to ensure they were evidence based and current. The department had a number of information leaflets on display that complied with these requirements.

The ED contributed to internal and external audit processes to monitor their quality and performance. They undertook all RCEM audits; they also monitored their own arrival to treatment times.
A consultant we spoke with told us that practice had been changed in the department as a result of the RCEM audit for moderate and acute severe asthma 2016/17. Since the audit, they now give a leaflet to each asthmatic patient and ensure they do a repeat peak flow test, which they were not consistently doing before.

The department used technology to enhance the delivery of effective care including the use of a trigger tool, which calculated the number of patients in the department, the number of incoming ambulances and the acuity of the patients in the department. The trigger tool was displayed on a screen in the department that enabled the floor coordinator and operations team to escalate accordingly.

**Nutrition and hydration**

Members of a voluntary service offered hot and cold drinks to both patients and relatives throughout the day in majors. We observed the volunteers making drinks for families in the relative’s room. One patient we spoke to informed us that a member of the voluntary service had brought him a sandwich.

We observed healthcare assistants offering patients a drink in majors hourly when they performed observations. There was also a readily accessible cold drinks table for patients to help themselves. In the relatives room there were facilities to make hot drinks.

There was a water cooler machine in the minors’ waiting room in addition to a vending machine offering cold drinks and snacks.

In the CQC A&E Survey, the trust scored 7.42 for the question “Were you able to get suitable food or drinks when you were in the A&E Department?” This was about the same as than other trusts.

(Source: CQC A&E Survey 2014)

**Pain relief**

Data from the Care Quality Commission accident and emergency survey (2014) showed the emergency department was performing ‘about the same’ as other trusts in relation to the provision of pain relief and control of pain. We reviewed nine sets of notes and we saw that staff completed pain scores and gave patients prescribed analgesia. One patient we spoke to in the ED department informed us that he had been offered pain relief straight away and he had received it quickly.

We observed three assessments of children within the children’s emergency department during our inspection. All three children had completed pain scores on assessment and were offered appropriate analgesia in compliance with RCEM Management of Pain in Children guidance (2013).

The emergency department patient forms had a pain scoring system on the front page which stated that the pain score had to be recorded within 15 minutes of arrival.

A staff member informed us that there were occasional delays to patient’s receiving analgesia due to nurses being pressed for time. Additionally delays in receiving pain relief featured on the complaints board in the emergency department staff room.

In the CQC A&E Survey, the trust scored 5.1 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was about the same as other trusts.
The trust scored 8.0 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

<table>
<thead>
<tr>
<th>Question – Effective</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q29. How many minutes after you requested pain relief medication did it take before you got it?</td>
<td>5.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q30. Do you think the hospital staff did everything they could to help control your pain?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. Were you able to get suitable food or drinks when you were in the A&amp;E Department?</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC A&E Survey 2014)

**Patient outcomes**

The department were performing well in national audits. Audit results were discussed in clinical team meetings and the service used the results to change local protocols and highlight where further education was needed for staff. We saw action plans from the audits that evidenced improvements that were implemented as a result of audit findings. For example following the Royal College of Emergency Medicine (RCEM) Asthma audit 2016/2017 the department updated the ED record card to include oxygen prescription to try to ensure asthmatics are prescribed it on arrival.


The department submitted data to the Trauma Audit and Research Network (TARN). The department was fully compliant with all submissions and were in the median quartile for rate of survival at the hospital.

**RCEM Audit: Asthma audit 2016/17**

In the 2016/17 RCEM audit for paracetamol overdose, the trust was in the upper quartile compared to other hospitals for one of the 15 measures, in the median quartile for six measures and was in the lower quartile for seven of the 15 measures.

The measure for which the trust performed in the upper quartile was:

- Standard 8: The patients inhaler technique is satisfactory: Trust 19%

The measures for which the trust performed in the lower quartile were:

- Standard 1a: O2 should be given on arrival to maintain saturations 94-98%: Trust 17%
- Standard 1b: O2 should be prescribed on arrival to maintain saturations 94-98% : Trust 2%
- Standard 2a: As per RCEM standards, vital signs should be measured and recorded on arrival at the ED: Trust 21%
- Standard 3: High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the ED: Trust 5%
- Standard 4: Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy : Trust 73%
- Standard 10: Written discharge advice given to the patient : Trust 4%
• Standard 11: GP or clinic follow-up arranged according to local policy for discharged patients within 2 working days: Trust 11%

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17

In the 2016/17 RCEM audit for severe sepsis and septic shock, the trust was in the upper quartile compared to other hospitals for one of the five measures and was in the middle quartile for the remaining four measures:

• Standard 4: Serum lactate measured: Within one hour of arrival: 75.4% compared to the national average of 60%

• Standard 5: Blood cultures obtained: Within one hour of arrival: 37.1% compared to the national average of 44.9%

• Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given: Within one hour of arrival: 54.8% compared to the national average of 43.2%

• Standard 7: Antibiotics administered: Within one hour of arrival: 53.6% compared to the national average of 44.4%

• Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival: 16.9% compared to the national average of 18.4%

(Source: Royal College of Emergency Medicine)

The Sepsis Six audit in the Emergency Assessment Unit (EAU) found that not many patients were diagnosed in EAU because patients transferred from the emergency department had some or all aspects managed. However it was noted that the sepsis six documentation was not always fully completed. The EAU was an assessment area in the hospital for medical and surgical patients. The unit assessed medical and surgical patients who required extensive assessment or stabilisation of their condition. The emergency department referred patients to the EAU but we did not inspect the EAU as part of our inspection.

We were informed by staff that whilst the trust had previously submitted data for the RCEM audit with regards to sepsis there was no formal local sepsis audit and the audit was not continued once it was no longer in the RCEM audit cycle.

RCEM Audit: Vital Signs in Children (2015/16)

In the 2015/16 RCEM audit for vital signs in children, Ipswich Hospital was in the upper quartile compared to other trusts for three of the six measures and was in the lower quartile for one of the six measures.

The measures that performed in the upper quartile were:

• 1. All children attending the emergency department with a medical illness should have a set of vital signs consisting of:

  o 1a. temperature, respiratory rate, heart rate, oxygen saturation, GCS or AVPU score, and
1b. capillary refill time recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest.

3. There should be explicit evidence in the ED record that the clinician recognised the abnormal vital signs (if present).

The measure that performed in the lower quartile was:

5. Children with any recorded persistently abnormal vital signs who are subsequently discharged home should have documented evidence of review by a senior doctor (ST4 or above in emergency medicine or paediatrics, or equivalent non-training grade doctor).

(Source: Royal College of Emergency Medicine)

RCEM Audit: Procedural Sedation in Adults (2015/16)

In the 2015/16 Procedural Sedation in Adults audit, Ipswich Hospital was in the upper quartile for four measures, and had no measure in the lower quartile and was in the middle quartiles for the remaining three measures.

The measures that performed in the upper quartile were:

1. Patients undergoing procedural sedation in the ED should have documented evidence of pre-procedural assessment, including a) ASA grading, b) Prediction of difficulty in airway management and c) pre-procedural fasting status.

4. Procedural sedation requires the presence of all of the below a) a doctor as sedationist, b) a second doctor, ENP or ANP as procedurist, c) a nurse.

5. Monitoring during procedural sedation must be documented to have included all of the below a) non-invasive blood pressure b) Pulse oximetry, c) Capnography, d) ECG.

7. Following procedural sedation, patients should only be discharged after documented formal assessment of suitability, including all of the below:
   o 7a Return to baseline level of consciousness
   o 7b Vital signs within normal limits for the patient
   o 7c Absence of respiratory compromise
   o 7d Absence of significant pain and discomfort
   o 7e Written advice on discharge for all patients

(Source: Royal College of Emergency Medicine)

Between July 2016 and June 2017, the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5%, but better than the England average. The trust’s performance is however showing an overall trend of decline, and in latest period, June 2017, the trust’s performance was 7.5% compared to an England average of 7.9%.

Unplanned re-attendance rate within 7 days - Ipswich Hospital NHS Trust
The department had a comprehensive programme for training both medical and nursing staff, using innovative training methods such as a simulation centres and educational leads. On a Wednesday afternoon the consultants would run simulation training in the dedicated simulation centre, a recent scenario that staff had experienced would be chosen and replicated to see what could be improved. These sessions were attended by medical staff, nursing staff, paramedics and allied professionals and they included multi-agency simulations. The simulations provided immediate feedback, which was called an after action review. Additionally trends were identified within the simulations and escalated to the appropriate leads within the department.

Consultants told us that there was a study budget for specialist training for consultants. Additionally, weekly training, run by a consultant in the department, was offered to the junior doctors on a Thursday afternoon.

Junior doctors spoke highly of their induction period. They informed us that they had both a departmental and corporate induction. As part of the departmental induction they were supernumerary for two days to adjust to the trust’s emergency department.

The occupational therapy induction involved two weeks of shadowing and then an observation by a senior occupational therapist before being allowed to practice independently.

The department had an induction passport for agency and bank staff which included competencies that had to be signed off by a senior nurse. We viewed completed induction checklists for bank staff.

The department kept a spreadsheet of when nurse’s revalidation was due and when it was completed. The revalidation of 38 staff nurses within the department was due by the end of September 2017. Of those 38 members of staff, only one member of staff had not been revalidated and that staff member had applied for exceptional circumstances.

Within the department two educational leads provided clinical support to nursing staff. The leads had developed classroom based teaching that focussed on improving the competencies of junior staff.

The department ran emergency department refresher training three times a year; it was mandatory for staff to attend at least one session per year.
The department had two trauma immediate life support trainers. Staff were expected to be trained in advanced immediate life support. The department provided two places each year for external advanced life support training to registered nurses. The paediatric emergency department always had a senior nurse trained in paediatric intermediate life support (PILS) and advanced paediatric life support (APLS) on shift. Within the adult emergency department there was always a senior nurse on shift who had been trained in advanced life support (ALS) and intermediate life support (ILS). Forty four per cent of all medical and nursing staff in the department had been trained in PILS and APLS. The department’s training was inclusive of all staff. A human factors course was run for all ward staff which included porters and cleaners.

Between July 2016 and June 2017, 90% of staff (all staff groups) within urgent and emergency care at the trust had received an appraisal compared to a trust target of 95%

Medical & dental staff within urgent and emergency care had a 91% appraisal completion rate, which did not meet the trust target of 95%.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

**Multidisciplinary working**

Medical and nursing staff told us that MDT working between nurses and doctors was effective and well established.

We observed excellent examples of allied professionals working together on the ward, including a physiotherapist and occupational therapist working in tandem to assist a patient with a frame to walk down the majors’ ward. An occupational therapist we spoke to told us that one of the best aspects of working at the trust was how integrated the occupational therapists were with the physiotherapists and how they will often assess patients together.

The emergency therapy team consisted of physiotherapists, occupational therapists and therapy assistant practitioners. The team could be bleeped by the staff if needed but additionally came down daily to scope the wards for suitable patients for therapy intervention. The team worked with the emergency department staff to prevent unnecessary hospital admissions and assisting to discharge those who were clinically fit to go home.

We saw that staff gave comprehensive handovers when transferring patients to another department of the hospital. We also saw handovers from the ambulance crews to the staff in the department. All of handovers we observed demonstrated effective communication between the staff in the emergency department and other services.

The frailty assessment base (FAB) team were a nursing team that came down to the emergency department to assess which patients would be suitable to be transferred to the FAB ward which specialised in assisting the elderly and frail with effective discharges. The team worked closely with the crisis team and admissions avoidance team to increase flow of patients in the ED and the wider hospital. We were told by the FAB team that admissions to the hospital had been reduced by five percent since the introduction of the team.

The department had recently implemented an office for the psychiatric liaison team within the department to improve working between the two teams. Staff we spoke with informed us that as a result of this co-location the links with the psychiatry team had strengthened. Between the hours of 7am and 7pm the psychiatry team were available in the office or contactable by telephone if they were in another part of the hospital. Out of hours the department would contact the local crisis action team.
An emergency medical technician who worked for the ambulance service told us that the staff within the department worked well with the ambulance crews to get patients handed over quickly.

**Seven-day services**

The emergency department at Ipswich hospital was open 24 hours a day seven days a week in line with the NHS Seven days a week Priority Clinical Standard 6.

NICE guidelines on *Achieving Better Access to Urgent and Emergency Mental Health Care – Part 2*, Core 24 states that where a the hospital has a 24/7, ED then it should be able to respond to a mental health crisis within ED within one hour. The mental health liaison team at Ipswich hospital were in the department from 7am to 7pm seven days a week. The associate director of nursing told us that the trust was working with the local mental health trust to establish an out of hour’s provision of mental health services in the emergency department.

The department had access to imaging services 24 hours a day, seven days a week. The department had its own x-ray suite which was open 24 hours a day. CT scans were performed in another department within the hospital. The reporting of the x-ray images and CT scans out of hours was contracted out to another provider but enabled the department to have 24-hour access to imaging results.

The Frailty Assessment Base team were currently only in the department Monday to Friday in working hours, however the team were looking at ways in which they could expand the service to cover weekends.

The department had access to the emergency therapy team from 8am to 8pm seven days a week.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

The department provided Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS), and mental capacity training. This involved the psychiatric liaison team pre-filming scenarios that the department may encounter including teenagers refusing treatment.

Both doctors and nurses that we spoke to understood their responsibilities under the MCA and could explain how they would assess capacity. A junior doctor that we spoke with was aware of DOLS, knew the mechanism and correct local authority to refer to. The doctor also stated that he had attended MCA and DoLS training with other junior doctors recently.

Another speciality doctor we spoke with told us they had attended two hour training on the MCA and could effectively explain to us how they would determine whether a patient had capacity.

The dementia lead within the trust was a mental capacity act and DoLS ‘super trainer’ who provided training for all staff on the MCA and DoLS

The department had green MCA record stickers that they could put in patient records that clearly outlined the stages required for a mental capacity assessment. Staff we spoke to could tell us where to locate the stickers and how they would use them.

The trust had a policy for MCA and DoLS which was in date and evidence based.
Is the service caring?

Compassionate care

We observed staff performing compassionate care during our inspection. We saw that staff were kind and patient and ensured that patient dignity was maintained at all times.

Staff maintained that patient’s privacy and dignity by ensuring cubicle curtains were closed during transfer from bed to wheelchair and active treatment. We observed a member of nursing staff checking that a patient’s blankets adequately covered her for transfer to a different ward and asked whether the patient was warm and comfortable.

We observed a member of staff interacting with an elderly patient whilst assisting them to transfer; the staff member put the patient at ease by laughing and chatting with the patient throughout the transfer.

All of the patients we spoke to told us they had a positive experience in the emergency department. All of the patient feedback was positive about the care they had received in the department; one patient described it as “faultless”.

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was worse than the England average between July 2016 and June 2017. Between February and April 2017 the percentage of patients that would recommend the trust was between 6% and 68%, which was the trust’s lowest performance. In the latest month, June 2017, the trust’s performance was 76.1%, compared to the England average of 87.6%.

**A&E Friends and Family Test Performance - Ipswich Hospital NHS Trust**

![Graph showing A&E Friends and Family Test Performance](Source: NHS England Friends and Family Test)

Emotional support

The chaplain sat in on morning handover and carried a trauma bleep; he informed us that he would come down to the department to assist relatives or staff that needed emotional support.

We observed staff drawing the cubicle curtains every time a new patient was brought into the resus area to ensure the patients privacy and dignity was maintained.
We observed members of the volunteer service emotionally supporting families of critically ill patients by making them drinks and chatting to them.

**Understanding and involvement of patients and those close to them**

The Care Quality Commission accident and emergency patient survey results showed the department performing higher than other departments when patients were questioned on whether members of staff explained in way that they could understand both the results of the tests and the purpose of the medications they were being asked to take home. The department also scored better than other trusts when patients were questioned about whether their family or someone close to the patient wanted to talk to a doctor and whether they had the opportunity to do so.

Staff within the department involved relatives in the patient’s care by ensuring they were informed of the treatment they were receiving and the reasoning for this. A patient’s relative described how the doctors involved in her mother’s care explained to them what treatment they were administering and explained that she was having a CT scan because there was a possibility she had a stroke.

A number of patients that we spoke with informed us that staff had explained their treatment in a way that they could understand.

Staff told us that they use “this is me” documentation for patients with learning disabilities in order to assess the best way to communicate with patients and ensure they are partners in their care and treatment.

We observed a nurse explaining medication to a patient on discharge, she was clear on the dosage, how often they could be taken and checked that the patient did not have any drug allergies. Throughout speaking with the patient the nurse asked whether they understood the advice given.

The results of the CQC A&E survey 2014 showed that the trust scored better than other trusts in four questions, worse than other trusts for one question and about the same as others for 19 the 24 questions relevant to caring.

<table>
<thead>
<tr>
<th>Question</th>
<th>2014 RAG</th>
<th>Trust 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q8. Were you told how long you would have to wait to be examined?</td>
<td>Worse than other trusts</td>
<td>2.63</td>
</tr>
<tr>
<td>Q10. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>About the same as other trusts</td>
<td>8.70</td>
</tr>
<tr>
<td>Q11. While you were in the A&amp;E Department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>About the same as other trusts</td>
<td>8.24</td>
</tr>
<tr>
<td>Q12. Did the doctors and nurses listen to what you had to say?</td>
<td>About the same as other trusts</td>
<td>8.90</td>
</tr>
<tr>
<td>Q14. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>About the same as other trusts</td>
<td>8.61</td>
</tr>
<tr>
<td>Q15. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>About the same as other trusts</td>
<td>9.21</td>
</tr>
<tr>
<td>Q16. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>Better than other trusts</td>
<td>8.30</td>
</tr>
<tr>
<td>Q17. While you were in the A&amp;E Department, how much information about your condition or treatment was given to you?</td>
<td>About the same as other trusts</td>
<td>8.81</td>
</tr>
<tr>
<td>Question</td>
<td>2014 RAG</td>
<td>Trust 2014</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Q19. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>About the same as other trusts</td>
<td>8.13</td>
</tr>
<tr>
<td>Q20. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?</td>
<td>About the same as other trusts</td>
<td>8.92</td>
</tr>
<tr>
<td>Q21. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>Better than other trusts</td>
<td>8.51</td>
</tr>
<tr>
<td>Q42. Overall, did you feel you were treated with respect and dignity while you were in the A&amp;E Department?</td>
<td>About the same as other trusts</td>
<td>9.15</td>
</tr>
<tr>
<td>Q13. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>About the same as other trusts</td>
<td>7.20</td>
</tr>
<tr>
<td>Q22. If you were feeling distressed while you were in the A&amp;E Department, did a member of staff help to reassure you?</td>
<td>About the same as other trusts</td>
<td>6.91</td>
</tr>
<tr>
<td>Q24. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>About the same as other trusts</td>
<td>8.67</td>
</tr>
<tr>
<td>Q25. Before you left the A&amp;E Department, did you get the results of your tests?</td>
<td>About the same as other trusts</td>
<td>8.26</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>Better than other trusts</td>
<td>9.15</td>
</tr>
<tr>
<td>Q36. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>Better than other trusts</td>
<td>9.89</td>
</tr>
<tr>
<td>Q37. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>About the same as other trusts</td>
<td>5.66</td>
</tr>
<tr>
<td>Q38. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>About the same as other trusts</td>
<td>5.78</td>
</tr>
<tr>
<td>Q39. Did hospital staff take your family or home situation into account when you were leaving the A&amp;E Department?</td>
<td>About the same as other trusts</td>
<td>5.30</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>About the same as other trusts</td>
<td>6.04</td>
</tr>
<tr>
<td>Q41. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the A&amp;E Department?</td>
<td>About the same as other trusts</td>
<td>7.26</td>
</tr>
<tr>
<td>Q43. Overall... (please circle a number)</td>
<td>About the same as other trusts</td>
<td>8.06</td>
</tr>
</tbody>
</table>

(Source: CQC A&E Survey 2014)

Is the service responsive?

Service delivery to meet the needs of local people

The emergency department had commissioned an external review of the services provided to patients. The review resulted in 13 recommendations to improve the performance of the department and meet to the needs of local population. These recommendations included a doctor led rapid assessment and treatment process, more efficient streaming of patients through the department and further nursing staff were required following a dependency assessment.

The hospital had an action plan in place to meet the 13 recommendations. We saw some of the actions were being implemented within the emergency department. The outstanding actions were dependent changes to be made trust wide. We were given an example of the recommendation for
an orthopaedic assessment unit which would require a clinical area and resources such as equipment and staffing.

The ED was developing their ability to competently stream appropriate patients to a primary care centre. The trust had a GP assessment unit under construction at the time of our visit. Staff were excited about this development, as the new unit would allow them to stream patients that required GP services rather than emergency service appropriately. The new GP was expected to improve the patient flow within the emergency department.

The hospital had a frailty assessment base (FAB) for the assessment of frail elderly patients to prevent admissions to the hospital due to social needs. The clinical manager for the FAB worked with staff from the emergency department Monday to Friday between 9am and 5pm to identify patient that meet the FAB criteria. These patients received a consultant review and a plan of care and a decision to admit or discharge the patient. The clinical manager of the FAB worked closely with the crisis and admission prevention teams.

**Meeting people’s individual needs**

All patient with complex needs were placed in a cubical visible from the doctors and nurses station. Staff we spoke to were able to give examples of patients with complex needs and a rationale for maintaining closer observation of those patients.

The emergency department had access to translation service for patients. Staff we spoke with told us that they used the services when they were required especially due to the close proximity to an international shipping port. Staff had access to information leaflets on other languages which could be printed for patients.

The department had specific room identified to support the families of patients that were critical ill or following bereavement. The room had a section of comfortable chairs and facilities to make hot drinks. We saw Red Cross volunteers supporting relatives and making hot drinks during our visit. The emergency department did not have a dedicated play specialist to support children. However staff had access to a play specialist from the paediatric wards and short distance from the department. Staff reported that they had not had any difficulties accessing a play specialist when they were required to support individual children.

We saw that the emergency department had access to a hospital chaplain. The chaplain carried one of the trauma bleeps and would visit the department to assist relatives and support distressed staff.

The emergency department had processes in place to identify patients living with dementia. A yellow flower sticker was placed on the patient record and staff drew a flower on the white board to denote the cubicle the patient was being cared for. Staff could easily identify patients living with dementia using this system

The hospital participated with an integrated dementia pathway ‘This is me’ used in both the community and hospital setting. The document contained information about the patient to aid staff personalise care to the individual patient to minimise anxiety and further confusion due to the change in their environment.

We saw that the emergency department had dementia aids such as twiddle muffs. Twiddle muffs are knitted woollen sleeves with buttons on to aid anxiety. Staff we spoke to reported that patients that were very confused are sometimes sat in a wheel chair by the main staff desk for closer observation to prevent the risk of falls or wondering in the busy department.
The hospital had a learning difficulties specialist nurse that staff could contact to help support patients with learning difficulties. The department used a recently developed pathway which were patient held records called ‘This is me’. Staff completed as new pathway with the assistance of the learning difficulties specialist nurse in the event that no record was in place. The record aids staff to make reasonable adjustments to the department environment and the care delivered. Staff we spoke to told us the tool was very useful to ensure the patient felt as relaxed as possible in the department.

Staff had access to communication cards in the event verbal communication issues between staff and patients. One member of staff told us they were very helpful in lots of situations such as initial language barrier before access translation services.

A&E Survey

The trust scored “about the same as other trusts” for all three A&E Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Overall, how long did your visit to the A&amp;E Department last?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. Were you given enough privacy when being examined or treated?</td>
<td>9.3</td>
<td>Better than other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC A&E Survey 2014)

Access and flow

We found there were systems in place to manage the flow of patients from the emergency department into the main hospital. Information about patients waiting in the emergency department were computerised with a red amber green system. Red denoted that a patient was near to the four hour waiting target and black was used to denote patients that had been in the department for more than four hours. All department managers had access to this tool and the tool was continually monitored by the trust’s patient flow team.

The hospital used internal daily meeting with representatives from the wards to track patients the expected discharges from the wards called ‘red to green’. This new initiative had been in operation for less than a week at the time of our visit to the emergency department. The aim of these daily meetings was to improve the flow through the hospital to decrease delays in moving admitted patients from the emergency department to the wards.

The hospital had 612 black breaches in the reporting period from June 2016 to May 2017. Black breaches are defined as where handover from ambulance arrival to the patient being offloaded to A&E or ED took longer than 60 minutes. The emergency department had patient pathways in place for stroke management, fractured neck of femur and myocardial infarction (heart attack). The pathway was well organised with ambulance crews contacting the department while they were on route to the hospital. The majority of patients went straight to the CT scanner and from there straight to a specialist ward.

The hospital had ambulatory care pathways in place to reduce the need for hospital admission for example the deep vein thrombosis pathway. Patients were assessed and were given an
appointment to receive their results, so they could wait at home if they had no red flags that required additional monitoring by staff.

**Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)**

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the A&E.

The trust did not meet the standard between August 2016 and July 2017.

Between August 2016 and July 2017 the trust’s performance against this target has shown an overall trend of improvement. Since January 2017 the trust has consistently performed better than the England average.

**Four hour target performance - Ipswich Hospital NHS Trust**

![Graph showing four hour target performance](image)

*(Source: NHS England - A&E Waiting times)*

**Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted**

Between August 2016 and July 2017, Ipswich Hospital NHS Trust’s monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted was better than the England average. Performance against this metric showed a trend of improvement with the trust percentage ranging between 1-5% compared to the England average range between 9-22%

**Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted - Ipswich Hospital NHS Trust**

![Graph showing percentage waiting between four and 12 hours](image)
Number of patients waiting more than 12 hours from the decision to admit until being admitted

During the 12 months between August 2016 and July 2017, no patients waited more than 12 hours from the decision to admit until being admitted. The number of patients waiting between four and 12 hours was highest in January 2017 with 106 patients and in November 2016 with 100 patients.

<table>
<thead>
<tr>
<th></th>
<th>Number of patients between 4 and 12 hours</th>
<th>Number of patients over 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug-16</td>
<td>28</td>
<td>0</td>
</tr>
<tr>
<td>Sep-16</td>
<td>27</td>
<td>0</td>
</tr>
<tr>
<td>Oct-16</td>
<td>49</td>
<td>0</td>
</tr>
<tr>
<td>Nov-16</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>Dec-16</td>
<td>43</td>
<td>0</td>
</tr>
<tr>
<td>Jan-17</td>
<td>106</td>
<td>0</td>
</tr>
<tr>
<td>Feb-17</td>
<td>42</td>
<td>0</td>
</tr>
<tr>
<td>Mar-17</td>
<td>22</td>
<td>0</td>
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<tr>
<td>Apr-17</td>
<td>21</td>
<td>0</td>
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<tr>
<td>May-17</td>
<td>26</td>
<td>0</td>
</tr>
<tr>
<td>Jun-17</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>Jul-17</td>
<td>15</td>
<td>0</td>
</tr>
</tbody>
</table>

Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment

Between August 2016 and July 2017 the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was worse than the England average, although the performance shows an overall trend of improvement the trust remained above the England average aside from April 2017 where the trust met the England average with 2.8%.

Percentage of patient that left the trust without being seen - Ipswich Hospital NHS Trust
Median total time in A&E per patient (all patients)

Between August 2016 and July 2017 the trust’s monthly median total time in A&E for all patients was consistently higher the England average. Performance against this metric showed a slight trend of improvement with the latest data for June 2017 showing the trust’s monthly median total time in A&E for all patients was 160 compared to the England average which was 144.

Median total time in A&E per patient - Ipswich Hospital NHS Trust

(Source: NHS DIGITAL - A&E quality indicators)

Learning from complaints and concerns
The three main themes from complaints within the emergency department were attitude of staff, patients feeling that they had not received the required treatment and long waiting times. The matron for the emergency department was able to discuss the themes of the complaints received and had implemented changes to the department. An example of this was the television that displayed the waiting times in the waiting room following a complaint about patients not knowing how long the expected waiting time was.

Staff told us that the themes from complaints were discussed in the five topics huddles every day within the department. The matron told us that it was important that staff understood what the themes of complaints were in order to improve the quality of the service provided to patients. The emergency department matron contacted all complainants by telephone within 24 hours of receiving a complaint. The aim was to discuss the concerns raised and resolve the complaint as soon as possible. The matron also offered complainants a face-to-face meeting to discuss complaints. The matron reported that most complaints were resolved with a telephone call; patients did not often take up offers of face-to-face meetings offered during the telephone call.

The Chaplain had worked with the staff in the department to deliver resilience training. Members of the senior leadership team for the department informed us that since this training they have seen an improvement in staff attitude and a drop in complaints.

Between June 2016 and May 2017 there were 83 complaints about urgent and emergency care services. The trust took an average of 39.9 working days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 28 working days from receipt unless a longer timeframe has been agreed with the complainant.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Is the service well-led?

Leadership

The emergency department was in the process or re-organising the nursing leadership at the time of our inspection. The nursing lead had been in post for four weeks prior to our inspection. The nursing lead was supported by the matron for the department and the emergency assessment unit.

The matron told us the they were in the process of recruiting a further band seven nurse to share the management responsibilities of the department. The aim of the dual leadership was to allow each of the leads to have protected management time and clinical time to work with staff on the floor as a positive role model.

Each of the band six and seven nurses had been allocated a staffing team to performance manage. The matron reported that she supported the senior staff to complete sickness reviews and staff appraisals with a view that they would undertake this independently once the process was fully embedded.

The matron told us that the trusts senior management team were supportive and had an open door policy to discuss any concerns.

Staff we spoke to knew could name the director of nursing and the chief executive. Staff reported that both the director of nursing and the chief executive visited the department and spoke to staff. The clinical lead talked passionately about the department and praised the staff that worked in the department for their team work approach. The clinical lead also reported that the department
worked well with other teams across the trust to improve the flow through the department and had close links with medical colleagues.

**Vision and strategy**

The vision of the emergency department was to be in the top 20% of hospitals for performance and quality in England.

The department had seen a downward trend in their performance data in the past 18 months and commissioned an external review of the department. This review identified 13 areas where the department and the trust could develop to improve the flow of patients through the emergency department and the rest of the hospital.

The emergency department had trialled tools to improve flow and implemented the tools that worked well within the department. One of the senior consultants gave an example of the regular board rounds which included medical, nursing and therapies staff to discuss the patients with the major’s streaming of the department.

**Culture**

All of the staff we spoke to told us that they enjoyed working the department and they felt valued. All of the staff reported that there was an open culture to raise concerns or to discuss difficult situations.

Junior doctors told us that the emergency department was a supportive learning environment and they had good opportunities to learn.

Staff were encouraged to share ideas about how to improve services. The matron gave us an example of the technicians had noticed that there was no service provision to cover phlebotomy and ECG monitoring services out of hours. The technician team had developed a plan to alter their shift times to trial out of hours cover.

The chaplain assigned to the emergency department told us that he regularly supported staff following a trauma case and had open door policy if staff wanted to talk about a difficult case. The associate director nursing also told us that the divisional chaplain had undertaken a lot of work to provide resilience training for staff to reduce stress in the emergency department.

Ambulance crews we spoke to told us that staff in the emergency department worked collaboratively with them and liked to bring patients to the department as staff were organised. They reported that the handover times within the department were quick and staff engaged with this process.

**Governance**

The department had established governance systems in place to monitor performance and quality. The emergency department held monthly governance meetings attended by the senior nursing staff and consultants. The meetings covered incidents, complaints and audit data to form a report presented at the clinical delivery group.

The clinical delivery group met monthly and had governance oversight of the emergency department and the emergency assessment unit which were in the matrons portfolio. The matron presented the report to the divisional clinical governance meeting and reports from the division were presented to the divisional board. Divisional reports in turn were submitted to the executive team as part of the accountability framework oversight meetings.
We reviewed the minutes for the clinical delivery group for March, April, May and July 2017, which showed that actions from previous meetings were followed up. The rolling agenda covered finance and staffing, governance including serious incidents and complaints, performance, development and strategy and business cases.

There was a clear governance process from the emergency department to the board. We also saw there were mechanisms in place to for clinical governance update for staff within the department through the five topics huddles and staff meetings.

The children’s emergency department had a band seven nursing lead who was working collaboratively with the paediatric department to align with governance processes but to report performance with the adult emergency department.

**Management of risk, issues and performance**

The emergency department had six risks open on the risk register. The risk were rated red, amber and green, red the most severe and green low risk. The department had two risks that were red for the delivery of the emergency department standards and extended waits in the emergency assessment area impacting on patient well-being. Four risks had an amber rating. The risks identified dated actions taken to mitigate the risks.

The matron and the clinical lead for the emergency department could identify the top three risks for the department that were on the risk register. The top three risks were the performance of the department across the England standards, the oversight of ambulatory patients in the waiting room and nurse staffing within the department. However local leaders had not identified potential risks in the use of bays within the majors’ area for patients presenting with acute mental health illness. There was no formal risk assessment in place however staff we spoke with could articulate the potential risks when the bays were in use and actions they would take to reduce that risk. We raised our concerns with the trust and a risk assessment was undertaken with specific steps identified to reduce risk to both patients and staff in this situation. The processes was yet to be embedded and further improvement was required to provide assurance that actions outlined in the risk assessment, such as altering the environment and reorganising the bays to ensure direct line of sight, will be monitored to ensure appropriate steps are taken when required to reduce the risk of harm to patients and staff.

We saw that the children’s emergency department was restructured following a serious incident. The children’s department was staffed by two registered children’s nurses for all shifts following the recommendations of the root cause analysis. In the event of staff sickness an adult nurse with paediatric competencies could cover one of the nurse roles but there had to be at least one register children’s nurse within the department.

The department was in the process of implementing higher surveillance of ambulatory patients within the main waiting room. A nurse was allocated to monitor the patients within the waiting room at 30 minute intervals. The department was also due to start GP streaming service two weeks after our inspection. A band 7 emergency nurse practitioner was to be based in the waiting room to assess patients appropriate for GP streaming.

**Information management**

Information needed to deliver effective care and treatment was available to staff in a timely and accessible way. All staff had access to policy and procedure documents electronically.

Staff used paper based records within the ED. However staff had access to an electronic patient record system which meant that the information needed, to deliver effective care and treatment was available to staff in a timely and accessible way for example clinical investigations.

**Engagement**
The ED gathered and acted on people’s views and experiences to shape and improve the service and culture.

People who used the service, those close to them and their representatives were actively engaged and involved in decision making to shape the service and the culture.

Patients were invited to provide feedback and comments through comment cards or electronically with a hand held devise. We saw that children had specially adapted comment cards and access to a hand held device to give feedback.

The department had a patient feedback notice board in the staff room which displayed thank you cards and patient comments.

The matron engaged with the ‘I hug’ user group which was a trust wide patient user group. She gave an example of a patient who had not understood why patients had not been seen in the order of walking into the ED. The matron wrote to the patient to explain the process in ED and why patients were not seen in the order of walking in.

The matron was also in the process of working with the patient user groups to redesign the waiting room within the emergency department. The waiting room has been described as too dark and not a calming environment and feedback from the user group aid the redesign of this area.

The trust took part in the NHS staff survey where staff were able to give feedback about working for the trust. In 2016 the response rate was 46% which was higher than the England average. However the response rate in 2017 was 49% showing a 3% decrease between 2015 and 2016 in the response rate.

We saw that the trust performed in the top 20% of trusts in England in the staff survey for the following areas; believing the trust provides equal opportunities for career progression, feeling unwell due to work related stress in the last 12 months and experiencing physical violence from staff in the last 12 months.

The senior leadership team had held listening events for staff of all levels within the emergency department with the launch of the ‘Red to Green’ project. The clinical director told us that these events were held to communicate to staff the importance of achieving success together.

The emergency department held a staff meeting every two months where senior staff were able to share developments within the department. These meetings also gave staff an opportunity to share ideas about improvements to the environment and services offered within the department. The staff we spoke to told us that they felt encouraged to share ideas to improve the department.

The five topics huddles held at the start of every shift gave staff an opportunity to share information such as recent complaints and incidents.

There were notice boards within the staff room which displayed information for example the mandatory training completion rates and updates for staff.

**Learning, continuous improvement and innovation**

The department had completed an external audit of the flow through the department and had implemented a number of the recommendations to improve the flow. An example of this was the introduction of the floor co-ordinator and regular board rounds to update staff about the patients in the department. The floor co-ordinator was responsible for escalating issues to the matron or the operations team.
The trust had recently won an award from the Health Service Journal for ‘Red to Green’ project in the ‘value and improvement in emergency medicine’ category. The ‘Red to Green’ project demonstrated system wide working to tackle the barriers which keep patients in hospital longer.

The Frailty Assessment Base (FAB) had won three national awards. The service provided an alternative to acute admission for individuals with complex co-morbidities, and was supported by the “geriatric hotline”. This service provided instant advice for GPs or community teams as well as same/next day assessment by a dedicated multidisciplinary team. A fast track referral to FAB was available in ED to support a decision to discharge and could be facilitated out of hours.
Medical care (including older people’s care)

Facts and data about this service

The medical care service at Ipswich Hospital NHS Trust provides care and treatment for most medical specialities. There are 244 medical inpatient beds and 81 day-case/short stay beds located across 14 wards. The trust has 64 community beds across three locations. At June 2017 in medical services there were 352 nursing whole time equivalents (WTE) and 347 other clinical WTE.

A site breakdown can be found below:

- Ipswich Hospital Trust 325 beds are located within 14 wards
  *(Source: Provider Information Return Acute-Sites)*

The trust had 49,425 medical admissions between April 2016 and March 2017. Emergency admissions accounted for 22,031 (45%), 1,360 (3%) were elective, and the remaining 26,034 (53%) were day case.

Admissions for the top three medical specialties were:

- General Medicine 20,011
- Clinical Oncology 9,792
- Clinical Haematology 6,086
  *(Source: CQC Insight)*

Is the service safe?

Mandatory Training

The trust set a target of 95% for completion of mandatory training. Between April and September 2017, the medical division had an average mandatory training rate of 87.6%, against a target of 95%.

A breakdown of compliance for mandatory courses between June 2016 and June 2017 for all staff in Medicine is shown below:
The trust target of 95% was not achieved for any of the mandatory training modules. Blood awareness training had the highest completion rate of 81% whereas conflict resolution had the lowest completion rate of 32%. The trust did not provide training data per staff group.

The trust did provide a completion rate for e-Assessments that covers Equality and Diversity, Adult Safeguarding 1, 2, 3, Infection Control, Health and Safety, Information Governance, Child Safeguarding Level 1, Manual Handling Level 1. A breakdown of completion rates per e-Assessment module was not provided. Staff within Medicine had a training completion rate of 95% for e-Assessments overall thereby meeting and exceeding the trust target of 90%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The majority of nursing and health care assistant staff we spoke with said that they found accessing training easy. Sometimes they had to cancel training that have been booked due to staffing issues but were able to rebook on the next available slot.

Most training was offered via E-Learning packages, however some were face-to-face. There were systems and processes in place to ensure newly appointed, bank and agency staff completed local inductions.

**Safeguarding**

There were clear processes and procedures in place for safeguarding adults and children, accessible through the trust’s electronic system. Staff we spoke with knew how to recognise abuse and make a referral. All of the nursing and health care assistants we spoke with knew how to raise, record and escalate a safeguarding concern. Staff we spoke with gave examples of the types of abuse, for example domestic violence, neglect, sexual and psychological abuse.

Staff within the trust had dedicated information boards within the ward areas, offering advice and guidance to staff on recognising and responding to abuse.

Data supplied by the trust showed that between June 2016 and May 2017, 63 adult safeguarding referrals were made by the medicine division. The trust monitored safeguarding allegations and provided reports to the trust governance teams, to ensure transparency regarding safeguarding concerns.

Staff completed safeguarding training as part of their mandatory training. The trust only provided for Safeguarding Children Level 1, 2 and 3, where the compliance rate at September 2017 was 93%, 81% and 100% respectively, against a target of 95%.

The trust set a target of 90% for completion of safeguarding training. The trust only provided data for one module, Safeguarding Children Level 2. Figures per staff group were not provided. Between June 2016 and June 2017 all staff in Medicine had a safeguarding training completion rate of 74% set against a trust target of 90%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Cleanliness, infection control and hygiene**

All clinical areas we visited were visibly clean. Nursing and medical staff adhered to the trust hand hygiene and ‘bare below the elbow’ policy, and wore personal protective equipment such as gloves and aprons during care.

Staff washed their hands in line with the World Health Organisation’s “Five Moments of Hand Hygiene” guidance between personal care activities with patients and utilised the hand sanitiser...
where appropriate. Hand hygiene compliance audits carried out by the trust within the medicine division showed that in May 2017, 100% was achieved. The Trust compliance target was 98%, which was above the 85% recommended by the NHS Commissioning Board Special Health Authority.

Hand sanitiser was available at the entrance to each ward area and clear signage was in place asking all staff and visitors to wash their hands and to follow the trust policy on infection prevention, protection, and control when entering or leaving wards or departmental areas. All wards we visited had a stock of cleaning and sanitising equipment and key guidance for staff and patients on infection prevention, protection, and control was available at all hand washing areas.

In May 2017, the trust carried out clinical equipment cleaning audit of all medical wards, which achieved a 98.3% compliance rating. Items checked included commodes, bathroom hoists, weighing scales, and drip stands amongst others.

Data supplied by the trust showed that staff carried out Methicillin-resistant Staphylococcus Aureus (MRSA) screening on both elective and non-elective patients within the medicine division. In April and May 2017, staff screened 100% of elective patients. In April 2017, staff screened 73.5% of non-elective patients, in May 2017 68.2%. Elective patient screening was below the trust 95% compliance target.

Environment and equipment

We examined a sample equipment check labels, for example on airflow mattresses, blood pressure monitors, hoists and patient monitoring equipment, amongst others. Staff from the hospitals Electrical and Biomedical Engineering (EBME) team serviced equipment within the medicine wards and we found no out of date equipment during our inspection.

Resuscitation equipment was visibly clean and was stored in an accessible location on all the wards we visited. We reviewed records of safety checks for resuscitation equipment from 1 to 19 September 2017, which showed that staff completed daily checks.

In Bramford ward there was a comment on the daily safety checks from August 2017 that the transfer bag was missing from the resuscitation kit and had not been replaced. We raised this with ward Matron who explained that the critical care outreach team were notified and were in the process of replacing the missing transfer bag.

There was no provision of emergency resuscitation equipment in the discharge lounge. The nurse in charge told us that in case of an emergency they would use the resuscitation trolley in the Maternity unit, which was in separate part of the building. We raised our concerns regarding the discharge lounge and lack of emergency resuscitation equipment and impact this may have on managing the deteriorating patient. An emergency grab bag was put in place on the day.

Patient trolleys, equipment, and curtains providing privacy, appeared visibly clean throughout the wards. Curtains displayed an expiry check date and we found all curtains to be within service date and in good condition.

All wards utilised signage to identify the nurse in charge, the number of staff planned and actual staff on duty. Signage was clear and enabled staff, patients and relatives to see the number of staff on duty, identify staff roles, and see who was in charge of the department. Staff managed clinical waste in line with trust guidance. Waste bins were appropriately colour coded for the appropriate waste disposal method and we noted bins routinely emptied by domestic staff during our inspection.
Assessing and responding to patient risk

Staff used early warning scores (EWS) on the medical wards to monitor and identify any deteriorating patients. All records we reviewed showed that staff routinely completed EWS and alerted senior staff to any patient that may be deteriorating. Data supplied by the trust showed EWS documentation audits for April and May 2017 were above the trust 90% compliance rate at 93.2% and 93.8% respectively.

Nursing staff completing patient observations on hand held computers (nerve centre pads). The nerve centre provided the ward manager and matron an overview of patients and provided continuity between nurses and shifts.

There was a critical care outreach team, who supported staff with management of deteriorating patients on the ward. Staff told us that the critical care outreach team were easily accessed by ward staff to gain help for deteriorating patients. Staff also told us that consultant advice or review was also available when needed.

The MEWS scores in the patients’ records were accurate and showed that patients were being regularly reviewed and escalated as appropriate.

We reviewed 17 patient records in ward areas. There were standard broad risk assessment tools completed on admission. This was followed by use of specific tools for pressure ulcer risk, moving and handling, and bed rails risk, nutrition, falls, and dementia screening. The risk of blood clotting was noted on medication charts. These were included in an assessment booklet which different professional and care staff could use.

Nurse staffing

The trust utilised the “Safer Nursing” acuity tool to allocate staff based on patient acuity. Most of the wards we visited had vacancies for either registered nurses (RN) or health care assistants (HCA). We noted during our inspection that some wards were understaffed against the planned establishment; in these cases, the trust employed agency or bank staff. Staffing and recruitment was a recognised risk on the trusts risk register.

Data supplied by the trust between April 2016 and May 2017 showed the majority of wards within the medicine division were below the required nurse staffing requirements with a reported vacancy rate of 19%. Between July 2016 and June 2017, the trust reported a staff turnover rate of 1%. For the reporting period April 2016 to March 2017 trust reported a sickness rate of 1% in medicine, which is lower than the trust target of 3.5%.

The trust were actively recruiting to various nursing roles, and utilising bank and agency staff to fill any gaps in working rotas. Bank usage rate was 7.3% and agency usage was 11.1% between June 2016 and May 2017. The trust reported an unfilled shift rate of 6.27%. We spoke with nursing staff who told us that they had actively been engaged in supporting the trust with its recruitment processes, including travelling abroad to recruit nurses internationally.

Nursing staff completed a handover of information between each shift, which included discussion of patient care, staffing issues and any patient safety issues.

Ipswich Hospital NHS Trust has reported their staffing numbers below for June 2017 for Medicine. The trust did not provide data for whole time equivalent (WTE) established staff; we can therefore not calculate staffing rates.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Actual WTE Staff</th>
<th>Actual Staff WTE – Headcount June 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ipswich Hospital NHS Trust</td>
<td>345.89</td>
<td>407</td>
</tr>
</tbody>
</table>
Between April 2016 and May 2017, the trust reported a vacancy rate of 19% in Medicine.

<table>
<thead>
<tr>
<th>Ward or clinical area</th>
<th>Vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>7%</td>
</tr>
<tr>
<td>Capel</td>
<td>17%</td>
</tr>
<tr>
<td>Shotley</td>
<td>18%</td>
</tr>
<tr>
<td>Washbrook</td>
<td>17%</td>
</tr>
<tr>
<td>Waveney</td>
<td>33%</td>
</tr>
<tr>
<td>Woodbridge</td>
<td>34%</td>
</tr>
<tr>
<td>Pain</td>
<td>16%</td>
</tr>
<tr>
<td>Claydon</td>
<td>12%</td>
</tr>
<tr>
<td>Debenham</td>
<td>24%</td>
</tr>
<tr>
<td>Discharge</td>
<td>11%</td>
</tr>
<tr>
<td>Frailty Unit</td>
<td>28%</td>
</tr>
<tr>
<td>Grundisburgh</td>
<td>28%</td>
</tr>
<tr>
<td>Haughley</td>
<td>21%</td>
</tr>
<tr>
<td>Kesgrave</td>
<td>53%</td>
</tr>
<tr>
<td>Kirton</td>
<td>18%</td>
</tr>
<tr>
<td>Oncology</td>
<td>9%</td>
</tr>
<tr>
<td>Somersham</td>
<td>4%</td>
</tr>
<tr>
<td>Rushmere DU</td>
<td>7%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Between July 2016 and June 2017, the trust reported a turnover rate of 1% in Medicine;

<table>
<thead>
<tr>
<th>Ward or clinical area</th>
<th>Turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division 1 Management</td>
<td>2%</td>
</tr>
<tr>
<td>Medical Specialty 1 / Cost Centre</td>
<td>1%</td>
</tr>
<tr>
<td>Medical Specialty 2</td>
<td>1%</td>
</tr>
<tr>
<td>Medical Specialty 3</td>
<td>1%</td>
</tr>
<tr>
<td>Medical Specialty 4</td>
<td>0%</td>
</tr>
<tr>
<td>Oncology &amp; Haematology</td>
<td>0%</td>
</tr>
<tr>
<td>Pathology</td>
<td>0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P18 Turnover)
Between April 2016 and March 2017, the trust reported a sickness rate of 1% in Medicine, lower than the trust target of 3.5%.

<table>
<thead>
<tr>
<th>Ward or Clinical Area</th>
<th>Sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division 1 Management</td>
<td>0.0%</td>
</tr>
<tr>
<td>Medical Specialty 1 / Cost Centre</td>
<td>2.6%</td>
</tr>
<tr>
<td>Medical Specialty 2</td>
<td>3.0%</td>
</tr>
<tr>
<td>Medical Specialty 3</td>
<td>0.0%</td>
</tr>
<tr>
<td>Medical Specialty 4</td>
<td>10.1%</td>
</tr>
<tr>
<td>Oncology &amp; Haematology</td>
<td>6.3%</td>
</tr>
<tr>
<td>Pathology</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Medical staffing**

Between June 2016 and July 2017 the trust reported a medical staffing vacancy rate of 5% in medicine. In the reporting period April 2016 to March 2017 the trust reported a turnover rate of 0.3% and a sickness rate of 1.1% (lower than the trust target of 3.5%) in medicine. As a result between June 2016 and May 2017 bank and locum usage were variable in medicine. Data from the trust showed that 300 shifts were filled by bank staff, 522 by agency staff and 15 were left unfilled in medicine.

In May 2017, the proportion of consultant and junior (foundation year 1-2) staff reported to be working at the trust was similar to the England average.

In the cardiac unit there was consultant cover 24 hours for seven days a week, provided by consultants on the rota. This meant that all patients were seen every day by a consultant, to review their progress.

Clinical decisions in medical ward areas were led by a consultant allocated for that area. This meant that patients did not have to wait for different ward rounds. There was a daily review of care, with a consultant leading the multidisciplinary team.

In the Frailty Assessment Base (FAB) all GP referrals were assessed by a consultant as appropriate for admission. There was consultant attendance through the day (9am to 7pm), with a dedicated registrar and junior doctors. During the weekend there was consultant cover from 9am to 1pm and then on call via the site office. This meant that all patients were seen on admission by a senior doctor, who could judge the need for admission, and make an immediate plan of the care and treatment.

All medical wards had a dedicated level of medical cover on a daily basis. Acute physicians provide consultant cover. Medical doctors on call from FY1 (F1 enables medical graduates to begin to take supervised responsibility for patient care and consolidate the skills that they have learned at medical school) grade to speciality trainees (ST), general practitioners (GP), or core medical trainee (CMT) level, provide the remainder of the medical cover.

In the majority of clinical areas, consultants reviewed patients on a daily basis from Monday to Friday and all new admissions are seen by a consultant at weekends.
We observed the 9am to 9.30am informal handover meeting. Handovers were comprehensive and included reviews of any patients deemed as high risk due to their condition, or likely deterioration. The meeting focused on patient admissions and changes overnight and included discussion of clinical incidents, unexpected deaths, intensive care admissions, unwell patients and scans and investigations requiring urgent review. The handover meeting also included a review of medical staffing gaps and agreed redistribution of doctors. Senior staff told us that a more formal handover took place at 10pm in the hospital operations room.

Ipswich Hospital NHS Trust has reported their staffing numbers below for June 2016 for Medicine. The trust did not provide data for WTE established staff; we can therefore not calculate the staffing rates.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Actual WTE Staff</th>
<th>Actual Staff WTE – Headcount June 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ipswich Hospital NHS Trust</td>
<td>115.91</td>
<td>120</td>
</tr>
<tr>
<td>Total</td>
<td>115.91</td>
<td>120</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Between June 2016 and July 2017 Ipswich Hospital reported a vacancy rate of 5% in Medicine.

<table>
<thead>
<tr>
<th>Ward or clinical area</th>
<th>Vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>5%</td>
</tr>
<tr>
<td>Older People Med</td>
<td>-4%</td>
</tr>
<tr>
<td>Stroke Services</td>
<td>24%</td>
</tr>
<tr>
<td>Pain</td>
<td>20%</td>
</tr>
<tr>
<td>Gastro</td>
<td>8%</td>
</tr>
<tr>
<td>Oncology</td>
<td>0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Between April 2016 and March 2017 Ipswich Hospital reported a turnover rate of 0.3% in Medicine.

<table>
<thead>
<tr>
<th>Ward or clinical area</th>
<th>Turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Specialty 1</td>
<td>0.7%</td>
</tr>
<tr>
<td>Medical Specialty 2</td>
<td>0.2%</td>
</tr>
<tr>
<td>Medical Specialty 3</td>
<td>0.0%</td>
</tr>
<tr>
<td>Medical Specialty 4</td>
<td>0.0%</td>
</tr>
<tr>
<td>Oncology &amp; Haematology</td>
<td>0.5%</td>
</tr>
<tr>
<td>Pathology</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P18 Turnover)
Between April 2016 and March 2017 Ipswich Hospital reported a sickness rate of 1.1% in Medicine, lower than the trust target of 3.5%.

<table>
<thead>
<tr>
<th>Ward or clinical area name</th>
<th>Sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division 1 Management</td>
<td>0.00%</td>
</tr>
<tr>
<td>Medical Specialty 1</td>
<td>0.54%</td>
</tr>
<tr>
<td>Medical Specialty 2</td>
<td>2.85%</td>
</tr>
<tr>
<td>Medical Specialty 3</td>
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</tr>
<tr>
<td>Medical Specialty 4</td>
<td></td>
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<tr>
<td>Oncology &amp; Haematology</td>
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<tr>
<td>Pathology</td>
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</tr>
<tr>
<td>M&amp;D</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Between June 2016 and May 2017, Ipswich Hospital reported that 300 shifts were filled by bank staff, 522 by agency staff and 15 shifts were left unfilled in Medicine. The trust did not provide total shifts and therefore a usage rate could not be calculated.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

As at May 2017, the proportion of consultant staff reported to be working at the trust was similar to the England average and the proportion of junior (foundation year 1-2) staff was similar.

Staffing skill mix for the 134 whole time equivalent staff working in Medicine at Ipswich Hospital NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
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</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>44%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career</td>
<td>7%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>28%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior</td>
<td>21%</td>
<td>22%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital - Workforce statistics (01/05/2017 - 31/05/2017)

Records

We reviewed 17 patient records as part of this inspection. Staff kept patient records either outside the patient’s room, or at the end of the patient’s bed and in an unlocked records trolley by the nurses station meaning records were not secure at all times.

Staff completed risk assessments and reviews frequently during the patient’s admission. Risk assessments included Early Warning Scores (EWS), Malnutrition Universal Screening Tool (MUST), Waterlow score (a tool for assessing the risk of developing a pressure sore) and falls risk assessments amongst others.

We found good evidence of multidisciplinary team recording in patient records, to provide accurate details of care pathways needed to ensure consistency of care. All of the records we reviewed were signed and dated by staff and legible.
However in eight of the 17 patient records we reviewed, there was an inconsistency between the electronic records of venous thromboembolism (VTE) assessments completed by the medical staff and the paper records. This was raised with senior ward staff and discussed with the medical director who appreciated the concerns and stated they would follow this up. Work was already underway to trial electronic prescribing and the medical director stated that the implementation of electronic prescribing would solve the issue around the issue VTE assessments not being completed.

**Medicines**

We found that there were effective systems in place for medicine management with regard to handling, storage, and security of medicines. On all the wards we visited, staff stored medication in locked rooms, neatly within locked cupboards.

Controlled drugs (CD) records were legible and dated by nursing staff without any omissions and CD’s were stored securely in an appropriate cupboard within the medicines storage rooms.

We found the books for recording fridge temperatures on all wards we visited were well maintained and completed daily with no omissions. For example on Claydon ward and Debenham ward amongst others, staff recorded the refrigeration temperatures between April 2017 and 19 September 2017, with no omissions. We noted if the fridge temperature exceeded the stated range, staff would record the details, take the appropriate action and if the temperature doesn’t return to the acceptable range would report as an incident and escalate with pharmacy. All the wards we visited had a named pharmacist that visited the ward regularly and followed up on any medication or stock query from the ward staff.

Medicines incidents were reported and we saw evidence of lessons learnt and positive action taken to prevent them happening again.

We checked the expiry dates on a selection of medications on Claydon, Debenham, Bramford, Waveney, Stradbroke, Shotley, and Grundisburgh wards, including CDs, bags of fluid and other medications. All the medications we checked were in date and stored according to manufacturer’s storage condition.

We reviewed 13 patient medication records. Allergies were clearly recorded on the drug chart. Records were accurate, and reflected the needs of the patients.

**Incidents**

In accordance with the Serious Incident Framework 2015, the trust reported 44 serious incidents in medicine, which met the reporting criteria set by NHS England between August 2016 and July 2017. Of these, the most common type of incidents reported were pressure ulcer (43%) and slips, trips, falls (34%) meeting serious incident (SI) criteria.

All staff we spoke with knew how to report incidents on the trust electronic reporting system and stated that they received feedback from any incidents via email, monthly ward newsletter, from their line manager at team meetings and also discussed in ‘5 Topics 7 day ward huddles’, where the ward team have a daily 5 minute huddle process where five topics a day are discussed seven days a week. Staff also said that they were actively encouraged to report incidents by their managers, to enable learning and to ensure incidents were minimised in the future.

On all the wards we visited learning from incidents were kept in a governance and learning folder. Feedback on the incident included what went wrong, the method of reporting and all actions taken by the trust to prevent the incident happening again.
We reviewed the route cause analysis (RCA) of three SI’s involving falls, held within the governance and learning folders. All of the SI’s had been thoroughly investigated, and detailed the recommendations and actions taken to minimise events in the future. Staff could access the governance and learning folder at any time and SI’s were discussed at team meetings.

The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. All nursing and medical staff we spoke with knew what the duty of candour was and that it was about being open and transparent when things go wrong.

The trust held monthly mortality and morbidity meetings that included a wide range of multi-disciplinary support.

**Never Events**

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Between August 2016 and July 2017, the trust reported one incident classified as a never event for Medicine.

The incident was reported as a medication incident in October 2016 at Ipswich Hospital. Medication had been prescribed incorrectly on discharge to the wrong patient. This resulted in the patient taking medication that was not appropriate for them. We reviewed the root cause analysis (RCA) relating to the incident. The report included care and service delivery problems, contributory factors, root causes and lessons learnt. Actions included the implementation of two nurse check of TTA medication at the final stage of issue.

*Source: NHS Improvement - STEIS (01/08/2016 - 31/07/2017)*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 44 serious incidents (SIs) in Medicine which met the reporting criteria set by NHS England between August 2016 and July 2017. All incidents were reported at Ipswich Hospital.

![Graph showing breakdown of serious incidents](image)

Of these, the most common type of incidents reported were:

- Pressure ulcer meeting SI criteria with 19 (43% of total incidents).
- Slips/trips/falls meeting SI criteria with 15 (34% of total incidents).
- Treatment delay meeting SI criteria with 3 (7% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with 3 (7% of total incidents).
- All other categories with 3 (7% of total incidents).
- Abuse/alleged abuse of adult patient by staff with 1 (2% of total incidents).

(Source: Strategic Executive Information System (STEIS))

The trust had a major incident plan and business continuity plan in place. There were clear escalation procedures in place for managing staffing pressures and capacity. Staff understood their responsibilities in relation to these procedures.

**Major incident training completion rates**

The trust did not provide data for major incident training.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Safety thermometer**

The ‘Safety Thermometer’ thermometer is used to record data relating to aspects such as the number of patient falls, pressure ulcers, catheter and urinary tract infections and venous thromboembolism (VTE). Data collection takes place one day each month, a suggested date for data collection is given but wards can change this. Staff must submit data within 10 days of suggested data collection date.

Data from the patient safety thermometer showed that the trust reported 50 new pressure ulcers, 22 falls with harm, and 44 new catheter urinary tract infections between July 2016 and July 2017 for medical services.

Data supplied by the trust showed that in April and May 2017, VTE risk assessment completion across medicine wards was below the trust compliance rate of 98%. Compliance was 58%, and 56.9% respectively. Senior members of the ward staff told us that there was an issue with medical staff completing the electronic assessment and inconsistent recording in paper records. This was raised on site and discussed with the medical director who appreciated the concerns and stated they would follow this up.

Data supplied by the trust showed that VTE prophylaxis compliance across medicine wards in April 2017 was 93.3% and May 2017 was 98%, against the trust compliance rate of 95%.

The trust had implemented the use of a heat map system, which showed where incidents were more prevalent and enabled staff to identify issues of concern and trends in safety performance. All wards we visited used the heat map to record performance against pressure ulcers, medication omissions, Methicillin-resistant Staphylococcus Aureus (MRSA), C-diff, complaints and incidents relating to patient falls where no harm occurred.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Ipswich Hospital NHS Trust**

...
From July 2016 to January 2017 between one and three pressure ulcers were reported per month. However from February 2017 to June 2017, with the exception of May and July 2017 the number of pressure ulcers reported escalated to between eight and six reported per month. Although the overall trend deviated month on month an increase in trend can be seen.

Falls with harm followed an increasing trend over the period. In July 2016 one fall was reported and in July 2017 five falls were reported.

The overall trend for new C.UTIs found increased over the period although some deviations can be seen. High numbers were reported in September (4) and October 2016 (5) and again in February (10), March (4) and June 2017 (5)

(Source: Safety thermometer - Safety Thermometer)
Is the service effective?

Evidence-based care and treatment

On Shotley Ward (stroke unit) nursing and medical staff, assessed patient needs, care, and treatment in line with the National Institute for Health and Care Excellence (NICE) quality standard CG58 Stroke: Diagnosis and initial management of acute stroke and transient ischaemic attack (TIA). The unit have implemented a new thrombolysis acute pathway where by patient are admitted taken straight for CT scan and treatment given in less than 30 minutes, improving the patient outcome.

Across the division of medicine, staff followed NICE guidance (CG92) in the assessment and management of venous thromboembolism (VTE). We reviewed 13 medication prescription charts, all of these demonstrated where patients had received a venous thromboembolism (VTE) risk assessment and had prophylactic venous thromboembolism (VTE) medication if indicated. However there was an inconsistency in the recording of VTE assessments between the paper prescription record and the electronic observation record (Nerve centre).

Local policy and procedure guidelines for all specialties were available on the trust intranet and were easily accessible by all members of staff. Regular audits of documentation were undertaken on all wards to ensure care was following best practice and identify areas that required improvement.

Local audits were also taking place in the medicine division, for example hand hygiene, the assessment of deep vein thrombosis (DVT) and venous thromboembolism (VTE) and early warning scores (EWS), amongst others.

Nutrition and hydration

Patients on medicine wards could choose meals from a menu supported by staff to make choices if required. We noted that patients could ask for vegetarian, vegan, and soft options to promote their wellbeing and respect individual beliefs.

The medicine wards used a ‘red tray’ system to identify patients who needed help with eating. This enabled staff to identify and monitor those patients who needed encouragement or special diets in order to maintain their well-being.

The trust used the malnutrition universal screening tool (MUST) to identify patients at risk of malnutrition. We reviewed 17 patient records and found that in all cases where it was appropriate the MUST score had been completed and the patient’s fluid and diet chart completed and escalated accordingly.

We saw that patients had access to water jugs at the bed side, these were within patients’ reach. Meal times were well organised and not rushed. Staff ensured that patients, where possible, sat up in bed or at tables to eat meals.

Pain relief

We reviewed 17 patient care records during our inspection, staff routinely recorded the patient’s level of pain on the early warning score chart in line with the trust policy. Staff asked patients to rate their pain each time they took their physiological observations and staff assessed patient pain. Staff completed pain charts appropriately in all patient notes we reviewed.
Patients told us that they were always asked about pain during medication administration rounds. We examined prescription charts, and saw that as required medication was prescribed for pain where appropriate.

**Patient outcomes**

The trust regularly reviewed the effectiveness of care through the collection and monitoring of patient outcomes and participation in local and national audit. Between May 2016 and April 2017, patients at the trust had a lower than expected risk of readmission for elective and non-elective admissions when compared to the England average.

Elective Oncology and Haematology patients had a lower than expected risk of readmission based on count of activity. Elective gastroenterology patients had higher than expected risk of readmission.

The trust took part in the quarterly Sentinel Stroke National Audit programme (SSNAP). On a scale of A-E, where A is best, the trust achieved grade B in the latest audit, December 2016 to March 2017. Overall scores deteriorated from grade A in August to December 2016. At patient centred performance and team centred performance, all scores remained above C. However, the score from thrombolysis for both patient and team centre fell from A to B.

The trust results in the 2015 heart failure audit were much worse than the England and Wales average for all four of the standards relating to in-hospital care. The trust results were worse than the England and Wales average for six of the seven standards relating to discharge. The trust clinical practice indicators in the heart failure audit scored 74% or lower, which is notably lower than the England average. The clinical practice indicator for input for consultant cardiologist performed the worst at 29%, compared to the England average of 57%.

The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement. The audit attributes a quartile to each metric, which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25%, whereas quartile 4 means that the result is in the highest 25% for that audit year. The 2016 NaDIA audit identified 86 in-patients with diabetes at the trust. The overall results indicate that the trust is in the best performing 25% of trusts in England.

All hospitals in England that treat heart attack patients submit data to Myocardial Ischaemia National Audit Project (MINAP) by hospital site (as opposed to trust). Between April 2014 and March 2015, 62.9% of non-ST- elevation infarction (nSTEMI) patients were admitted to a cardiac unit or ward and 97% were seen by a cardiologist or member of the team compared to an England average of 55% and 95.1% respectively. The proportion of non-ST- elevation infarction (nSTEMI) patients referred for or receiving angiography at the trust was 71.9% compared to an England average of 79%.

The trust participated in the 2016 lung cancer audit and the proportion of patients seen by a cancer nurse specialist was 73%, which does not meet the audit minimum standard of 90%. The proportion of patients with histologically confirmed non-small cell lung cancer (NSCLC) receiving surgery was 16.4%; this is worse than the national level. The 2015 figure was 12%.

The proportion of medically fit patients with advanced (NSCLC) receiving chemotherapy was 55%; this is not significantly different from the national level. The 2015 figure was 77%. Trusts scores in 2016 did not meet the national aspirational standard of 60%

The proportion of patients with small cell lung cancer (SCLC) receiving chemotherapy was 72.2%; this is not significantly different from the national level. The 2015 figure was 74%.
The one year relative survival rate for lung cancer for the trust in 2016 was 42.9%, which is significantly better than the national level.

**Relative risk of readmission**

Between May 2016 and April 2017, patients at the trust had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

**Elective Admissions - Ipswich Hospital NHS Trust**

![Graph showing Elective Admissions]

**Non-Elective Admissions - Ipswich Hospital NHS Trust**

![Graph showing Non-Elective Admissions]

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite.

Top three specialties for specific trust based on count of activity

(Source: HES - Readmissions (01/05/2016 - 30/04/2017))

**Sentinel Stroke National Audit Programme (SSNAP)**

Ipswich Hospital NHS Trust takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade B in latest audit, December 2016 and March 2017. The overall score has deteriorated from grade A in August to December 2016.

**The Ipswich Hospital NHS Trust**

**Team-centred KI levels**

1) Scanning

2) Stroke unit

3) Thrombolysis

4) Specialist Assessments

5) Occupational therapy

6) Physiotherapy

![Team-centred KI levels table]
Heart Failure Audit (April 2014 – March 2015)

In-hospital Care Scores

Results for Ipswich Hospital NHS Trust in the 2015 Heart Failure Audit were much worse than the England and Wales average for all four of the standards relating to in-hospital care.

### Clinical practice in England (in-hospital care)

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<td>Cardiology inpatient</td>
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<td>48%</td>
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<tr>
<td>Input from consultant cardiologist</td>
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<td>59%</td>
</tr>
<tr>
<td>Input from specialist</td>
<td>33%</td>
<td>80%</td>
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<tr>
<td>Received echo</td>
<td>65%</td>
<td>92%</td>
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</table>

Discharge Scores

Results for Ipswich Hospital NHS Trust results were worse than the England and Wales average for six of the seven standards relating to discharge.
Discharge Scores

Results for Ipswich Hospital NHS Trust results were worse than the England and Wales average for six of the seven standards relating to discharge.

SOURCE: NICOR - Heart Failure Audit (01/04/2014 - 31/03/2015)
National Diabetes Inpatient Audit

The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The 2016 National Diabetes Inpatient Audit identified 86 inpatients with diabetes at Ipswich Hospital NHS Trust, 90% of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in quartile 4, amongst the best performing 25% trusts.

- 66.3% of patients with diabetes received a diabetic foot risk assessment within 24 hours of admission, which places this site in Quartile 4, amongst the best performing 25% of trusts.
- 89.5% of patients received a diabetic foot risk assessment at some point during their hospital stay, which places Ipswich Hospital in Quartile 4, amongst the best performing 25% of trusts.
- 73.5% of patients with diabetes were visited by a member of the diabetes team, which places this site in Quartile 4, amongst the best performing 25% of trusts.
- 14.3% of patients with diabetes experienced at least one medication management error, which places this site in Quartile 1, amongst the best performing 25% of trusts.
- Of the patients on insulin, 14.3 per cent experienced one or more insulin (prescription or medication management) error, which places this site in Quartile 1, amongst the best performing 25% of trusts.
- 12.0% of patients with diabetes experienced one or more mild hypoglycaemic episode (3.0-3.9mmol/L), which places this site in Quartile 1, amongst the best performing 25% of trusts.
- 70.7% of patients with diabetes reported that the timing of their meals was always or almost always suitable, which places this site in Quartile 4, amongst the best performing 25% of trusts.
- 46.6% of patients with diabetes reported that they could take control of their diabetes care while in hospital, which places this site in Quartile 1, amongst the worst performing 25% of trusts.
- 53.9% of patients with diabetes reported that all or most of the staff looking after them had enough knowledge of their diabetes to meet their needs while in hospital, which places this site in Quartile 1, amongst the worst performing 25% of trusts.
- 63.3% of patients with diabetes reported that staff were definitely, or to some extent, able to answer their questions in a way that they understood, which places this site in Quartile 1, amongst the worst performing 25% of trusts.

(Source: NHS Digital)

Myocardial Ischaemia National Audit Project (MINAP)

All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

Between April 2014 and March 2015, 62.9% of nSTEMI patients were admitted to a cardiac unit or ward at Ipswich Hospital NHS Trust and 97% were seen by a cardiologist or member of the team compared to an England average of 55% and 95.1% respectively.
The proportion of nSTEMI patients who were referred for or had angiography at Ipswich Hospital NHS Trusts was 71.9% compared to an England average of 79%.

<table>
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<tr>
<th>2014/15</th>
<th>nSTEMI patients seen by a cardiologist or a member of team</th>
<th>nSTEMI patients admitted to cardiac unit or ward</th>
<th>nSTEMI patients that were referred for or had angiography (incl after discharge)</th>
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<tbody>
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<td>The Ipswich Hospital NHS Trust</td>
<td>372</td>
<td>372</td>
<td>274 (274)</td>
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<tr>
<td></td>
<td>97%</td>
<td>62.9%</td>
<td>71.9% (No data)</td>
</tr>
<tr>
<td>England: overall</td>
<td>45500</td>
<td>45500</td>
<td>38099 (38099)</td>
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<tr>
<td></td>
<td>95.1%</td>
<td>55%</td>
<td>79% (No data)</td>
</tr>
</tbody>
</table>

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

Lung Cancer Audit

The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 73.0%, which was worse than the audit minimum standard of 90%. The 2015 figure was 84.0%

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 16.4%, this is worse than the national level. The 2015 figure was 12.0%.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 55%; this is not significantly different from the national level. The 2015 figure was 77%. Trusts scores in 2016 did not meet the national aspirational standard of 60%

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 72.2% this is not significantly different from the national level. The 2015 figure was 74%. trust scores in 2016 were better than the national aspirational standard.

The one year relative survival rate for the trust in 2016 is 42.9%, significantly better than the national level.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls

Ipswich Hospital NHS Trust have a multi-disciplinary working group for falls prevention where data on falls are discussed at most or all the meetings.

The crude proportion of patients who had a vision assessment was 75.9% this is below the national aspirational standard of 100%; although trust scores were better than the national aggregate of 48.3%

The crude proportion of patients who had a lying and standing blood pressure assessment was
0% this is much worse than the national aspirational standard of 100% and the national aggregate of 16.1%.

The crude proportion of patients assessed for the presence or absence of delirium was 50% this is below the national aspirational standard of 100%; although trust scores were better than the national aggregate of 36.7%.

The crude proportion of patients with appropriate mobility aid in reach (if applicable) was 62.5% this is below the national aspirational standard of 100% and the national aggregate 67.7%.

(Source: Royal College of Physicians)

Competent staff

As of June 2017, 89% of staff within medicine at the trust had received an appraisal. Appraisal completion varied across the medicine division, with medical and dental staff at 93%, allied health professionals 96% and nursing and midwifery registered staff at 67%.

All staff we spoke with said that appraisals were a positive experience and managers reviewed training needs and performance. We spoke with ward managers who were able to identify the appraisals that were due for the month and told us how they followed up with staff to ensure they had completed their appraisal and set targets.

We spoke with nursing staff who explained the process for revalidation. Staff had access to a named nurse who supported them through the process and helping gather evidence for their revalidation submission.

Nursing staff and health care assistants held a continual professional development (CPD) folder, to store certificates and details in relation to any training achieved. Staff could also access training information via the hospital intranet to see if they were up to date with mandatory training in order to book into sessions and update their CPD.

Staff reported having access to additional training to enable them to carry out their role effectively. Specialist clinical staff provided support to medical wards and departments. For example in Debenham ward staff were provided with advice and training on diabetes and diabetic ketoacidosis, management of pressure ulcers, and the support of patients with learning disability or living with dementia.

The trust developed a number of ‘Link’ nurses, linked to specific specialism to offer support, guidance, and advice to staff on issues such as diabetes, dementia, cardiac, falls and safeguarding amongst others.

Between June 2016 and June 2017, 89% of staff within Medicine at the trust had received an appraisal compared to a trust target of 95%. Qualified nursing staff had the lowest appraisal completion rate of 67% well below the trust target of 95%, while support to nursing and doctors had a 100% completion rate.

A split by staff group can be seen in the graph below:
Multidisciplinary working

During the inspection we saw regular consultant-led multidisciplinary meetings or rounds in clinical areas. There was a joined-up and thorough approach to assessing the range of patients' needs and a consistent approach to ensuring assessments were regularly reviewed and kept up to date.

We saw the daily inpatient board rounds and routine ‘Red to Green’ patient management meeting during the daily ward governance huddles. Ward teams had access to a range of allied health professionals and team members described good collaborative working practices between the teams. All staff described teams working well together and sharing best practice to improve patient outcomes.

Patient records showed multidisciplinary care and treatment took place. For example, occupational therapists, physiotherapists, and speech and language therapists fully documented patient progress and updates within the patient care record. Information was recorded within the patient’s daily records.

There was joint working with discharge coordinators and therapy teams to identify patients awaiting discharge. The discharge coordinators would review every patient awaiting a rehabilitation bed and attend ward rounds to promote early intervention and discharge where possible.

Seven-day services

Consultant medical staff provided a seven day service across the medical directorate. This meant that patients were reviewed each day, and admission reviews and discharges could be facilitated through weekends.

Staff reported good access to therapies such as physiotherapy, occupational therapy and speech and language therapy Monday to Friday, with reduced access at weekends for physiotherapy and speech and language therapy.

There was a seven day a week cardiology service, which meets the national requirements of a cardiac unit. The seven day service meant prompt review of patients attending any day of the week, and it had reduced length of stay for such patients.
Routine CT (computerised tomography) scanning and ultrasound services were provided at weekends. This enabled diagnosis when patients required these imaging diagnostic tests, and so maintained the progress of care towards discharge.

Clinical pharmacy services include pharmacists, technicians, and assistants covering designated wards five days per week. The service operates at weekends where pharmacists are available between 9am and 4pm, and an on call pharmacy service is available out of hours.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Data supplied by the trust prior to inspection showed that as of 31 March 2017, 96.4% of staff completed Mental Capacity Act (MCA) which is above the 95% trust target.

Staff sought consent before commencing care or treatment. We reviewed care records for 17 patients in medical wards. Consent was noted by therapy staff when recording episodes of therapy in ward or gym areas. We saw consent for diagnostic scans and interventions were in place and documented appropriately to show that patients understood the procedure and relevant risks.

Nursing and medical staff we spoke with could explain what MCA and DoLS meant and that this supported decision-making and best interests of the patients.

Mental Capacity Act and Deprivation of Liberty training completion

The trust did not provide data for mental capacity act or deprivation of liberty training.

(Source: Trust Routine Provider Information Return)

Is the service caring?

Compassionate care

Between August 2016 and July 2017, the Friends and Family Test (FFT) response rate for medicine at the trust was 37%, which was better than the England average of 25%. The results for recommendation of the hospital was consistently 100% for 11 of the 12 months over the reporting period.

During our inspection we spoke with 16 patients and two relatives. All were consistently positive about their experience of care and support at the hospital.

Staff respected and recognised patients' individual needs and choices at all times. Staff displayed kind and gentle behaviour, offering reassurance and positive support to patients who were often uncomfortable and needing reassurance.

We spoke with a patient on Haughley Ward who said, “I would recommend this hospital for treatment and care.”

The Friends and Family Test response rate for Medicine at the trust was 37% which was better than the England average of 25% between August 2016 and July 2017. Rushmere (ICU) and Woolverstone wards had the lowest response rates of 8% and 7% respectively. Haughley ward had a higher than trust average response rate of 51% and recommendation rate were consistently 100% for 11 of the 12 months over the period.
Friends and Family Test – Response rate between 01/08/2016 and 31/07/2017 by site.

<table>
<thead>
<tr>
<th>Site – level</th>
<th>Trust – level</th>
<th>National – level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>37%</td>
<td>3%</td>
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(Source: NHS England Friends and Family Test)

Emotional support

The hospital chaplain often supported patients, families, and staff in very difficult situations. The chaplaincy supported people of all faiths and beliefs and specialist support for various faiths was available. We saw the chaplaincy service advertised on notice boards within the wards.

A patient we spoke with commented that staff “bend over backwards to help” and another said “nurses can’t do enough”.

The cancer information which is situated within the oncology and haematology department provides practical advice and emotional support. This meant patients and their relatives could ask
for information or support and get the opportunity to talk with staff about the effects of their illness. The Centre also provides their services to meet the needs of those affected by cancer in other areas of the hospital, and works closely with all members of the healthcare team.

**Understanding and involvement of patients and those close to them**

The trust carries out local inpatient surveys and the results for April 2016 to March 2017 showed that the trust consistently meet the target cores. For example the trust achieved an average of 80 for patients and families feeling listened to and involved in the care and treatment decisions.

Nurses, health care assistants, doctors, and therapists all introduced themselves to patients at all times, and explained to patients and their relatives about the care and treatment options.

Family or carers could stay with patients who were cared for in a side room and visiting times were flexible. This was to promote the patients welfare for example, a confused patient or a patient not having appetite following treatment or to support a patient who may be at the end of their life. A relative on Debenham ward said, “Initially it was difficult to get information about my mum, but now I am regularly updated with what’s going on with my mum.” Another relative on Claydon ward stated, “The staff will always talk to us and go through things.”

### Is the service responsive?

**Service delivery to meet the needs of local people**

The trust had systems and process in place to manage admissions, discharges and peaks of workload.

The Frailty Assessment Base (FAB) provided an alternative to acute admission for individuals with complex co-morbidities. This service enabled instant advice for GPs or community teams as well as same/next day assessment by a dedicated MDT. This meant patients were quickly treated and early intervention of other services.

**Average length of stay**

Between June 2016 and May 2017 the average length of stay for medical elective patients at Ipswich Hospital was 5.2 days, which is higher than the England average of 4.2 days.

For medical non-elective patients, the average length of stay was 5.9 days, which is lower than the England average of 6.6 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in Clinical Oncology (Previously Radiotherapy) is higher than the England average.
- Average length of stay for elective patients in Gynaecological Oncology is similar to the England average.
- Average length of stay for elective patients in Cardiology is lower than the England average.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in General Medicine is similar to the England average.
• Average length of stay for non-elective patients in Geriatric Medicine is much lower than the England average.

• Average length of stay for non-elective patients in Clinical Oncology (Previously Radiotherapy) is lower than the England average.

Elective Average Length of Stay – Ipswich Hospital NHS Trust

Meeting people’s individual needs

The trust was undertaking a comprehensive ward renovation project. For example the environment in the Constable Suite (Grundisburgh and Haughley wards) was developed to support patients living with dementia and other complex needs. The layout and décor of the suite was visually striking. There were visual prompts for direction, and colours were used to promote independence. During our inspection Washbrook and Sproughton wards were undergoing similar refurbishment to create a dementia friendly environment.

The trust utilised ‘health passports’ which were designed to communicate health care needs of people with learning difficulties to doctors, nurses and other healthcare professionals. This passport gave detailed information in relation to patient’s preferences of care, family, and social circumstances.

We observed occupational and physiotherapists working closely with the nursing and medical teams to promote patient welfare and condition management. Therapists reviewed individual needs and the use of specialist equipment to promote mobility and activities of day-to-day living to support patient’s independence.

Staff had access to specialist equipment including bariatric and pressure relieving equipment. The trust had a system in place to access telephone and face to face translation and interpreter service. Leaflets on various conditions were available throughout the wards, as guidance for patients and families. Staff could order these in different languages formats when necessary.

At the time of our inspection there was no access to an acute psychiatric pathway and therefore delays in psychiatric assessment was an issue on the inpatient wards. We raised this issue with the leadership team who told us that a mental health business plan was being signed off by the trust board imminently which would bring system wide alliance to resolve the issue. Delay in psychiatric assessment was an identified risk on the divisional risk register.

Access and flow
Between April and September 2017, the main reasons for delayed transfer of care at the trust were waiting for a care package followed by awaiting nursing home placement or availability. The trust had introduced a ‘red to green’ system. The system enabled staff to identify patients as red if they required further intervention or services, or green if their pathway was on track.

The trust invested in the recruitment of discharge co-ordinators who worked across the wards to promote the safe and timely discharge of patients. The coordinators worked with the ward staff, multidisciplinary team, and external agencies, for example community care and families to improve discharge outcomes. All staff we spoke with on the wards valued the support of the discharge coordinators and felt the role had made a positive impact on the patient discharge process.

Between June 2016 and May 2017, the trust’s referral to treatment time (RTT) for admitted pathways for medicine was consistently better than the England average. All the specialties were above the England average for admitted RTT (percentage within 18 weeks) including cardiology, gastroenterology, general medicine, geriatric medicine, neurology, rheumatology and thoracic medicine.

Between June 2016 and May 2017, the average length of stay for medical elective patients at the trust was 5.2 days, which is higher than England average of 4.2 days. For medical non-elective patients, the average length of stay was 5.9 days, which is lower than England average of 6.6 days. Clinical Oncology had the greatest difference between the hospitals length of stay (3.8) compared to the England average (2.4).

Between April and September 2017 there were on average 48 medical outliers. The medical service aimed to keep the number of medical outliers to a minimum, but to ensure that such patients were reviewed by consultants regularly.

Referral to treatment (percentage within 18 weeks) - admitted performance

Between June 2016 and May 2017 the trust’s referral to treatment time (RTT) for admitted pathways for Medicine were consistently better than the England average.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

Seven specialties were above the England average for admitted RTT (percentage within 18 weeks).

There were no specialties that were below the England average for RTT times.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: NHS England)
<table>
<thead>
<tr>
<th>Service</th>
<th>Quality 1</th>
<th>Quality 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>89.2%</td>
<td>83.6%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>98.6%</td>
<td>94.2%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>100%</td>
<td>95.5%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>100%</td>
<td>98.0%</td>
</tr>
<tr>
<td>Neurology</td>
<td>100%</td>
<td>92.1%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>100%</td>
<td>93.5%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>100%</td>
<td>93.9%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Learning from complaints and concerns

Between January 2017 and June 2017, there were 109 complaints about medical care. Poor care was the most frequent primary theme for complaint with 26% of the complaints, followed by attitude (21%) and discharge arrangements (16%).

Staff were able to tell us about the most recent complaints in their clinical area and any themes arising from the complaints. On Waveney ward staff told us about a recent complaints feedback regarding communication with a family member. The learning from complaints and the identified change in practice was to have a named staff member that communicates with the relatives of a patient.

All staff we spoke with knew how to report a complaint and that feedback from complaints would be shared on a one-to-one basis where necessary or via team meetings.

Between June 2016 and May 2017 there were 152 complaints about medical care at Ipswich Hospital NHS Trust. The trust took an average of 29 work days to investigate and close complaints. Brantham ward and the Neurology department received the most complaints 14% and 10% of all complaints respectively. Most complaints were in relation to care received (24%), treatment (22%) and communication (19%).

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Is the service well-led?

Leadership

The division was led by the divisional clinical director, head of nursing & clinical services and head of operations. All of the nursing, medical, therapy and health care assistant staff felt supported and valued by their direct line manager.

In clinical areas we saw that ward managers and consultant staff were visible, and closely involved in day-to-day management of care and services. There was support from senior clinicians to the teams in the medical directorate, and close working with operational leads for the hospital. We saw strong leadership from the ward managers and they were supported by the matrons who were committed to delivering a high quality service. All of the ward managers we spoke to reported that they were proud of their team due to the dedication and commitment they had shown.

However we were concerned regarding the discharge lounge and lack of emergency resuscitation equipment, lone working and impact this may have on managing the deteriorating patient. There was a lack of senior oversight with no formalised admission criteria outlined. We raised this with the director of nursing who confirmed this would be addressed, an emergency grab bag was put in place on the day and that an appropriate risk assessment would be undertaken.
Vision and strategy

Senior division leadership had a clear strategy for the development of the services and need to manage capacity and different ways of working. For example, the development of the Frailty Assessment Base (FAB) and pathway to support frail older patients, both within the acute setting and the community.

Staff we spoke with knew the values of the trust and we saw these displayed throughout the wards we visited.

We saw that the division had a clear strategy for service and quality improvement. We saw evidence of regular update meetings to gauge the progress of ongoing projects.

Culture

Staff were aware of the trust values and demonstrated these during the inspection to the team and their patients. All staff were polite, friendly, helpful and open to questions, showing a genuine commitment to the organisation.

Nurses told us that the medical division was a good place to work in. Managers gave them clear leadership and feedback on their performance on a regular basis and made them feel valued as part of the team.

All staff we spoke with told us they felt the medicine division was a supportive and interesting place to work. We saw staff interacted in a supportive way within the department to ensure safety and efficiency for patient care and that there was a positive and calm feeling within the team, even during very busy periods.

We found a strong culture of multidisciplinary staff working on the wards we visited. Therapy staff felt included by nursing and medical staff in decisions related to patient care and treatment. We observed staff working closely to meet the needs of patients and staff on the wards.

Governance

We reviewed monthly clinical governance meeting minutes from May 2017 to July 2017 and they included a broad mix of nursing, medical, and multidisciplinary staff amongst others and details of the meeting and minutes were circulated to staff.

We saw newsletters and performance displays in each ward area, so that staff knew the quality indicators for their area of work. Ward meeting minutes showed the discussions with teams about incidents, quality of care and patient feedback.

The medicine departments participated in a number of audits to measure the quality of provision, these included local audits, for example hand hygiene, record keeping, medication, and care planning. These audits formed part of ward monthly reports that were completed by the ward managers.

Management of risk, issues and performance

We reviewed the medicine division risk register, the risks included amongst others:

- Psychiatric Liaison provision
- Staffing
- Delayed Transfers of Care
The risk register had clear lines of accountability, including staff roles and timelines for the management of risks across the medicine division. The trust had action plans in place to address performance issues, for example in relation to the National Lung Cancer Audit (NLCA).

We noted on all wards we visited that localised risks for each ward were on display, these included issues such as patient falls, hospital acquired patient pressure sores and call bell response times amongst others.

**Information management**

Information needed to deliver effective care and treatment was available to staff in a timely and accessible way. Policies and procedures were available in paper format and via the trust intranet. We saw that in the clinical areas, there was good access to computer terminals, and this enabled the different members of the multidisciplinary team to search for or enter data when needed. This included clinical guidelines and protocols, along with the operational systems, such as ordering tests or referrals to other professionals.

All staff had access to the governance and learning folders held on each medicine area. The folders contained information relating to current trust issues, incidents, and complaints.

**Engagement**

The trust encourages every patient to complete a short survey at the end of their stay as appropriate via a questionnaire. The results from the survey are reported monthly to the trust board.

The trust performed a monthly phone survey of 10 dementia carers to see how confident they felt leaving their loved one in the care of the hospital staff and how supported they felt as carers. Data provided by the trust from April 2016 to March 2017 showed that average scores range consistently between 90% and 100%.

Staff we spoke with told us they attended regular team meetings with their managers and received information in a number of ways including face-to-face, email, and newsletters. Staff said that the senior leadership team held open forums, and that often the Chief Executive Officer would go onto the ward areas, sometimes as early as 6.00am to see the patients and staff.

**Learning, continuous improvement and innovation**

The Frailty Assessment Base (FAB) provides an alternative to acute admission for individuals with complex co-morbidities, and is supported by consultant geriatrician, therapist, specialist nurse, pharmacist and dietitian who will work together and holistically review the patient. The FAB has received three national awards.

The trust collaborated with the local CCG and voluntary charitable organisations to develop an integrated model of care for diabetes. The implementation of the service has seen diabetes outcomes move from below to above the national average. This collaborative working in diabetes care won the team an award at the recent Healthcare Transformation Award.
Services for children and young people

Facts and data about this service

The Ipswich Hospital paediatric service cares for children up to and including the age of 16 years. The service includes Bergholt inpatient ward with 25 beds, a paediatric assessment unit (PAU) with a triage and assessment room, four side rooms, and two bed spaces in its ambulatory care waiting area, a day surgery unit, and a paediatric investigations unit (PIU). There is a level two neonatal unit (NNU) called Framlingham ward, where babies who require additional support following birth are cared for, with 18 cots, and a children’s outpatient department.

The service was previously inspected in January 2015. At the last inspection, we rated three key questions for the service, safe, effective and well led, requires improvement resulting in a rating of requires improvement overall. The trust was issued with a requirement notice in relation to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Concerns related to the provision of care to extremely sick children including staffing numbers, competency and provision of specialist children’s nurses as well as the critical care pathway for children was not well defined. We inspected all key questions to ensure that the issues in the requirement notice had been met. At this inspection we rated safe as requires improvement, with effective, caring, responsive and well led rated as good, providing a good rating overall.

We completed an unannounced inspection on 30 and 31 August 2017. Before our inspection, we reviewed performance information from, and about, the trust. During the inspection, we visited all areas of the paediatric service.

The trust had 5,405 spells between 1 April 2016 and 31 March 2017.

Emergency spells accounted for 86% (4,674 spells), 8% (411 spells) were day case spells, and the remaining 6% (320 spells) were elective.

Percentage of spells in children’s services by type of appointment and site, 1 April 2016 and 31 March 2017, Ipswich Hospital NHS Trust.

![Percentage of spells in children’s services by type of appointment and site](image)

Total number of children’s spells by site, Ipswich Hospital NHS Trust

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Ipswich Hospital NHS Trust</td>
<td>5,405</td>
</tr>
<tr>
<td>This trust</td>
<td>5,405</td>
</tr>
</tbody>
</table>
England total 1,101,631
(Source: Hospital Episode Statistics)

Below is a list of the most common diagnoses in children under the age of one. This table shows data for the five most common primary diagnoses recorded at the trust:

<table>
<thead>
<tr>
<th>Primary diagnosis (CCS category)</th>
<th>Ipswich Hospital NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Discharges (n)</td>
<td>Proportion of discharges</td>
</tr>
<tr>
<td>125: Acute bronchitis</td>
<td>343</td>
<td>21.3%</td>
</tr>
<tr>
<td>224: Other perinatal conditions</td>
<td>227</td>
<td>14.1%</td>
</tr>
<tr>
<td>7: Viral infection</td>
<td>128</td>
<td>8.0%</td>
</tr>
<tr>
<td>222: Hemolytic jaundice and perinatal jaundice</td>
<td>88</td>
<td>5.5%</td>
</tr>
<tr>
<td>135: Intestinal infection</td>
<td>76</td>
<td>4.7%</td>
</tr>
</tbody>
</table>

Below is a list of the most common diagnoses in children aged 1-17 years old. This table shows data for the five most common primary diagnoses recorded at the trust:

<table>
<thead>
<tr>
<th>Primary diagnosis (CCS category)</th>
<th>Ipswich Hospital NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Discharges (n)</td>
<td>Proportion of discharges</td>
</tr>
<tr>
<td>7: Viral infection</td>
<td>479</td>
<td>12.5%</td>
</tr>
<tr>
<td>125: Acute bronchitis</td>
<td>254</td>
<td>6.6%</td>
</tr>
<tr>
<td>124: Acute and chronic tonsillitis</td>
<td>251</td>
<td>6.5%</td>
</tr>
<tr>
<td>135: Intestinal infection</td>
<td>202</td>
<td>5.3%</td>
</tr>
<tr>
<td>251: Abdominal pain</td>
<td>181</td>
<td>4.7%</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

Is the service safe?

Mandatory training

Mandatory training included basic life support, clinical fire safety, moving and handling, prevent, conflict resolution, safeguarding level two and three. Equality and Diversity, Adult Safeguarding 1,2,3, Infection Control, Health and Safety, Information Governance, Child Safeguarding Level 1, Manual Handling Level 1, blood awareness. The average completion rate for the children and young people’s service was 89% against a target of 95%. Training completion was below target
for child health specialist nurses (83.3% average), paediatric assessment unit (81.6%), the play team (85.7%) and the neonatal unit (84.9%).

All registered nurses had three study days a year and non-registered nursing staff had two and a half study days a year to complete their mandatory training.

Neonatal unit staff had some mandatory training days cancelled in the period leading up to our inspection due to increased clinical activity which had affected the compliance figures. The practice development nurse was responsible for re-booking those staff.

Staff had a mandatory training handbook and a booklet to read as part of mandatory training, which included a section on the mental capacity act and deprivation of liberty safeguards.

A breakdown of compliance for mandatory training between 30 June 2016 and 30 June 2017 for children’s services is shown below.

Equality and Diversity, Adult Safeguarding levels 1,2 and 3, Infection Control, Health and Safety, Information Governance, Child Safeguarding level 1 and Manual Handling level 1 are all completed as an E-learning Assessment.

Ipswich Hospital had a 98% mandatory training completion rate overall. A more detailed breakdown cannot be provided as the majority of modules have been grouped into “Other: e-Assessment”.

(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training)

Safeguarding

Safeguarding training completion rates

Safeguarding adults level 1 and safeguarding children level 1 modules are both completed as an E-learning assessment course. There was relatively poor performance for the safeguarding children level 3 module, with 85 (76%) staff members trained out of an eligible 112. Safeguarding level three training compliance levels within the service were as follows: play team 33.3%, neonatal unit 65.4%, and child health specialist nurses 66.7%, with an average rate of 78.2%. Safeguarding level two compliance was 98.2% on average. This data was not broken down by staff group.
A breakdown of compliance for safeguarding courses between 30 June 2016 and 30 June 2017 for children's services is shown below.

![Safeguarding Training Completion Trust-Wide](chart)

Please note that the Ipswich Hospital had a 95% safeguarding training completion rate. Not achieving its 95% target is due to the low percentage of staff trained in safeguarding children level 3.

(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training)

The Director of Nursing was the safeguarding lead and accountable officer for safeguarding children within the trust. There was a named nurse for safeguarding children. This nurse was the lead person for child sexual exploitation (CSE) for the trust. The service was supported by two senior safeguarding liaison nurses. A paediatrician was the named doctor for safeguarding children.

Safeguarding supervision was offered to paediatric nursing staff and allied health professionals (AHP) annually within the set study days, although staff could seek supervision as and when required in complex cases. The safeguarding liaison nurses were trained to deliver supervision sessions. Medical staff participated in peer review sessions with consultant paediatricians for supervision when required.

An electronic alert system had been implemented for when children attend the hospital. The system had a flagging mechanism and linked with other organisations. This meant that when a child attended and was known to other services, such as having a child protection plan in place, this was raised as a flag.

The safeguarding children’s policy (0-18 years) v 11, was ratified and in date. This was a controlled document with document control showing updates and changes with each review. Staff were aware of who the lead nurses for safeguarding were. Staff told us they were accessible by phone and responsive to requests to attend the ward regarding any safeguarding issues and concerns. There was a weekly, multidisciplinary psychosocial meeting to discuss current and expected inpatients and any requirements that may need to be implemented for those patients.

Chaperoning policy signs and information leaflets for patients were available and displayed throughout the service as were posters highlighting contact details for the safeguarding team.

The process for outpatient attendances started with families receiving a telephone message one week prior to the appointment, giving them the option to confirm attendance or cancel and rebook.
Staff we spoke with stated that patients that did not attend were highlighted to their consultant who would determine the next course of action. This was good practice and there was a section on missed appointments and actions to be taken included in the safeguarding children’s policy (0-18 years) v11.

There was an established governance reporting framework via the safeguarding children team to the safeguarding children operational and committee meetings. Emerging risks are discussed in divisional governance meetings. Quarterly reports and policies are approved via the Patient Safety and Clinical Effectiveness Group which allows for broad dissemination of information across all directorates.

On the neonatal unit, children subject to child protection orders would always have a discharge planning meeting and staff would liaise with social workers and foster carers. Staff would document visits and parent’s interactions with their babies.

**Cleanliness, infection control and hygiene**

**CQC Children’s Survey 2014 – Q26**

The service was visibly clean throughout. There was signage above alcohol gel reminding staff to clean their hands immediately before and after touching patients (clean your hands campaign). “I am clean stickers” were used to indicate equipment had been cleaned and was ready for use. Personal and protective equipment (PPE) such as aprons, gloves and wipes were well stocked throughout the service. Staff were observed to adhere to the principal of being ‘bare below the elbows’.

There was a process in place to ensure all new admissions to the neonatal unit all had swabs taken to screen for *methicillin resistant Staphylococcus aureus* (MRSA) which were then followed up by weekly swabs.

Cleaning checklists and audit results were noted to be displayed throughout the service for staff and visitors to review. Infection prevention and control audit data was entered on to the trust electronic database, including hand hygiene, equipment cleaning, general cleaning and high impact intervention audits. Audit results were shared in staff briefings. Information was placed in staff areas. Audit results demonstrated that IPC process were embedded and effective across the service.

The scorecard results for division three (Women, Children and Cancer services) demonstrated cleaning audit score results of 98% in April 2017 and 99% in May 2017 against a target of 95%. For the same time period, clinical equipment cleaning scored 98% and 99% respectively, hand hygiene compliance scored 100% in both months. Bergholt ward, PAU and Framlingham scored 99%, 100% and 97% respectively for cleaning audit 97%,100% and 100% for equipment cleaning and 100% for hand hygiene in May 2017.

In addition, monthly cleaning audits were carried out by an external cleaning company. If concerns were highlighted from these audits, the senior sister for the service shared this information in the staff briefing. The cleaning audit was entered monthly onto the trust’s electronic quality management system. The external cleaning company were responsible for such tasks as cleaning the environment, emptying bins and changing curtains.

Internal staff cleaned equipment and toys after each use. The play team had a cleaning rota. In outpatients the nursery nurse cleaned toys daily. If books were used in side rooms for infectious patient they were disposed of afterwards.

Clinical waste was segregated appropriately and taken to a central store and was removed on a daily basis. Four sharps bins were checked throughout the service and all were appropriately
labelled, signed and the contents were all below the fill lines. Cytotoxic waste bins were emptied by an external contracted company, however, cytotoxic spillages were cleaned by nurses with a cytotoxic spill kit.

Parents and children were educated by both posters on hand hygiene and infection prevention and control, and on a one to one basis where appropriate. Oncology staff taught parents how to manage cytotoxic spillages. Education was individualised by nurses, specific for each child.

The children’s day surgery unit had a child-friendly information board on infection control in the play room, including a dot to dot activity where the lines connected to form two hands and had information about hand hygiene.

The service had an infection prevention and control link nurse who ensure audit results were shared with nursing staff. Non touch taps at sinks and hand gel dispensers were available throughout the whole service, all with handwashing technique posters on display by each sink and we found that dispensers were consistently full.

In the CQC Children’s Survey 2014 the trust scored 8.93 out of 10 for the question ‘How clean do you think the hospital room or ward was that your child was in?’ This was about the same as other trusts.

(Source: CQC Children’s Survey, RCPCH)

Environment and equipment

Equipment servicing and repairs were undertaken by the trusts for Electrical and Biomedical Engineering (EBME) department. The EBME team kept logs of equipment for servicing and repair and housekeepers on the neonatal unit kept their own log of equipment requiring servicing and repair. There was a technician dedicated to the service that tracked and logged all equipment requiring servicing and repair.

On the paediatric investigations unit (PIU), all equipment servicing had been done in June 2017 so that all equipment would be due for servicing at the same time in the future and this would reduce the chance of servicing being missed. 33 pieces of equipment were checked throughout the neonatal unit, Bergholt ward, PIU, children’s day surgery and children’s outpatients and all were within date for servicing and portable appliance testing.

43 items of disposable equipment such as needles, syringes and gloves were checked throughout the neonatal unit, Bergholt ward, PIU and the children’s day surgery unit. All were found to be within their expiry dates.

Resuscitation trolleys were located throughout the service on the neonatal unit, PIU, the paediatric assessment unit (PAU) and Bergholt ward. The resuscitation trolley on PIU was accessible for use by the children’s outpatients department is required. PIU and children’s outpatients department were located adjacent to each other. The children’s day surgery unit had a resuscitation grab bag rather than a trolley. The trust’s resuscitation team collected paperwork for trolley checks to audit the checking of resuscitation equipment.

The resuscitation trolleys in PAU and PIU did not have a defibrillator due to cost. The resuscitation trolley on Bergholt ward would be accessed if a defibrillator was required. This had been risk assessed. There was information on both trolleys to tell staff that the defibrillator was located on Bergholt ward.

The resuscitation trolleys on PIU, the neonatal unit and Bergholt ward had completed daily and weekly checks for all of August 2017 with the exception of one day on the PIU. The oxygen cylinder on the PIU resuscitation trolley had expired on 15th March 2015; therefore we were not
assured that the checks were thorough. This was highlighted to a nurse, who replaced the cylinder and reported the issue.

The service was secure and all areas were accessible only by badge access with the exception of the children’s outpatients department.

In the CQC Children’s Survey 2014 the trust scored 9.49 out of 10 for the question ‘Did you feel safe on the hospital ward?’ This was about the same as other trusts. The trust scored 9.74 out of 10 for the question ‘Did you feel that your child was safe on the hospital ward?’ This was about the same as other trusts. The trust scored 9.20 out of 10 for the question ‘Did the ward where your child stayed have appropriate equipment or adaptions for your child?’ This was about the same as other trusts. A list of all scores from the survey which fall under the safe domain are listed below.

### CQC Children’s Survey questions, safe domain, Ipswich Hospital NHS Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>KLOE</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>25. Did the ward where your child stayed have appropriate equipment or adaptions for your child?</td>
<td>S3</td>
<td>0-15 Adults</td>
<td>9.20</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>26. How clean do you think the hospital room or ward was that your child was in?</td>
<td>S3</td>
<td>0-15 Adults</td>
<td>8.93</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>53. For most of their stay in hospital what type of ward did your child stay on?</td>
<td>S3</td>
<td>0-15 Adults</td>
<td>9.94</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>7. Did you feel that your child was safe on the hospital ward?</td>
<td>S3</td>
<td>0-7 Adults</td>
<td>9.74</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>2. Did you feel safe on the hospital ward?</td>
<td>S3</td>
<td>8-15 CYP</td>
<td>9.49</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC Children’s Survey, RCPCH)

### Assessing and responding to patient risk

Doctors and nurses used an electronic hand held system at patient’s bedsides to record patient observations such as temperature, pulse, respiration and blood pressure. There was an early warning scores utilised to indicate patient deterioration. The system and devices alerted staff when patients’ scores were over a set threshold and the need to escalate concerns. Early warning score completion was audited on a monthly basis. Information for April 2017 to September 2017 showed that the proportion of patients not having an EWS calculated was zero. This means that for this time period, all inpatient children had their observations recorded and scored.

The neonatal unit staff used an early warning scoring system that was reflective of the newborn early warning trigger and track tool (NEWTT). The service was linking with the regional network to discuss development of a neonatal specific tool.

One doctor told us that Sepsis 6, which is a bundle of medical therapies designed to reduce the mortality of patients diagnosed with sepsis, was emphasised at induction to the trust and was widely promoted in all areas.

On our last inspection we found that the children’s department was providing high dependency care without sufficient and trained staff to do so. On this inspection we found that a high dependency specialist nurse role had been introduced and that there was a consultant lead for high dependency care. This nursing role carried out training and education for staff, including competencies for high dependency care.
The high dependency nursing lead role held responsibility for managing the high dependency care policy and pathway which was being reviewing at the time of our inspection. Simulation training had been rolled out to ensure the high dependency care pathway was effective.

There had been challenges for nurses in completing a high dependency care training module. Funding had been provided by the trust, however places on the external course were limited. Staff were being selected to commence the course throughout the period of September 2017 to January 2018. High dependency competencies were based on Royal College of Paediatrics and Child health (RCPCH) guidance. These competencies were being worked through with an expected completion date of February 2018.

Sepsis was not included as a topic in child health study days. This could mean that staff knowledge of sepsis screening and management, as well as the trust's sepsis policy would be limited. However, staff told us that training on sepsis was available to all junior doctors at induction and this included simulation training.

On our last inspection we found that the critical care pathway for children was not well defined, and there was a lack of consistency in explanations with regards to roles and responsibilities. On this inspection we found that the high dependency lead nurse had improved communication and the working relationship with critical care staff. Work had been undertaken jointly around patient flow and expectation of staff when a patient is not imminently due to be transferred. Various initiatives had been introduced, such as a stickers alert for patient notes, a document for every high dependency child on the ward, a record for staff and action prompts such as when to communicate with critical care staff.

Work had been undertaken with critical care staff around appropriate paediatric criteria to the critical care unit. There had also been teaching sessions around paediatrics in critical care. Critical care staff had the same competency book for high dependency care nursing in paediatrics. A proforma was in place which included a flow chart of expectations. There was a review sticker in patient notes around time to admission and how many consultant reviews had taken place. This was a recent introduction and auditing was planned to review effectiveness of the provision of critical care for paediatrics. Training simulations sessions for the deteriorating paediatric patient were held across the emergency department and critical care.

A Transfer of Babies, Children and Young People Guideline and a Paediatric High Dependency Care guideline were in place to advise and inform staff on the transfer of a child with a time sensitive condition and managing a critically ill child for an extended period. This included a transfer risk assessment tool which indicated the minimum personnel, equipment and monitoring required depending on whether the patient was low risk, medium risk, high risk or critically ill. The guideline clearly set out the roles and responsibilities of each staff group involved in transferring a patient and included actions to be taken for every transfer.

The neonatal unit had admissions criteria information available by the nursing desk so that staff could advise callers about potential admissions for this unit and the other units in the regional neonatal network.

A proforma was available for staff to use if they were concerned a patient may abscond. Tasks included checking belongings and making sure additional doors were locked to ensure the location was secure.

There were two ‘Access and assess’ teams, one for children under 13 years of age and one for adolescents over 13 years of age presenting with mental health problems. Patient pathways were dependent on risk assessment outcomes. When a patient was found to be high risk, they would be admitted overnight. Patients under the age of 13 were always admitted and seen the
next working day if medically fit. Patients were expected to be discharged within a day, with exceptions around those in foster care.

There was a distance of approximately half a mile between the neonatal unit and the rest of the children’s services. This could pose a risk to the timeliness of treatment for on-call staff across the service. This was noted on the service’s risk register and mitigating actions and plans were in place, such as working towards splitting the rota between the two locations.

Not all areas where children were admitted had staff trained in paediatric life support. On critical care 89% of staff had been trained on paediatric life support training. However no staff on the ophthalmic day case unit, Deben ward, Orwell ward and the Stour Gynae Centre which all receive children under 16 had this training

Paediatric basic life support (BLS) training was undertaken by staff on the childrens wards annually as part of the mandatory training schedule. Twenty-two members of staff on the neonatal unit had completed neonatal life support training.

The nurse staffing for Bergholt Ward comprised of 35 registered nurses and 12 nursery nurses. Nursing staff compliance with BLS training was 100% with all 47 staff having completed the training. Of the 35 registered nurses 27 had completed paediatric immediate life support (PILS) training (77%). In addition 10 of the 35 registered nurses were advanced paediatric life support (APLS) trained with a further six nurses booked on an advanced life support course in December 2017. The service ensured that there were staff with PALS training on shift via the nurse staffing rota and a daily review with cross cover available from an APLS trained nurse in the emergency department.

Nurse staffing

The nursing acuity tool had been developed since our last inspection. Data from completion of this tool is fed into the trust’s accountability framework. The tool was being considered for roll out across the whole trust. The acuity tool was completed twice daily, and had several categories such as breathing, circulation, feeding, monitoring and observations, skin integrity and personal hygiene, mobility, administration of medications, psychosocial needs, and consciousness. The tool was completed for every patient and calculated the numbers of staff required.

The trust’s integrated performance report for May, June and July 2017 stated that Bergholt ward scored 70.9%, 71.9% and 75.4% respectively against target of 80% for the meeting of acuity. However these scores did not reflect any mitigation taken to meet the acuity by other means (such as supernumerary staff working clinically, usage of bank staff or reviewing and sending appropriate patients home).

The British Association of Perinatal Medicine (BAPM) guidelines state that 70% of registered nursing staff on a neonatal unit ought to be qualified in service (QIS). The neonatal unit at this trust had between 50-52% of its registered nursing staff QIS. Two staff were due to finish their QIS courses and there was a year on year plan to send newly qualified staff on the course.

The nursing rota for PIU, PAU and Bergholt ward were separate for each area. The senior sister had reviewed this and was considering the requirement of the whole unit when we inspected the service. The senior sister planned staffing a month in advance. The trust did a ‘week forward look’ for staffing where the senior sister would enter the staffing figures onto the system so that the trust could review staffing for each day over the whole organisation.
Between 1 July 2016 and 30 June 2017, Ipswich Hospital reported a vacancy rate of 8.17% in children’s services with a reported a turnover rate of 0.99% and a sickness rate of 1.73% which was below the trust target of 3.5%. Between 1 June 2016 and 31 May 2017, the Ipswich Hospital reported a nursing bank and agency usage rate of 3.56% in children’s services the clinical leadership told us that a business case was in place for future staffing.

They whole service was expected to be up to establishment in October 2017. The senior sister worked four days a week between the hours of 8am and 6pm. At weekends there was a senior paediatric nurse bleep rota including the senior sister, the high dependency lead nurse, the neonatal unit sister, and nurse specialists. There was always a senior nurse on day shifts, and a nurse-in-charge at night.

The trust has reported their staffing numbers below for the period 1st January 2017 and 20th June 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>449.07</td>
<td>573</td>
</tr>
<tr>
<td>Total</td>
<td>449.07</td>
<td>573</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs Actual tab)

(Medical staffing)
The service had nine consultant paediatricians, two associate specialists (one in urinary problems and chronic fatigue syndrome and one in endocrinology), and nine visiting consultants holding clinics in the children’s outpatients department from other trusts.

There was a workforce plan in place and the service was aiming to recruit two further consultants and to create a split rota for the children’s service and the neonatal unit.
Weekend ward rounds took place to support the night time and weekend on call rota.
There was a neonatal consultant ward round once a week, although there was consultant oversight of the medical staff conducting ward rounds throughout the week.
There were two consultant led handovers daily and one on weekends for the children’s service.
The handover exhibited good understanding of patients medical and psychosocial needs.

Registrar level doctors were physically present in the service 24 hours a day, seven days a week. They carried a bleep and were available via the switchboard to provide advice for all specialties. There was also a consultant on-call rota 24 hours a day, seven days a week to provide advice when required. The paediatric assessment unit had access to the opinion of a consultant paediatrician via the ‘consultant of the week’.

An audit of facing the Future Standards (2015) was carried out in the department between February and March 2017. The audit found that the department was meeting the standards of having a consultant paediatrician present and readily available in the hospital during times of peak activity, seven days a week. The department was also meeting standards of having adopted a ‘consultant of the week’ system, of the paediatric assessment unit (PAU) having access to the opinion of a consultant paediatrician throughout the hours they were open, and of every child with an acute medical problem referred for a paediatric opinion being seen by or having their case discussed with a clinician before discharge.

Between 1 July 2016 and 30 June 2017, Ipswich Hospital reported a vacancy rate of -2.03% in children’s services. This indicated an over establishment of staff. Between 1 April 2016 and 31
March 2017, the service reported a turnover rate of 0.80% and a sickness rate of 0.55% in children’s services.

Between 1 July 2016 and 30 June 2017, the Ipswich Hospital reported a bank usage rate of 0.52% and locum usage rate of 0.61%. Senior clinical leaders told us that the service had recently used two middle grade locums, closely supervised by a consultant, and one consultant locum.

**Staffing skill mix**

Between 1 April 2017 and 30 April 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

The trust has reported their staffing numbers below for the period 1 January 2017 and 20 June 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>161.13</td>
<td>177</td>
</tr>
<tr>
<td>Total</td>
<td>161.13</td>
<td>177</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs Actual tab)*

**Staffing skill mix for the 27 whole time equivalent staff working in Children’s services at Ipswich Hospital NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>30%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career</td>
<td>9%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>50%</td>
<td>45%</td>
</tr>
<tr>
<td>Junior</td>
<td>11%</td>
<td>7%</td>
</tr>
</tbody>
</table>

*(Source: NHS Digital Workforce Statistics)*

**Records**

Nursing documentation was audited monthly. The results were accessible by the trust’s heat map tool. There were plans for a neonatal specific documentation audit to be implemented although this was not in place at the time of our inspection.

For the period April 2017 to August 2017, the neonatal unit consistently achieved above the target of 95% compliance in the nursing documentation audit, as did PAU (with the exception of May 2017 where compliance was 0.3% below the target). Bergholt ward achieved compliance for two of these five months, was marginally under the target for two of the five months and was under the target at 86.8% for one of the five months (June 2017).
During our inspection we looked at 17 sets of medical records and 18 prescription cards. Records we reviewed were completed appropriately. For example, they were signed and dated by the clinician making notes, diagnoses and management plans were documented, nutritional status was consistently recorded, family discussions were documented and patient observations were documented. However the exception was on the neonatal unit we reviewed five ‘first hour of care’ documents and found that medical staff had not completed any of them.

Records were a mix of electronic and paper based. For example, in the children's outpatients department an electronic record was used alongside paper records. Paper records included the clinic sheet with patient details, weight and height. Consultant notes and growth charts were on paper. Inpatients had their early warning scores (EWS) recorded onto electronic devices, accessible by both nursing and medical staff. The devices alerted staff regarding EWS. Drugs charts were accessible on the devices and information transferred to the electronic records system. Prescriptions however were paper based and an electronic system was being trialled. Admissions were completed on paper.

Medicines

Medicines were securely stored throughout the service with electronic card entry or coded access to rooms where medications were stored, with the exception of the treatment room on PIU. Controlled drugs were kept in locked cupboards inside of locked rooms throughout the service.

Medication and fridge temperature checks were not consistently completed across the service and this was not acknowledged on the service risk register. We raised this with senior staff during inspection. On the neonatal unit, controlled drug cupboard and fridge temperature checks were missing on 11 days throughout July and August 2017, with three out of 11 temperature breaches not being rechecked. The total parenteral nutrition fridge was missing 22 checks throughout the same time period.

Medication checks on Bergholt ward were consistently checked, however there were 17 days where temperature breaches were noted but not rechecked throughout July and August 2017. The chemotherapy fridge on PIU was checked consistently throughout August 2017, with two days missing in July 2017.

The non-chemotherapy medications fridge on PIU was missing checks on six days throughout July and August 2017. Six temperature breaches were noted in the same time period with no action taken.

Controlled drugs and fridge temperature checks were consistently checked on the children’s day surgery unit for July and August 2017. There were no breaches in fridge temperature noted in that time.

The room where medications were stored on the children’s day surgery unit was noted to be hot. A mobile air conditioning unit had been provided to mitigate the risk of the heat to the medications stored in the room. However, staff felt this was not effective at reducing the room temperature. An informal log of temperatures had been kept, with the temperature range throughout July and August 2017 being 24 to 29 degrees Celsius. Medications stored in this room included ibuprofen oral, morphine oral, and chlorphenamine, all of which should not be stored above 25 degrees Celsius. This was not entered onto the service risk register.

The service used pre-populated analgesia, anti-emetic and IV fluid prescription charts which reduced the risk of prescription errors. A pilot had been in place on the neonatal unit since March 2017. This pilot focused on the care of new-borns requiring antibiotics or observation on the unit. The outcome of the pilot so far showed that a typical 24 hour stay was reduced to four hours, allowing babies to remain with their parents, thus encouraging bonding.
Incidents

At our last inspection we found that the service had a good incident reporting culture; however, more work was needed to embed and demonstrate a learning culture and we found that this had improved. During this inspection we found that staff across the service were aware how to report incidents on to the electronic reporting system and that feedback was received in various ways such as emails, team meetings, and staff notice boards.

Both the matron and the senior sister for the service published newsletters with learning from incident trends and complaints. Medical staff were updated about lessons learnt from incidents at handovers.

Examples of learning from incidents were given by staff throughout the service. For example, an incident was reported on the neonatal unit (NNU) where less compatible circuits were being used on new ventilators. Although there were no episodes of harm relating to this, the unit had learnt how to reduce the risk of this occurring. Old and new circuits and ventilators had been labelled and kept at opposite ends of the store room. An example from the paediatric assessment unit (PAU) was given of an incident in relation to a lumbar puncture procedure that had led to a new checklist for medical staff completing the procedure, and the learning was shared with all staff.

Mortality and morbidity meetings took place on a monthly basis to share information and learning from complex cases with staff. However these meetings were not well attended by junior staff members.

The most common incidents reported via the National Reporting and Learning System (NRLS) were medication (34.2%) and implementation of care and ongoing monitoring (18.4%). 97.4% of all incidents reported via NRLS were categorised as no or low harm. The average number of days taken to report incidents to NRLS was 36. 96% of incidents were reported within 60 days, 36.8% were reported within 30 days.

There were two recorded applications of the duty of candour in the period June 2016 to May 2017. The duty of candour is a regulatory duty that related to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

Never Events

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Between 1 July 2016 and 30 June 2017, the trust reported no incidents classified as never events for children’s services.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in children’s services which met the reporting criteria set by NHS England between 1 July 2016 and 30 June 2017.

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering
harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given, but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new catheter urinary tract infections between 1 July 2016 and 31 July 2017 for children’s services. *(Source: NHS Digital)*

Staff were informed of the safety thermometer results in briefings and in the accountability framework or ‘heat map’ tool. There were no issues picked up by the safety thermometer that required action to address.

### Is the service effective?

#### Evidence-based care and treatment

The hospital had been given the ‘baby friendly’ accreditation by UNICEF in December 2016. The baby friendly initiative is a global programme which provides a practical and effective way for health services to improve the care provided for all mothers and babies. The hospital was also participating in the Bliss Baby Charter, which is a framework for neonatal units to self-assess the quality of family-centred care they provide and enables units to audit their practices.

There was a process in place for determining whether or not updated or new National Institute for Health and Care Excellence (NICE) guidelines were applicable to the service. We saw reference to this in the minutes of governance meetings.

Many policies and guidelines were in place, with clear links to the evidence-based care they related to, such as guidance issued by the Royal College of Paediatrics and Child Health (RCPCH) and NICE. However, seven out of 40 policies we reviewed on inspection were out of date. This meant that the policies and guidelines may not have reflected the most up-to-date evidence-based care. The policy tracker provided after the date of our inspection showed one policy and two guidelines were out of date. In addition, the policy tracker showed that 23 of the regional guidelines and policies used by the service were out of date.

During our last inspection in January 2015 we found that the service did not have its own local procedure for epilepsy and there was no evidence of a guideline for asthma, bronchiolitis or epilepsy. The service had produced an *Operational Plan for children and young people with Epilepsy* in December 2015, which included reference to NICE guidance. The service had also produced a guideline for bronchiolitis in babies and young children. We requested a copy of an asthma guideline during our inspection but this was not provided. When we checked the service’s policy and guideline tracker for such a guideline being in place, this was not documented and we were not fully assured that all necessary guidelines had been embedded.

A *Paediatric High Dependency Care Guideline* had been introduced in 2016 and this set out admission and discharge pathways for high dependency care, as well as the arrangements for transfer to the adult critical care unit when necessary. This addressed concerns identified at the time of our last inspection.

Local audits were being carried out to assess compliance with guidelines and evidence-based care. For example, in 2016 an audit was carried out to measure performance against the NICE publication *Feverish illness in children* (NICE CG47), the service had audited their performance against Royal College of Paediatrics and Child Health (RCPCH) Facing the Future standards, and
another audit reviewed clinical practice against the national Standards for Radiological Investigations of Non-accidental Injury set by the RCPCH. This showed that 45% of patients had not been seen by a middle grade doctor within four hours of admission. The audit also showed that 88% of children admitted with an acute medical problem had not been seen by a consultant paediatrician within 14 hours of admission. There was evidence that action was taken to improve practice as a result of audit findings. For example, when an audit on prolonged jaundice showed that the service was not following NICE guidelines, the service re-designed guidelines and pro forma. The service planned to re-audit this topic to assess whether there had been improvement.

The service also participated in national audits to assess compliance with evidence-based care. For example, the service participated in the 2015/16 National Paediatric Diabetes Audit. There are seven key care processes recommended by NICE for children and young people with Type 1 diabetes (NICE NG18 and NG19) that should be performed at least once annually. Data from the audit showed that 33% of young people aged 12 years and older at Ipswich Hospital had received all seven care processes between April 2015 and March 2016 compared to 35.5% nationally. Structured patient education programmes are also recommended by NICE as part of the ongoing management of children and young people with diabetes. Data from the audit showed that 21.3% of patients were receiving structured education, which was below the national average of 71%. The audit results therefore showed that the service was not always following NICE guidance in the provision of diabetes care.

The service had also participated in the 2015 National Paediatric Asthma Audit. The British Thoracic Society (BTS) British guideline on the management of asthma states that prior to discharge, inpatients should receive written personalised asthma action plans. Data from the 2015 National Paediatric Asthma Audit shows that Ipswich Hospital achieved this in 100% of cases, which was above the national average of 56%. However, information such as leaflets was given at discharge in 0% of cases, which was below the national average of 47%. The BTS guideline also states that discharge plans should include an assessment of inhaler technique. Data from the audit showed that Ipswich Hospital achieved this in 18% of cases, which was below the national average of 42%. The BTS guideline also states that discharge plans should include arranging a follow up by primary care services within two working days of discharge. Data from the audit shows that Ipswich Hospital advised patients to attend their GP within two days in 45.5% of cases, which was above the national average of 24%. The hospital’s learning from this audit included a need to increase focus on discharge planning, ensure that asthma plans were properly completed, focus on continuous education for parents, and improve checking and documentation of inhaler technique.

NICE standards for neonatal units state that parents of babies receiving specialist neonatal care should be encouraged and supported to be involved in planning and providing care for their baby. During ward rounds on the neonatal unit, babies were separated from their parents and staff had limited open discussion with parents during the ward round. This was therefore not in line with the NICE standard. However, the unit was meeting other NICE standards for neonatal units, including monitoring of health outcomes, breastfeeding and coordinated transition to community care.

Care provided to patients with mental health conditions was in line with NICE guidance. The service had a ‘Child Under the Age of 18 Mental Health Assessment Form’, which included triage questions about background history, general observations, appearance and behaviour. The form assisted staff to risk assess patients as low, medium, high or very high risk and prompted outcomes and actions for staff to take in response. The form also included a suicide risk screen and if a child or young person was thought to be at risk of suicide, an urgent mental health assessment from CAMHS was required, attempts would be made to stop patients leaving before the assessment and an action plan was drawn up to address immediate and short-term risk factors. For any child that had self-harmed, the risk assessment matrix prompted a specialist mental health assessment from CAMHS. The risk assessment matrix also ensured that children and young people displaying severe depression or a first episode of psychosis would be referred to CAMHS.

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Staff told us that the hospital security team were supportive in helping them to deal with any violence and aggression in an appropriate way. A pro forma was completed for any patient at risk of absconding. The handover we observed exhibited a good understanding of patients’ psychosocial needs.

**Nutrition and hydration**

The Paediatric Yorkhill Malnutrition Score (PYMS) Dietetic Management Pathway was used for any patients over the age of one who were in the hospital for over 24 hours. This included consideration of a child’s body mass index (BMI), recent weight loss, reduced intake, and whether the child’s condition was affecting their nutrition. The screening tool included a flow chart to help staff determine whether a patient should be referred to a dietician. Fluid charts were also used by staff to monitor the input and output of fluids.

Children and their parents or carers were asked about eating and drinking preferences, appetite and ability to feed themselves in an ‘activities of daily living’ document. For infants this included the type of milk normally consumed, how much and how often.

We reviewed 17 care records and found that there had been an assessment of nutritional status in all cases where this was applicable. We also saw that handovers between staff included a consideration of patient’s nutritional status. However, minutes from the July divisional risk and performance meeting indicated that there had been poor compliance with nutritional assessments due to increased activity.

Paediatric dieticians were available for advice and guidance, as well as developing care plans for children.

There was a dedicated room on the neonatal unit for breastfeeding and expressing milk. Mothers could also take expressing machines to their baby’s cot side if they wished. In addition, there was a separate feeding room on the unit which included sterilising units and a freezer for donated milk. There was an area in the feeding room to provide training to mothers on feeding their babies. There was a milk kitchen on Bergholt ward, with equipment for feeds.

The neonatal unit used the necrotising enterocolitis (NEC) care bundle, which had been developed by the East of England Neonatal Network. NEC is an inflammatory disease of the bowel, prevalent in premature babies and a major cause of morbidity and mortality. The NEC care bundle was developed in response to concerns from clinicians in the East of England about an increase in the incidence of NEC in their local units. The care bundle includes early promotion of expressing to enable the use of mothers’ own milk when enteral feeding (using a feeding tube), ongoing support for expressing and breastfeeding up to discharge, following a standardised enteral feeding guideline when establishing enteral feeds, and a standardised ‘clean’ approach to the preparation of milk feeds using an aseptic non-touch technique. As part of the NEC care bundle, the neonatal unit used a nutritional care pathway with two algorithms, one for initiating and advancing enteral feeds and one for choice of milk. This set out feeding plans for neonates based on whether they had been assessed as standard, moderate or high risk. The use of the NEC care bundle shows that the neonatal unit were providing evidence-based nutritional care.

There were feeding and breastfeeding information boards for children and their parents or carers. On the neonatal unit, mothers were given breastfeeding information packs. Staff on Bergholt ward, PAU and the neonatal unit had received a breastfeeding updating training session.

Some children on Raedwald Day Surgery Unit were experiencing extended fasting times prior to surgery. Patients having their procedure in the morning were asked not to eat after 12 midnight and not to drink after 6am. Patients who were having their procedure in the afternoon were asked not to eat anything after 7am and not to drink after 11am. Morning procedures generally took place between 8:45am and 12:30pm and afternoon procedures took place between 1:45pm and 5pm. This therefore meant that some children could be fasting from food for 12 hours before their
procedure and from fluids for six hours. *Perioperative fasting in adults and children: guidelines from the European Society of Anaesthesiology* state that children should be fasted from clear fluids and water up to two hours before induction of anaesthesia and from food six hours before induction of anaesthesia.

There was a diabetic nurse specialist and a link nurse to provide support to diabetic patients. A booklet was available for newly diagnosed diabetic patients with information about what they could eat, with pictures of portion sizes and advice about snacks. There were also plans to introduce a booklet for young people with eating disorders and work was being carried out with the eating disorders team, dieticians and the mental health team.

**Pain relief**

Pain relief was prescribed on the PAU via patient group directions (PGD). PGDs provide a legal framework which allows some registered health professionals to supply and/or administer specified medicines, such as painkillers, to a predefined group of patients without them having to see a doctor. There were two nurse prescribers on PAU. Nurse prescribers are able to prescribe any medication, provided it is in their competency to do so.

There was no paediatric pain team but staff indicated that the adult pain team would provide advice if required. In addition, there were two full time paediatric pharmacists employed by the service who could provide advice to staff and patients. We saw that handovers included consideration of acute and chronic pain.

Children and young people’s pain was assessed through the use of the Wong Baker faces pain rating scale. This scale asks a child to rate their pain on a scale of zero (no hurt) to 10 (hurts worst) by choosing which face best describes how much pain they are in. Staff also used the FLACC (Face, Legs, Activity, Cry, Consolability) scale as part of the assessment pathway. The FLACC scale is designed for use with younger children or those unable to communicate their pain and staff using the scale assign a score to observations of a child’s behaviour.

Staff used a pain ladder tool as a guideline for determining the most appropriate method of pain relief. Pain ladders use a stepped approach to pain relief, where patients can be started on non-opioids such as paracetamol for mild pain, then increasing to weak opioids like codeine for moderate pain and finally escalating to strong opioids like morphine for the highest level of pain. The general principle is to start with first step drugs, and then to climb the ladder if pain is still present.

There was a *Managing your Child’s Pain at Home* information leaflet for parents and carers. This included advice about using medication to manage a child’s pain, as well as other ways of managing a child’s pain, including exercise, controlled breathing, distraction, socialising and a good sleep routine.

**Patient outcomes**

The children’s service participated in national audits for which it was eligible. These included the National Paediatric Diabetes Audit (NPDA), National Paediatric Pneumonia Audit (NPPA) and the National Neonatal Audit Programme (NNAP). The service did not take part in the Paediatric Intensive Care Audit Network (PICANET) as they were not commissioned to provide paediatric intensive care but they did participate in a regional audit for high dependency care. The service had chosen to continue participating in this audit as they had found it useful in identifying patient outcomes.

During our last inspection we found that there was a lack of initiatives to measure and monitor patient outcomes as there was only one local audit listed on the service’s 2014-15 audit plan.
However, the 2017-18 child health and neonatal audit plan included 22 audits. An audit plan was generated at the start of the audit year and this was monitored by the audit department. Whilst the majority of audits on the audit plan had a lead clinician, rationale and priority identified, most audits did not have a start date or expected completion date. In addition, there continued to be a lack of initiatives to measure outcomes for neonates as the majority of audits were for the paediatric specialty.

Decisions on which local audits would be carried out were based on common conditions, any recent or amended guidance and the individual interest of members of staff. There was a nominated clinical lead for audit. Audits were discussed within the medical teaching programme but this had led to limited multi-disciplinary attendance. Audit discussions were not normally formally minuted but we were provided with evidence that results had been discussed in multi-disciplinary meetings. Doctors were able to describe audits that had recently been presented for shared learning. From October 2017 the service was planning to introduce bi-monthly half-day governance meetings which would include audit discussion. Clinic timetables would be amended when the meetings were planned to improve multi-disciplinary attendance.

There was evidence of changes to practice being introduced to improve patient outcomes as a result of local audit findings. For example, an adrenaline auto-injector audit carried out in May 2016 had led to clinicians being told to complete an emergency protocol before discharging patients back to the GP and to give consideration to which patients may need a second auto-injector at home. We requested action or improvement plans for any national audits. Only limited formal action plans were available, where the majority of actions related to sharing the findings of the audit rather than changes to practice. Many of the recommendations from audits therefore did not have formal actions attached to them, and lacked dates for completion and individuals allocated as responsible for completing actions.

The data shows that in the 2015/16 diabetes audit, Ipswich Hospital performed similar for the ‘Crude proportion of patients receiving all key care processes annually’ metric. When comparing the organisation nationally, Ipswich Hospital performed worse for the ‘Case mix adjusted mean HbA1c (mmol/mol). HbA1c levels are an indicator of how well an individual’s blood glucose levels are controlled over time. The NICE Quality Standard QS6 states “People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%)”. The organisational performance compared between years indicates a similar median HbA1c (mmol/mol) to the 2014/15 report. An increase of 1mmol/mol indicates that performance is deteriorating, whereas a decrease of 1 mmol/mol indicates improved performance. Staff told us that they had introduced a meeting to discuss patients with high HBA1C levels, those that had not attended appointments and those with frequent admissions to discuss whether more focussed work would be required.

Between 1 February 2016 and 31 January 2017 there were no emergency readmissions after elective admission at Ipswich Hospital NHS Trust for the one year and under age group. For patients aged 1 to 17 years, there were a higher percentage of patients readmitted following an elective admission compared to the England average.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Ipswich Hospital NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>1.3%</td>
<td>713</td>
</tr>
<tr>
<td>ENT</td>
<td>1.3%</td>
<td>477</td>
</tr>
</tbody>
</table>

No other specialty at the trust had six or more readmissions

The tables below show the percentage of patients (by age group) who were readmitted following an emergency admission. The tables show the three specialties with the highest volume of
readmissions, and only those specialties where six or more readmissions recorded are shown in the table. Between 1 February 2016 and 31 January 2017 there was a lower percentage of
patients aged one year or less readmitted following an emergency admission compared to the
England average, and a similar percentage of patients aged 1 to 17 years old readmitted
following an emergency admission compared to the England average.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Ipswich Hospital NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>2.6%</td>
<td>1,527</td>
</tr>
</tbody>
</table>

No other specialty at the trust had six or more readmissions.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Ipswich Hospital NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>3.0%</td>
<td>3,060</td>
</tr>
<tr>
<td>General Surgery</td>
<td>3.3%</td>
<td>241</td>
</tr>
</tbody>
</table>

No other specialty at the trust had six or more readmissions.

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

Between 1 March 2016 and 28 February 2017 there is no data for patients under the age of one
who had multiple readmissions for asthma, diabetes and epilepsy. Between 1 March 2016 and 28
February 2017 the trust performed worse than the England average for the percentage of
patients aged 1-17 years old who had multiple readmissions for asthma, diabetes and epilepsy.
The trust was also performing worse than average for epilepsy readmission rates at the time of
our last inspection. This meant that care provision for long-term conditions may not always be
effective to keep those children stable at home.

<table>
<thead>
<tr>
<th>Long term condition</th>
<th>Ipswich Hospital NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Multiple admission rate</td>
<td>At least one admission (n)</td>
</tr>
<tr>
<td>Asthma</td>
<td>Under 1 -</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>1-17 20.7%</td>
<td>111</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Under 1 -</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>1-17 25.7%</td>
<td>35</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>Under 1 *</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>1-17 32.3%</td>
<td>31</td>
</tr>
</tbody>
</table>

Note - For reasons of confidentiality, numbers below 6 and their associated proportions have been removed and replaced with '*'.

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

In the 2015 National Neonatal Audit, Ipswich Hospital performance was as follows:

Do all babies < 1,501g or a gestational age of < 32 weeks at birth undergo the first
Retinopathy of Prematurity (ROP) screening in accordance with the current guideline
recommendations? There were 31 babies born with a birth weight < 1,501g or with a gestational age at birth < 32 weeks who were assigned to the unit for ROP screening. One hundred percent of these babies were screened on time in accordance with the NNAP extended screening window; this was above the national average, where 98% of eligible babies had their screening performed within the NNAP extended screening window.

Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission? There were 564 first episodes of care that were eligible for inclusion in this audit measure for the unit. Episodes of care lasting less than 12 hours have been excluded from analysis. The first consultation following admission occurred within 24 hours for 92% of the eligible episodes; this was above the national average, where 88% of eligible episodes had the first consultation within 24 hours of admission.

Are rates of normal survival at two years comparable in similar babies from similar neonatal units? There were 33 babies born at < 30 weeks born between July 2012 and June 2013 who were assigned to the hospital for two year health assessment based on their final neonatal discharge. Data was entered for 79% of the babies assigned to the unit, whilst nationally data was available for 62% of babies born at < 30 weeks born between July and June 2013.

What is the proportion of babies born <32 weeks who develop Bronchopulmonary Dysplasia? There were 81 babies born < 32 weeks in your hospital who were included in the analysis for Bronchopulmonary Dysplasia. Of these babies 27 were identified as having Significant BPD.

Competent staff

Between 30 June 2016 and 30 June 2017, 93% of staff within children’s services at the trust had received an appraisal compared to a trust target of 95%. The data shows that 138 staff received an appraisal out of a possible 149. A split by staff group can be seen in the graph below:

![Appraisal Completion Graph](image)

The largest proportion of staff appraisals (67%) were reported without being allocated to a staff group.

(Source: Routine Provider Information Request (RPIR) P46)

Staff had access to learning and development courses to help support them in their roles. The children and young people’s service had developed child health study days which included content specific to paediatric and neonatal care. For example, topics included paediatric diabetes, paediatric asthma and paediatric oncology. There was monthly simulation training on the neonatal
unit, with two nurses and one doctor on the unit ‘trained to train’. Simulation training was also available for high dependency care.

Staff were developing a preceptorship programme for six members of staff due to start working in the service in October 2017. The new members of staff would rotate between four areas, and would spend six months in each area. Preceptors had been identified in each of the four rotation areas so that there would be continuity. There were plans for the preceptorship programme to include study days on topics including high dependency care.

Child health students had access to ‘practice focus sessions’ on topics including aseptic non-touch technique, sepsis, care of the high dependency patient, care of the diabetic child, non-accidental injury full skeletal survey, respiratory illness and inhaler technique, intravenous (IV) fluid administration and blood products, interpreting blood gases, assessment of an unwell child, and an epilepsy update.

Junior medical staff said that there were good learning opportunities, and that attendance was encouraged. Junior medical staff told us that they had good support from consultants.

A high dependency specialist nurse role and a consultant lead for high dependency care had been introduced since our last inspection. The specialist nurse worked on high dependency care training and competencies for staff. Competencies were based on Royal College of Paediatrics and Child Health (RCPCH) guidance and it was anticipated that these would be completed by February 2018. A High Dependency of the Acutely Ill Child specialist course at Anglia Ruskin University had been completed by three members of staff since 2014/15. There had been delays in staff completing the programme due to a lack of funding. However, additional funding had become available and six further members of staff were expected to complete the training by January 2018.

On the neonatal unit, 35 out of 45 registered nurses (77%) were qualified in specialty (QIS). Nurses who are QIS have completed a programme of post registration education. Six nurses had completed the Neonatal Nurse Specialist course at the University of East Anglia since 2014/15. Two further nurses were booked to commence the training in September 2017.

The service had one advanced neonatal nurse practitioner (ANNP) and one advanced paediatric nurse practitioner (APNP) to support the clinical teams on the neonatal unit and children’s ward. All staff who undertook post-anaesthetic care of children and young people in recovery were required to complete a paediatric core competencies workbook within six months of starting their role. This included competencies in paediatric basic life support and paediatric immediate life support.

Royal College of Nursing (RCN) neonatal competency packs were used on the neonatal unit. New staff on the neonatal unit were required to complete competencies through study days within six months of starting their role. A practice development nurse was available to support staff on the unit. Senior staff acknowledged that further work was required to develop a system for processing some competencies.

A range of volunteers were used in the children and young people’s service, including in the play room and the school room. Volunteers attended the same half day corporate induction as all new staff members and they completed a mandatory training handbook. Volunteers were asked to complete applicable sections of the handbook every year. Volunteers were assigned a placement manager for day to day supervision.

**Multidisciplinary working**

Working relationships with other providers of specialist care were established and effective. Children with complex renal and gastroenterology, as well as some complex asthma, respiratory, neurology, neuromuscular, and rheumatology went to tertiary centres for joint care. Consultants
from tertiary centres visited to operate shared care clinics for cardiac, oncology, rheumatology, urology, epilepsy and neurological patients.

Learning, policies and guidelines were shared through regional networks. Play specialists were part of the East Anglian Play Specialist group, who met twice a year for study days. The neonatal unit was part of the East of England Neonatal Operational Delivery Network. The oncology team were part of the Anglia Children’s Cancer Network and policies had been agreed and implemented across the region.

The trust strategy included a 2017/2018 milestone to work collaboratively with the third sector (such as hospices and home carers) where patients are shared to improve services provided to children in the community. Staff gave examples of where they had worked collaboratively with hospices in the provision of end of life care.

Staff worked together to assess and plan ongoing care and treatment. Weekly multidisciplinary meetings were held on the neonatal unit and these included consultants, physiotherapists, the neonatal outreach team, dieticians, nursing staff, and the lead midwife for safeguarding. A hospice link would also attend if required. The paediatric service held a weekly psycho-social meeting, which was also attended by play specialists and safeguarding staff to share and discuss concerns. Multidisciplinary meetings were also held for specialties such as diabetes and oncology. Multidisciplinary clinics were carried out for cystic fibrosis, oncology, cardiology, epilepsy, allergy, asthma and diabetes.

Governance meetings were attended by multidisciplinary staff groups, including paediatricians, specialist nurses, pharmacists and staff from the neonatal unit. Ward rounds were attended by a multi-disciplinary team and included effective nursing input.

We reviewed 17 care records and found that there was evidence of multidisciplinary input in all but one of the cases where this was applicable. There was evidence of a daily ward round including review with senior clinicians in all cases where this was applicable.

Staff had access to paediatric pharmacy advice five days a week. At weekends staff had access to a general on-call pharmacist, who would not have specific paediatric expertise. Staff had access to physiotherapists who had paediatric specific training and there was a 24/7 on-call rota. A team of play specialists worked in the children’s department, including on Raedwald Day Surgery Unit, five days a week. Parents and staff spoke positively about the support provided.

Transition for adolescents was not yet established in all areas. There was no standard transition pathway for young people transitioning from children’s services to adult services, a transition policy was still in draft form and a consultant lead for transition had not yet been identified. The draft transition business case recognised that the trust was not in line with NICE guidance and transition was ad hoc and inconsistent. Staff indicated that transition worked best when children’s care was provided under a single specialty. Arrangements for patients with multiple co-morbidities and other conditions required further development. A transition working group had been set up, which included nursing staff and the Voice4Change young person’s group was consulted as part of this process. There were plans to introduce a nurse lead for transition and a youth worker. A national transition model known as ‘ready, steady, go’ was being implemented in epilepsy, oncology and respiratory and endocrine. There were plans to include transition as a topic in staff study days in 2018.

The newly introduced high dependency specialist nurse worked collaboratively and built relationships with staff in the emergency department and the critical care unit. For example, work had taken place in critical care around the expectation on staff if a child was not imminently due to be transferred out.
The neonatal unit had a service level agreement (SLA) with the charity ‘SERV’ who provided blood product and donor milk transport. The Children’s Acute Transport Service (CATS) provided the regional retrieval service for paediatric patients requiring intensive care therapy.

In the CQC Children’s Survey 2014 the trust scored 8.93 out of ten for the question ‘Did the members of staff caring for your child work well together?’ This was about the same as other trusts.

**Seven-day services**

The service did not have scheduled seven-day access to diagnostic services and this was not in line with NHS Seven Day Services Clinical Standards. This meant that children and young people could experience delays in their treatment on weekends. However, there was seven-day access to diagnostic services for emergency cases.

There was a 24 hours a day, seven days a week on-call rota for physiotherapy and diabetic support. The neonatal outreach team worked from 8:30am to 4:30pm, seven days a week and the chaplaincy team provided a 24 hours a day, seven days a week service to patients, carers and staff.

The play team was not available on weekends and therefore children being treated during this time would not have access to the support this team provided to cope with pain, anxiety or fear.

**Health promotion**

Children who may need extra support were identified through flags on the electronic patient record system to alert staff to patients with a confirmed diagnosis of a learning disability, autism, or visual impairment.

The use of the personal child health record (PCHR), also known as the red book, was actively encouraged in the children and young people’s service. Parents or carers were advised over the phone and by letter to bring the red books when attending the hospital. The PCHR is the main record of a child’s health and development. The parent or carer retains the PCHR, and health professionals should update the record each time the child is seen in a healthcare setting. This meant that parents and carers were involved in regularly monitoring their child’s health. The ongoing reviews that formed part of the record also provided an opportunity for staff to support national priorities to improve the population’s health, for example through discussions about diet.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Not all staff were confident in assessing Gillick competency. Gillick competence assesses whether a child has the appropriate understanding and maturity to consent to care. However, all staff indicated that they would contact the safeguarding team for advice on consent. Staff gave examples of occasions where they had liaised with social services to gain consent for looked after children. Staff indicated that support would be provided to patients and their parents/carers during the consent process by taking additional time to explain the proposed care or treatment and by answering any questions that they may have.

Consent forms, both generic and customised, were available on the trust intranet. The consent form for parents or other persons with parental responsibility included a section to record the child’s agreement to treatment. The form included guidance for health professionals about consent and Gillick competence. This also directed staff to the Department of Health publications *Reference guide to consent for examination or treatment* and *Seeking consent: working with children*. Children who legally had capacity to consent for themselves would sign the standard...
‘adult’ consent form, where there was space for a parent (or person who had parental responsibility) to countersign if a child who had capacity wished them to do so.

The trust had a Consent to examination or treatment policy which referred to the Department of Health Reference guide to consent for examination or treatment. The policy contained no direct reference to Gillick competency. However, it did state that parent’s consent should be obtained when a child did not have sufficient understanding or is under the age of 16. The trust also had a Mental Capacity Act and Deprivation of Liberty Safeguards policy but this did not make direct reference to the care of children.

The paediatric service had made the decision to signpost young people to websites with more detailed information about consent and Gillick competence rather than displaying posters after receiving feedback from the Voice4Change young person’s group.

The trust reported no data pertaining to Mental Capacity Act (MCA) training or Deprivation of Liberty training. However, we saw that MCA and Deprivation of Liberty Safeguards formed part of a booklet which staff were required to read as part of their mandatory training. However, this did not include any specific reference to children. Consent training was provided at induction and through teaching sessions for foundation year doctors. Staff also indicated that consent was discussed as part of their level three safeguarding training. In addition, there were plans to include mental health as a topic in upcoming mandatory study days. The safeguarding page on the intranet provided further guidance on consent for staff, including a ‘your next patient may lack capacity’ booklet, as well as General Medical Council (GMC) and Nursing and Midwifery Council (NMC) guidance on the MCA.

The service had a ‘Child Under the Age of 18 Mental Health Assessment Form’, which included triage questions around background history, general observations, appearance and behaviour. The form assisted staff to risk assess patients as low, medium, high or very high risk and prompted outcomes and actions for staff to take in response.

Staff did not have access to specific study sessions on patients with mental health conditions, learning disabilities or autism through child health study days. However, learning disabilities was covered as a topic in a 2017/18 mandatory training handbook, which staff were required to read. This provided advice for staff about reasonable adjustments, advice on communication, and the use of health and autism passports. There were plans to introduce mental health sessions in child health study days in 2018. Nursery nurses who were regularly involved in the supervision of patients with eating disorders had attended a study day on mental health. The trust employed a learning disability and autism liaison nurse who provided support and advice to staff.

Staff on Bergholt ward told us they felt the provision of mental health assessment had improved, and gave an example of waiting no more than an hour on the day of our inspection, from making a telephone call to the assessment team and them arriving on the ward.

We reviewed 17 care records and found that there was evidence of documented consent in all but one of the cases that this was applicable for. There was evidence of the assessment of competence in all cases that this was applicable for. Data provided by the trust showed that a mental capacity assessment had been carried out in 100% of cases on Bergholt ward in May 2017, which was above the target of 95%.

Leaflets which provided information about consent were available on Raedwald Day Surgery Unit, including a Department of Health Guide to Consent leaflet.

Is the service caring?
Compassionate care

CQC Children’s Survey 2014

The trust performed about the same as the England average in eight out of 14 questions relating to compassionate care in the CQC Children’s Survey 2014. The trust performed better than other trusts in five other areas:

Overall (both the 0-15 and 8-15 sub-groups)

Were you given enough privacy when you were receiving care and treatment?

Do you feel that the people looking after you listened to you?

Do you feel that the people looking after you were friendly?

CQC Children’s Survey questions, compassionate care, Ipswich Hospital NHS Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>KLOE</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. Overall… (please circle a number)</td>
<td>C1</td>
<td>0-15 adults</td>
<td>8.93</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>35. Were members of staff available when you or your child needed attention?</td>
<td>C1</td>
<td>0-15 adults</td>
<td>8.33</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>8. Was your child given enough privacy when receiving care and treatment?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>9.24</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>9. Did you think there were appropriate things for your child to play with on the ward?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>8.02</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>10. Did staff play with your child at all while they were in hospital?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>11. Did new members of staff treating your child introduce themselves?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>9.02</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>40. Do you feel that the people looking after your child listened to you?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>8.50</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>41. Do you feel that the people looking after your child were friendly?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>9.48</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>42. Do you feel that your child was well looked after by the hospital staff?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>9.12</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>43. Were you treated with dignity and respect by the people looking after your child?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>9.60</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>9. Were you given enough privacy when you were receiving care and treatment?</td>
<td>C1</td>
<td>8-15 CYP</td>
<td>9.48</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>18. Do you feel that the people looking after you listened to you?</td>
<td>C1</td>
<td>8-15 CYP</td>
<td>9.30</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>19. Do you feel that the people looking after you were friendly?</td>
<td>C1</td>
<td>8-15 CYP</td>
<td>9.75</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>20. Overall… (please circle a number)</td>
<td>C1</td>
<td>8-15 CYP</td>
<td>8.93</td>
<td>Better than other trusts</td>
</tr>
</tbody>
</table>

Key:  
- 🟢 Better than other trusts  
- 🟡 About the same as other trusts  
- 🟠 Worse than other trusts

(Source: CQC Children’s Survey, RCPCH)

The neonatal unit promoted the privacy and dignity of babies and their families in several ways. For example, the admissions board was kept out of eye sight of visitors behind the nursing station, coded stickers were used on the ‘at a glance’ board to indicate safeguarding concerns, which babies were ready for early discharge, and which babies were receiving continuous positive airway pressure (CPAP).

On PIU we observed staff showing a patient and their parent around whilst explaining investigations in advance. We also observed a member of staff asking a child what type of things they liked to play with so that they could find toys they would like. We also observed staff providing reassuring and compassionate care to a distressed oncology patient, offering to hold their hand and use distraction techniques and local anaesthetic creams to reduce pain and discomfort during treatment.
Examples of compassionate care included a member of staff who returned to the unit after their shift with items of their own clothing to give to a parent who could not leave their child on the ward and required clean clothing for themselves. Another was a member of staff often staying on the unit after their shift to plait the hair of a patient with a long term condition.

**Emotional support**

*CQC Children’s Survey 2014*

The trust performed about the same as other trusts for all three questions relating to emotional support in the CQC Children’s Survey 2014.

**CQC Children’s Survey questions, emotional support, Ipswich Hospital NHS Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>KLOE</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>37. Did a member of staff tell you what to do or who to talk to if you</td>
<td>C3</td>
<td>0-7 Adults</td>
<td>8.77</td>
<td>About the same as other</td>
</tr>
<tr>
<td>were worried about your child when you got home?</td>
<td></td>
<td></td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>7. If you had any worries, did someone at the hospital talk with you</td>
<td>C3</td>
<td>8-15 CYP</td>
<td>8.89</td>
<td>About the same as other</td>
</tr>
<tr>
<td>about them?</td>
<td></td>
<td></td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>15. Did hospital staff tell you what to do or who to talk to if you</td>
<td>C3</td>
<td>8-15 CYP</td>
<td>8.49</td>
<td>About the same as other</td>
</tr>
<tr>
<td>were worried about anything when you got home?</td>
<td></td>
<td></td>
<td></td>
<td>trusts</td>
</tr>
</tbody>
</table>

(Source: CQC Children’s Survey, RCPCH)

Up until July 2017 there had been a volunteer from the charity Bliss (Baby Life Support Systems) who attended the neonatal unit weekly to provide support to families. The unit was attempting to replace this volunteer at the time of our inspection.

The neonatal unit had a closed social media group for parents that had had babies on the unit, for peer support. There were posters displayed to make patients and families aware of support groups, including an epilepsy support group.

There was a bereavement midwife who supported the neonatal unit and worked with a local hospice to support parents. Parents and siblings specific evenings were hosted at a local hospice to support families of children and babies that had died.

A hospital chaplain was in the process of introducing reflective remembrance sessions, which would be non-religious, to support staff that had cared for children and babies that had passed away. The chaplain attended the schoolroom once a week to see patients and spent time with staff to ensure their support when required.

**Understanding and involvement of patients and those close to them**

Staff on PAU involved children and their families in their care. For example, patients going home after an asthmatic admission will be involved and educated in the use of their medication and management of their condition and inhaler techniques.
Staff worked with and involved the families of children with complex needs to ensure the best care for the child. One staff member referred to families of children with complex needs as being experts in the children’s conditions, stating “we have to listen to them, they’re the experts”. One parent told us that the medical and nursing staff listened to them and involved them on the ward round, and that staff in the hospital worked well with community staff to support their child at home.

The neonatal unit had a parent care plan in place. This document allowed parents to work with the unit to determine how the family would like to be involved in their baby’s care. The plan also included a section for parents to determine who can visit their baby in their absence, and how their baby should be fed. However we observed a ward round on the neonatal unit and found that the babies who had joined their parents in the parent bay were temporarily removed from their families to be reviewed by the medical staff. The parents were then called in to the ward round to be updated on their baby’s care. This reduced the transparency of the involvement of families in their baby’s care and we raised this at the time of inspection.

The service actively sought feedback from children and their families. There was a ‘your views matter’ feedback form specifically for children, which asked how likely they would be to recommend the children’s ward to their family and friends. This included teddy bears with a variety of expressions to represent ‘extremely likely’, ‘likely’, ‘neither likely nor unlikely’, ‘unlikely’ and ‘extremely unlikely’. The children’s outpatients department had a ‘top’ and ‘pants’ board where children could write their feedback. The children’s day surgery unit also had a ‘your views count’ board with thank you cards and drawings from children and emails from adolescents.

In April 2017 the children’s services had a response rate of 55% and a recommendation score of 98% in the friends and family test.

**CQC Children’s Survey 2014**

The trust performed about the same as other trusts for 16 out of 19 questions relating to understanding and involvement of patients and those close to them in the CQC Children’s Survey 2014. The trust performed better than other trusts in 3 other areas:

Before the operation or procedure, did a member of staff answer your questions about the operation or procedure in a way you could understand?

Were you given any written information (such as leaflets) about your child’s condition or treatment to take home with you?

Were you told different things by different people, which left you feeling confused?

**CQC Children’s Survey questions, understanding and involvement of patients, Ipswich Hospital NHS Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>KLOE</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>24. Did hospital staff tell you what was going to happen to your child while they were in hospital?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>8.63</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>27. Did members of staff treating your child, give you information about their care and treatment in a way that you could understand?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>9.38</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>29. Did you have confidence and trust in the members of staff treating your child?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>9.11</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>30. Were you encouraged to be involved in decisions about your child’s care and treatment?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>7.82</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>31. Did hospital staff keep you informed about what was happening whilst your child was in hospital?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>8.47</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>32. Did staff ask if you had any questions about your child’s care?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>8.35</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>38. Did a member of staff tell you what would happen to your child while they were in hospital?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>8.46</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
happen next after your child left hospital?

43. Before the operation or procedure did a member of staff explain to you what would be done during the operation or procedure?

|   | C2 | 0-15 adults | 9.52 | About the same as other trusts |

44. Before the operation or procedure, did a member of staff answer your questions about the operation or procedure in a way you could understand?

|   | C2 | 0-15 adults | 9.77 | Better than other trusts |

45. After the operation or procedure, did someone explain to you how the operation or procedure had gone in a way you could understand?

|   | C2 | 0-15 adults | 9.19 | About the same as other trusts |

47. Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?

|   | C2 | 0-15 adults | 9.69 | About the same as other trusts |

48. Did a member of staff give you advice about caring for your child after you went home?

|   | C2 | 0-15 adults | 8.94 | About the same as other trusts |

50. Were you given any written information (such as leaflets) about your child’s condition or treatment to take home with you?

|   | C2 | 0-15 adults | 9.16 | Better than other trusts |

13. Did members of staff treating your child communicate with them in a way that your child could understand?

|   | C2 | 0-7 adults | 8.55 | About the same as other trusts |

19. Were you told different things by different people, which left you feeling confused?

|   | C2 | 0-7 adults | 8.79 | Better than other trusts |

1. When you first arrived at hospital, did people working at the hospital tell you what was going to happen to you while you were there?

|   | C2 | 8-15 CYP | 9.15 | About the same as other trusts |

5. Did hospital staff talk to you about how they were going to care for you in a way that you could understand?

|   | C2 | 8-15 CYP | 9.29 | About the same as other trusts |

13. Before the operation or procedure, did someone tell you what would be done?

|   | C2 | 8-15 CYP | 9.49 | About the same as other trusts |

14. Afterwards, did someone from the hospital explain to you how the operation or procedure had gone in a way you could understand

|   | C2 | 8-15 CYP | 8.31 | About the same as other trusts |

(Source: CQC Children’s Survey, RCPCH)

Is the service responsive?

Service delivery to meet the needs of local people

There was evidence that children and young people had been involved in the design and running of the service. For example, a ‘take over day’ was held in 2015 and 2016, where young pupils aged 14 to 18 years came into the hospital from local schools and presented their thoughts on how to improve transitional care. The trust had set up a group called ‘developing services for young people at Ipswich Hospital’ to look at the recommendations. In July 2017, a 15 steps welcome assessment was carried out with the Voice4Change young people’s group, which included discussions about how the service could improve facilities for young people. “The 15 Steps Challenge” is a toolkit developed by the NHS Institute for Innovation and Improvement to help look at hospital care through the eyes of patients and relatives.
There were a range of initiatives in place in order to improve service delivery for local people. There was a one-stop allergy clinic, which meant that as many tests and investigations were carried out at one time as possible and this reduced the number of times patients needed to come to the hospital. There was also a neonatal outreach service in place. This service ran seven days a week and provided support to families in their own homes, with the aim of getting neonatal babies home sooner. The service provided education to parents, including basic life support and skills such as tube feeding.

Raedwald Day Surgery Unit carried out pre-assessments on Saturday mornings and this was more convenient for parents. During pre-assessment, children were introduced to the unit and the staff who would be treating them. Children were shown a DVD and a photo book, which explained what would happen on the day of their surgery. A teddy bear was used to show children the gowns that they would be wearing during surgery and to demonstrate how a cannula would be inserted.

During our last inspection we noted a lack of age-appropriate materials for older children and teenagers. An adolescent room was available on the PAU for those aged over 10, which had age appropriate entertainment including games consoles, a television, and table football. Staff recognised that this space was due for an update and that there had been a decline in the use of the room due to children bringing in their own electronic devices. Televisions and headphones were available by all chairs on the PAU, which were free to use between 7am and 7pm. Staff acknowledged that there continued to be limited age-appropriate materials for older children and teenagers on Raedwald Day Surgery Unit, the Paediatric Investigation Unit and the children’s outpatient department. However, children were in these areas for a shorter period of time and staff indicated that the majority of children brought their own electronic devices when attending these areas.

All areas of the children and young people’s service had child-friendly decoration. The environment was colourful and had children’s paintings and art work on display. There was access to an outdoor play area, as well as a play room on Bergholt ward and Raedwald Day Surgery Unit. Toys and books were available in the waiting areas on the PIU and children’s outpatient department. Bergholt ward and the PAU had quiet rooms, which provided a space for staff to have confidential and sensitive conversations with children and their parents or carers.

Children aged five to 16 had access to a school room, Monday to Friday during term time. The school room was run by a teacher and teaching assistant funded by the local council, and volunteers also provided support. Every child was seen on the day of admission to the ward and work was provided both bedside and in the school room. For all students who were inpatients longer than a week, data was obtained from the mainstream schools in order to ensure work was provided at the correct level and to maintain continuity of learning. All students could access their school virtual learning platforms, with Wi-Fi available, to ensure contact was maintained and work was shared between the two educational provisions.

Data provided demonstrated that there were a total of 36 children treated in adult areas between June 2016 and July 2017. Upon review, it was noted that in all cases these were clinically appropriate decisions due to the nature of the treatment being provided. These admissions were to areas where nurses trained to deliver care to adults were providing care to children and young people. This meant that the specific needs of children and young people might not have been met.

The nurse staffing for the day surgery recovery comprised of eight registered nurses and one paediatric recovery nurse. The paediatric recovery nurse was part time and worked three days a week, yet the unit was open five days per week. This meant that there were would be occasions where staff trained to deliver care to adults were providing care to children. To mitigate the risk all eight recovery nurses had received paediatric immediate life support training (PILS). The skill mix was allocated and checked by the clinical lead to ensure that the correct skill mix was provided.
There was always a minimum of two staff recovering a child. Further to PILS training, the staff were also required to complete a recovery paediatrics core competencies workbook.

There was no separate paediatric recovery area for children who had undergone day surgery. Instead, there were two bays designated for the use of children within the general recovery area. *Immediate Post-anaesthesia Recovery* (2013) by the Association of Anaesthetists of Great Britain and Ireland (AAGBI) states that children’s needs ‘are best met by having a designated, separate paediatric recovery area’.

Children were not segregated by gender on Bergholt ward, although staff tried to cohort older patients where practical.

There were no set visiting times for parents on the neonatal unit or Bergholt ward, meaning that they could visit at any time. There was ample accommodation available for parents to stay overnight on the neonatal unit, including two bedrooms, a four bedded parents bay (which was due to be extended to six beds), and two cubicles. Accommodation was prioritised for parents of particularly sick babies or before discharge but staff indicated that they were normally able to accommodate all parents who wished to stay overnight on the unit. The unit also had a lounge with a kettle, fridge, microwave and television, a feeding room and a quiet room. The quiet room had a sofa bed which could be used for the accommodation of parents, as well as a small amount of toys and books for siblings to use. Mothers who were staying at the hospital or who were travelling long distances were offered free meals on Brook postnatal ward. The trust performed about the same as other trusts for all four questions relating to responsiveness in the CQC Children’s Survey 2014.

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>37. Did you have access to hot drinks facilities in the hospital?</td>
<td>R1</td>
<td>0-15 Adults</td>
<td>9.02</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>39. How would you rate the facilities for parents or carers staying overnight?</td>
<td>R1</td>
<td>0-15 Adults</td>
<td>7.01</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>2. Did the hospital give you a choice of admission dates?</td>
<td>R2</td>
<td>0-7 Adults</td>
<td>3.69</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>3. Did the hospital change your child’s admission date at all?</td>
<td>R3</td>
<td>0-7 Adults</td>
<td>9.63</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC Children’s Survey, RCPCH)

**Meeting people’s individual needs**

An external company provided translation and interpreting services by telephone. Interpreters could also be arranged to attend the hospital in person if required. Staff indicated that family members, members of staff and an internet search engine were used for translation on occasion, although this was normally for non-sensitive communication. Communication cards were available for Makaton. Makaton is a language programme using signs and symbols to help people to communicate.

The service did not have a dedicated sensory room. However, the play specialist team had a portable sensory suite which projected interactive programmes onto the floor. Programmes included a stream with stepping stones, animals which moved when children touched images on the floor, savannah landscapes and outer space. Sensory equipment could also be brought to a child’s bedside.
The service had a play team who could help children cope with the pain, anxiety or fear they might experience during their time in hospital. Clown doctors visited young people on the wards and engaged them in clowning, storytelling, music, magic, circus skills and improvisation. Animal therapy was provided on a weekly basis during term times with small animals such as rabbits and bearded dragons.

The trust employed a learning disability and autism liaison nurse who worked with staff, patients, carers and families to ensure that reasonable adjustments were made to support patients with learning disabilities presenting to services and ensure services are accessible and able to meet the need of each individual. Staff indicated that the nurse was very pro-active and had introduced drop in sessions, which parents and children could also attend. The trust had a learning disability and autism policy, which included a focus on children and adolescent transition. The service used health passports to provide staff with information about patients with a learning disability.

Child and adolescent mental health services (CAMHS) and psychiatric liaison services were provided by a local NHS mental health trust. The CAMHS service did not have a presence on site, and there were no CAMHS inpatient beds in Suffolk. This meant that children were sent out of area if inpatient management was required. The psychiatric liaison service was commissioned by the clinical commissioning group and had an on-site presence at the hospital. The team comprised of a consultant psychiatrist and mental health nurses. Patients admitted to assessment units were seen within a maximum of 24 hours once medically fit, or sooner if clinical triage indicated the need for urgent assessment. The psychiatric liaison service was provided between 7am and 9pm, thereafter referrals were processed by the access and assessment service. The service was primarily adult focused, but supported timely assessment and intervention by the CAMHS on-call services.

The service had specialist paediatric nurses (including epilepsy, respiration and oncology) as well as link nurses for complex needs, to provide guidance and support to children and their parents or carers. There were plans for the oncology, epilepsy and respiratory link roles to be developed to have a greater involvement with the nurse specialists and their patient groups. Best practice ‘year of care’ clinics were held for paediatric diabetes. Year of care is focused on providing a personalised approach for people with long term conditions with improved patient involvement. There were a range of information leaflets and information boards throughout the service to provide children and their parents or carers with information about specific conditions. Child friendly leaflets were also available.

Staff referred children and their parents or carers to support groups for their individual needs. For example, the Ipswich Epilepsy Support Group, which provided information, advice, counselling and a helpline.

Staff on Bergholt ward used an ‘agreement of care’ document and an ‘activities of daily living’ document to set out a child’s normal routines and preferences. This included questions about any hearing, vision or communication problems, as well as interests, special toys and bedtime routines. A parent care plan was used on the neonatal unit, which set out how the family would like to be involved, feeding preferences, and preferences about visitors.

The neonatal unit provided knitted hats, blankets and teddies that had been donated by members of the public. Small bags were attached to babies’ cots to hold keepsakes of the time spend on the unit. ‘Snugglies’ were also given to mothers and their babies. Snugglies are small muslin squares which are knitted in one corner, one for the mother and one for the baby. One snuggly is placed in the cot close to the baby and the other stays close to the parent to pick up their scent. They are then swapped around so that the baby and parents share each other’s scent. It has been found that these help with bonding and stimulate milk production.
The neonatal unit liaised with the hospice, charities and the hospital bereavement team in the provision of end of life care. The care provided was based on a neonatal pathway for babies with palliative care needs. The neonatal unit had memory making boxes donated by the charity 4Louis, which included a box for a lock of hair and a clay impression kit to capture an impression of babies’ hands and feet. The hospital bereavement team provided support to parents on the neonatal unit. Parents could choose to wash and dress their baby after death and could accompany their baby to the mortuary if they wished. Moses baskets were available for babies to be nursed in after death. The neonatal unit arranged a consultant appointment six weeks after the death of a baby, which could also be attended by the obstetrician and neonatal nurses to provide an opportunity for parents to ask questions, to discuss the care that had been provided and to go through post-mortem results. The neonatal unit used a purple butterfly symbol on a baby’s cot to indicate to staff and other visitors on the unit that one baby from a set of twins had died.

Access and flow

Between 1 April 2016 and 31 March 2017, emergency spells accounted for 86% (4,674 spells), 8% (411 spells) were day case, and the remaining 6% (320 spells) were elective cases. Compared to the England average, this service had a higher proportion of emergency cases and a lower than average proportion of day and elective cases.

Only children up to the age of 16 could access services within this department. Children aged 16 and over would be placed in adult services. However, exceptions were made for children with complex needs. The neonatal unit provided care to babies born at 27 weeks gestation and over. Babies born at a younger gestation were transferred to neonatal units at other hospitals.

The PAU accepted referrals from GP’s, health visitors, midwives, community nurses and the emergency department. There was open access for children with complex needs, which was arranged in conjunction with the child’s consultant. The PAU monitored the length of time children spent on the unit and this averaged at 204 minutes between May and August 2017.

Admissions to Bergholt ward included elective admissions as well as emergency admissions from PAU, the emergency department, and transfers from other trusts. The community paediatric nursing team and the children’s hospice could refer children directly to the ward for urgent assessment. There was an open access policy for the first 24 hours after discharge on Bergholt ward and children could be given open access in agreement with their consultant. Raedwald Day Surgery Unit closed at 8pm and this meant that children who were late on the afternoon list may not have recovered sufficiently for discharge before the unit closed. These children were transferred to the children’s ward to continue their recovery. Bergholt ward was normally a 21 bedded ward but could be increased up to 24 beds during surges of activity.

Patients have the right to be treated within 18 weeks of being referred for treatment (RTT). A target of 90% was set for patients to receive inpatient treatment within 18 weeks. At the time of our inspection, 100% of paediatric patients were receiving inpatient treatment within 18 weeks of referral. A target of 95% was set for patients to receive non-admitted treatment within 18 weeks. At the time of our inspection, 98.9% of paediatric patients were receiving non-admitted treatment within 18 weeks of referral. This demonstrates that children and young people had timely access to initial assessment and diagnosis.

Minutes from the August 2017 governance meeting show that a new risk was to be added to the risk register regarding capacity to manage the child health follow up waiting list and referral to treatment position.

Patients have a right to be seen by a cancer specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected. This had been achieved at Ipswich Hospital in 98.3% of cases where children’s cancer was suspected between July 2016 and June 2017.
There were no delayed discharges for children and young people’s services or the neonatal unit between June 2016 and May 2017. There were three children whose admissions to an appropriate mental health bed were delayed and these were associated with eating disorders. There were 15 on the day cancellations of surgery for children and young people for non-clinical reasons between August 2016 and July 2017. Staff told us that children were prioritised on theatre lists, and were normally operated on in age order; this was dependent on clinical urgency.

There was a consultant led rapid access service for children to be seen within two weeks. If children needed to be seen within 48 hours then they were referred to PAU and would be reviewed there. This meant that children and young people had timely access to initial assessment, diagnosis or urgent treatment.

The neonatal unit cared for approximately 550 babies each year. Between 1 May 2016 and 30 April 2017 the trust had seen neonatal bed occupancy fluctuate at three points. The trust was below the England average in June 2016, at around 30% occupancy, before a stable period of 100% occupancy (above the England average) for July-November 2016. The occupancy rates then dropped again to around 30% in December 2016 and January 2017 before rising in February, and falling again in March and April 2017.

Note: the data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month. (Source: NHS England)

The neonatal unit had a potential admissions board which showed babies being cared for at other hospitals (who would return to the unit when they were stable) and pregnancies that were likely to result in an admission to the unit. This allowed staff on the unit to plan for the flow of patients in the coming weeks and months. The neonatal unit had an outreach team working seven days a week to facilitate early discharge. The team worked with a maximum of 11 babies at any one time.

The Paediatric Assessment Unit had a discharge information leaflet for parents and carers which included contact details for the unit, information about medication doses and when they were last given. If the child had been discharged from PAU then parents were advised to contact their GP with any concerns. If the child had been given open access, this leaflet advised them of what date and time they had open access until and advised them to contact the unit if the child deteriorated during that period.

There was no link consultant for local GP practices and GPs did not have access to the hospital’s electronic patient record system but GPs could phone medical staff at the hospital for advice, including access to the consultant on call via the switchboard if necessary. Discharge was communicated to GPs immediately through the electronic record system and the discharge information sent to GPs included care summaries as well as details about medication and co-morbidities. Information could also be sent to the community team. A paper copy of the discharge information was also provided to parents or carers.

The service had worked and was continuing to work with the clinical commissioning group, local primary care and community services to develop care pathways for the top three acute conditions. There were future plans to expand this work to include the top 10 conditions.
At the time of our last report, we were not provided with information which demonstrated that the department was safely managing increases in service demand. A redevelopment plan had been written in April 2017 and approved by the divisional management team in July 2017. The plan was awaiting board approval. The redevelopment plan sought to future proof the children’s department for the next 20 years and included plans to increase the numbers of outpatient consulting rooms and the availability of side rooms.

**Learning from complaints and concerns**

Between 1 June 2016 and 31 May 2017 there were six complaints about children’s services. Three related to treatment, two related to communication and one to delays. There was evidence that explanations had been given to complainants about the care provided and there was evidence that an apology had been given in one case.

The hospital's target for completing a complaint was 28 workings from the date of receipt, unless a longer timeframe had been agreed with the complainant. Four out of the six complaints received by the children and young people’s service had not been resolved within 28 working days of receipt.

Staff stated they would attempt to resolve complaints informally in the first instance and they gave examples of when they had done so. Staff said that they would refer patients and parents or carers to the Patient Advice and Liaison Service (PALS) if they were not able to resolve their concerns informally. Signposting to PALS was evident within the service.

Feedback and outcomes from complaints and compliments were communicated to staff via team meetings and briefings. Complaints were discussed and monitored at risk and performance meetings. There were also plans for a complainant to be involved in upcoming child health study days, so that they could speak to staff about their experiences.

There was evidence of changes to practice as a result of complaints. For example, the service was in the process of designing a parent information leaflet about the safeguarding process in response to a recent complaint. Staff felt that this may help to allay some parents’ fears about the process.

**Is the service well-led?**

**Leadership**

Services for children and young people sat in division three which covered cancer, pathology and women’s and children’s services.

Clinical leadership was provided by a clinical director, an associate director of nursing, a head of operations, a clinical lead, an operations lead and a matron who was supported by a senior sister.

Since our last inspection, the leadership team had some changes which staff told us had resulted in more visible leaders. The high dependency care nursing role was developed by the current interim matron and the current senior sister was noted by staff to be “visible, approachable, and proactive” and “very fair”. Staff told us the matron was “around and approachable”.

**Vision and strategy**

The service had a draft strategy in place which was expected to be finalised shortly after our
inspection. The strategy was developed to set the direction for the services over the next five years, and was drafted in line with both the trust's strategy and vision document and the Suffolk Wide Strategy for Children, Family 2020.

Staff across the service were aware of the draft strategy and told us that the focus was on high standards of care and pathways, and that they felt very involved in the creation of the document.

**Culture**

Nursing staff told us that they felt they worked well with permanent medical staff and that communication was effective. One registered nurse told us that medical staff "know that we are the children's advocates".

There was a sense of pride amongst nursing staff in their management of expectations. One nurse told us they were most proud of “managing patient and parent expectations and communicating well with them”. Another nurse told us they were most proud of their “ability to get children home well rather than admitting everyone”.

One nurse told us that they had gone into nursing and had been subsequently trained on the unit after remembering the care they had received as a patient when they were young. They stated that the same nurse that had cared for them as a child, became their mentor and signed off their competences as a newly qualified nurse. This was celebrated and we saw newspaper articles about this in the staff room.

**Governance**

Our previous inspection found that governance systems required development to ensure that the management of risk was effective, and that a poor audit programme represented a lack of continuous service monitoring and improvement. Throughout this inspection we found that supervisory and managerial staff were aware of the majority of service risks, governance issues such as the risk register, incidents and complaints received detailed scrutiny at risk and governance meetings, and there was a developed audit programme managed by an audit lead and reviewed by the audit department. Staff were able to give examples of improvement and shared learning from governance related issues.

The service inputs to an electronic accountability framework for each location (Bergholt ward, PAU) and this provides a governance oversight, feeding into the integrated performance overview. The system then generates a rating for each area. In May 2017 this overview stated that PAU was rated outstanding for 10 out of the 12 months between June 2016 and May 2017 and rated good for the remaining two months. The same overview stated that Bergholt ward was outstanding for one month, good for seven months and required improvement for four months.

The senior sister kept oversight to feedback to staff, of the safety thermometer performance, local audit performance such as hand hygiene and documentation audits, Friends and Family Test performance, staff training, professional registration renewal and resuscitation trolley checks.

Staff told us they received email notification as well as information being displayed on their notice boards, of governance related updates. This included complaints summaries, any never events, risks on the register, safer practice notices, and the ‘Risky business’ lessons learned newsletter. Staff also had access to a closed and secure online group forum on social media for governance related briefings.
Management of risk, issues and performance

The service had its own risk register. The register included both operational and strategic risks, and there was scoring, controls and mitigations in place for each risk.

Scrutiny of the risk register took place at monthly child health risk and governance meetings, attended by the matron, the clinical lead and other staff holding managerial roles throughout the service. Risks were weighted by the operations lead by the completion of a proforma, which included a review of the potential cause, impact and effect of the risk, as well as the controls in place and actions to address gaps.

Plans were in place for capacity issue planning. These included an escalation policy which included a paediatric accident and emergency pathway providing clarity about what to do if full capacity was reached. There was an example of recent high capacity on the neonatal unit. The unit was able to flex its number of beds and engage with the other trusts in the local neonatal network regarding capacity. Potential discharges were considered at every ward round and hand over.

Information management

Policies were accessible to staff via the hospital intranet, which included an easy access link to child health policies and guidelines. The child health policy page also contained links to national guidelines. Staff confirmed that the information was easily accessible. However, seven out of the 40 policies we reviewed were found to be out of date.

Staff had access to an electronic patient record system which meant that the information needed to deliver effective care and treatment was available to staff in a timely and accessible way. Although some paper records were used during a patient’s stay at the hospital, these would be available on the electronic system within four working days. However, growth charts were not compatible with the electronic system and were therefore in paper format. This had been added to the risk register as it meant that there was a risk of staff missing safeguarding concerns. The electronic patient record system included a flag to alert staff to patients with a confirmed diagnosis of a learning disability, autism, or visual impairment.

Discharge was communicated to GPs immediately through the electronic record system. The discharge information sent to GPs included care summaries as well as details about medication and co-morbidities. Information could also be sent to the community team. A paper copy of the discharge information was provided to parents or carers. GPs did not have direct access to patient records but GPs could phone medical staff at the hospital for advice, including access to the consultant on call via the switchboard if necessary.

The use of the personal child health record, also known as the red book, was actively encouraged in the children and young people’s service. Parents or carers were advised over the phone and by letter to bring the red books when attending the hospital. Immunisations would not be given unless the child’s red book was available. This meant that children’s health and developmental progress was readily available to all professionals involved in their care.

In the CQC Children’s Survey 2014 the trust scored 9.20 out of 10 for the question ‘Did a member of staff agree a plan for your child’s care with you?’ This was about the same as other trusts.

Engagement

The service had approached local schools and colleges to recruit adolescents as volunteers to the hospital, to assist in gaining feedback from children and young people using the service. In return, the volunteers were given work experience opportunities. The volunteer group had given feedback on the chaperone policy posters regarding them being understood by adolescents. The group had
also provided feedback on NHS England’s 15 Steps Challenge which is a toolkit that enables an understanding of care quality from a young person’s perspective, within 15 steps of walking on to a ward.

A parent group had been established to help both the service gain the views of children and their families of the care they received, but also to enable peer support from family to family. The clinical lead for the service produced a newsletter for all staff to keep them informed and engaged in the service.

Staff told us they were consulted on in the planning phase of the service redesign. This was evident as staff we spoke to all knew about and understood the upcoming redesign of the service.

Learning, continuous improvement and innovation

The implementation of the electronic system referred to under the heading of ‘Assessing and responding to patient risk’ in the ‘Safe’ domain has enabled clinical staff to monitor deteriorating patients more effectively and in a timely manner.

The matron for the service and a consultant were due to share their knowledge and work around high dependency care at a high dependency care in paediatrics conference. The acuity tool developed by the service, as referred to under the heading of ‘Nursing staffing’ under the ‘Safe’ domain, was being considered for roll out across the rest of the hospital and possible to other hospitals demonstrating interest in it.

The pre populated analgesia pilot on the neonatal unit demonstrated an improvement in outcome and service effectiveness by reducing the stay of new-borns requiring observations or antibiotics from 24 to four hours and allowing babies to remain with their parent(s).
End of life care

Facts and data about this service

Ipswich Hospital provides end of life care to patients across all clinical areas and treats patients with a variety of conditions, including cancer, stroke, cardiac and respiratory disease and dementia. End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services. The trust had 1,405 deaths between June 2016 and May 2017. (Source: Hospital Episode Statistics (HES))

Ipswich Hospital does not have a dedicated ward for end of life care. The specialist palliative care team (SPCT), which consists of specialist consultants and nurses, provide advice, assessment and treatment to patients across all clinical areas within the hospital. The SPCT also supports ward staff to deliver care to patients at the end of life.

The SPCT received 941 referrals from 01 October 2016 to 30 September 2017, 709 of these being for patients with a diagnosis of cancer. The SPCT was available five days a week, from 9am to 5pm, Monday to Friday. Outside these hours, advice was provided by the local hospice via telephone or in person if required.

A bereavement team provided support to relatives from Monday to Friday 8am to 4pm and a chaplaincy service was available to patients, relatives and staff, 24 hours a day, seven days a week. The director of nursing had responsibility for end of life care within the executive team.

The service was previously inspected in January 2015 and was issued with a requirement notice in relation to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Concerns included a lack of individualised end of life care planning, lack of staff training on end of life care, gaps in recording discussions with patients and families regarding end of life care and concerns around the documentation of patients’ mental capacity.

We completed a short notice inspection of the end of life care service on 19 and 20 September. We visited 11 wards, including the stroke unit, accident and emergency, medical wards, surgical wards and the ward at Aldeburgh community hospital. We also visited the mortuary and the chapel. We spoke with four patients and one patient’s loved one. We spoke with 38 members of staff including medical and nursing staff, allied health professionals, the SPCT, portering, mortuary and chaplaincy staff. We reviewed 16 patient care records, 14 Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms and information including policies, procedures and audits.

Is the service safe?

Mandatory training

The trust set a target of 90% for completion of mandatory training. Staff completed mandatory training through e-learning and face to face training. Data provided by the trust showed 83% of SPCT staff were up to date with mandatory training.

Staff completed training on end of life care as part of the trust’s mandatory training workbook. An annual report on end of life care training showed compliance with level one e-learning was 97% in
June 2017. We asked three staff about this training and two of them told us they had completed the training.

The SPCT provided ad-hoc ward based training for staff on end of life care. The SPCT were available to support ward staff with end of life care teaching for two hours every Wednesday afternoon.

**Safeguarding**

Safeguarding training was part of trust mandatory training and the trust set a target of 90% for completion. Information provided by the trust showed 86% of SPCT staff had completed safeguarding level one training, 86% had completed level two training and 100% had completed level three training. The information provided did not state whether these training rates related to adult or child safeguarding training.

All staff we spoke with understood their role with regard to keeping patients’ safe and reporting any potential safeguarding issues. Staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk.

Staff told us if they had any concerns they would speak to the trust safeguarding lead or their manager. This was in line with trust policy.

**Cleanliness, infection control and hygiene**

Mortuary staff completed training on infection control as part of trust mandatory training. Compliance with mandatory training for mortuary staff was 100%.

Mortuary staff completed competencies in ‘cleaning and decontamination’ and ‘working in the mortuary’. These competencies included assessment of compliance with cleaning procedures and infection control procedures during post mortem. Information provided by the trust indicated all mortuary staff had completed these competencies.

Staff took appropriate precautions when transporting deceased patients with transmissible infections. Stickers were used to alert staff to possible infection risks. Personal protective equipment was available for mortuary staff to use.

Staff were “bare below the elbow” and we observed staff using PPE appropriately when caring for patients receiving end of life care. A patient’s loved one told us staff “keep everything clean.”

In the mortuary and wards we visited, equipment such as trolleys and medical equipment were visibly clean. Audits of cleanliness showed some areas for improvement and action had been taken following the audit in June 2017. This audit noted that some areas for improvement would be addressed in the refurbishment programme. However, action that could be taken at an earlier date was undertaken by September 2017 when the action plan was reviewed.

**Environment and equipment**

Staff monitored fridge temperatures in the mortuary to ensure they were within required limits. Records dated 02 September 2017 to 02 October 2017, showed staff consistently monitored temperatures.

We checked five syringe drivers. All five were electrical safety tested and were in date for their next test.
Staff in the hospital equipment store told us there could be difficulties with return of syringe drivers for patients discharged from hospital this equipment. At the time of inspection there was only one spare syringe driver in the store. However, ward staff told us there were no problems in accessing equipment when needed. Staff in the equipment store told us they did a ‘sweep’ of the hospital to source equipment when needed.

The mortuary was in need of refurbishment. This was also noted at our last inspection in January 2015. Results of an infection prevention and control audit, dated 22 June 2017 highlighted concerns relating to the age of the mortuary environment. The audit concluded “the general condition of the department is poor” and “the infrastructure is old.” Senior staff had recorded the mortuary environment on the hospital risk register and had plans for a staged refurbishment. Actions were in place to address the issues identified in the audit.

Assessing and responding to patient risk

The trust had a system to identify patients in the last days of life. A blue butterfly symbol was used to indicate that a patient was near the end of life and to alert staff to be respectful of this. Ward staff told us that specialist support was available from the SPCT and confirmed that the team responded promptly to referrals.

Staff carried out risk assessments where appropriate for patients receiving end of life care, including waterlow scores (for assessing risk of pressure ulcers) and the malnutrition universal screening tool (for assessing risk of malnutrition).

A symptom assessment tool was used to identify symptoms including agitation, breathlessness and respiratory secretions. The form included advice for staff on what action to take and how to escalate concerns around patients’ symptoms.

The risks associated with patients with similar names being in the mortuary were minimised by patient passports, which highlighted the risk.

Nurse staffing

Specialist palliative care nurses were available Monday to Friday 9am to 5pm. Outside of these hours, specialist advice was available via telephone, or face to face if required, through an agreement with the local hospice. The SPCT completed a handover every morning, to review referrals and hand over relevant information about patients under their care.

Nursing staffing for the SPCT was in line with national guidance. The Association of Palliative Medicine for Great Britain and Ireland, and the National Council for Palliative Care recommends there should be a minimum of one specialist palliative care nurse per 250 beds. Information provided by the trust stated the trust has 613 inpatient beds, which would require at least 2.5 specialist palliative care nurses. The trust's SPCT consisted of 4.1 whole time equivalent (WTE) specialist palliative care nurses and 1.0 WTE lead cancer nurse. This was an improvement in staffing since our last inspection.

The SPCT did not have administrative support at the time of our inspection. Staff told us a business case had been approved to recruit a full time member of staff to support the team with administration and audit.

The mortuary service consisted of a service manager, a part time anatomical pathology technician, a full time trainee technician and a part time administration assistant. Total staffing for the mortuary was 4.6 WTE. There was one vacancy in the mortuary team.
The chaplaincy team consisted of 3.0 WTE chaplains and a part-time Roman Catholic chaplain (0.25 WTE). Information provided by the trust showed that there were 3.34 WTE vacancies in the chaplaincy team.

Total staffing for the bereavement team was 2.0 WTE. The service was provided by three part-time bereavement officers.

Between June 2016 and May 2017, the trust reported a vacancy rate of 3% in end of life care. This is better than the trust’s target vacancy rate of 5%. In the same time period the trust reported a sickness rate of 43% in end of life care; this is much higher than the trust target of 4%. However, such a high figure may indicate a smaller team size to other departments, where a member of personnel going sick has a much more noted effect on the overall percentage.

Between April 2016 and March 2017, the trust reported an annual average turnover rate of 4.5% in end of life care; this is better than the trust’s target annual turnover rate of 10%

**Medical staffing**

Consultant advice from the local hospice was available 24 hours a day, seven days a week via telephone.

However, consultant staffing was not in line with guidance from The Association of Palliative Medicine for Great Britain and Ireland, and the National Council for Palliative Care, which recommend there should be a minimum of one consultant to 250 beds. Information provided by the trust stated the trust has 613 inpatient beds, which would require at least 2.5 WTE consultants. The trust employed two part-time palliative care consultants (0.6 WTE). We did not find any evidence that the safety of care delivered to patients by the SPCT had been impacted by staffing.

A business case had been agreed to increase consultant staffing to 1.6 WTE, although this position had not been advertised at the time of our inspection. Palliative medicine has been recognised nationally as a difficult area to recruit into.

**Records**

Patients receiving end of life care had an individualised care plan, which included holistic assessment of physical, spiritual and psychological needs. This was an improvement since our last inspection.

Patients receiving end of life care had a symptom control form, which included assessment of common symptoms such as pain, agitation and respiratory secretions.

We reviewed 16 patient care records and found they were legible, signed and dated. Records contained assessments of patients’ needs, including physical needs, nutrition and hydration, spiritual and psychological needs. We saw care plans in place to meet these needs.

Records we reviewed showed that staff carried out risk assessments where appropriate for patients receiving end of life care, including waterlow scores (for assessing risk of pressure ulcers) and the malnutrition universal screening tool (for assessing risk of malnutrition).

SPCT staff audited use of the individualised care plan. Results of an audit in July 2017 showed 75% of patients who required a formal end of life care plan, had one of these plans in place.

**Medicines**
Staff prescribed anticipatory medicines for patients receiving end of life care. Anticipatory medicines are medicines prescribed for use on an "as required" basis to manage common symptoms that can occur at the end of life. Medicines were prescribed by ward based medical staff or by the specialist palliative care consultants. Nurses in the specialist palliative care team (SPCT) did not prescribe medicines.

Guidance on prescribing anticipatory medicines, dated August 2017 included advice for staff on which medicines to prescribe to manage common symptoms such as pain, agitation and respiratory secretions.

We reviewed 16 patient records and found that end of life medicines were prescribed and documented appropriately. We asked five nursing staff about prescribing of anticipatory medicines and all five told us doctors prescribed anticipatory medicines in a timely way.

Incidents

Never Events

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Between August 2016 and July 2017, the trust reported no incidents classified as never events within end of life care. (Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in end of life care which met the reporting criteria set by NHS England between August 2016 and July 2017. (Source: Strategic Executive Information System (STEIS))

Staff used an electronic system to report incidents in relation to end of life care. We asked six staff about incident reporting and all knew their responsibilities around reporting incidents relating to patients receiving end of life care. A member of staff on Somersham ward gave us an example of a recent incident they had reported in relation to a patient receiving end of life care.

Senior staff shared learning from incidents with ward staff through daily ‘huddle’ meetings and learning was documented in a staff folder on each ward. Staff gave us examples of learning from incidents related to end of life care. A nurse told us about an incident relating to delay in accessing medical support for a patient a night. Staff recorded this as an incident and had a joint meeting with nursing and medical staff to identify areas of learning.

Staff in the mortuary told us about an incident that occurred during a viewing, regarding the identity of a deceased patient. Staff reported this incident to the Human Tissue Authority and put a new process in place to prevent similar incidents. This included a sign in book and verbal checks with relatives before viewings. Meeting minutes for the end of life programme board dated July 2017 showed discussion of this incident and learning from it.

We asked five clinical staff about duty of candour and all five understood their responsibilities. The mortuary manager gave us an example of an incident where duty of candour had been applied. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.
Staff were aware of the trust’s major incident plan and the mortuary manager told us action cards were in place for each job role, in case of a major incident. Mortuary staff understood procedures to manage high risk, infectious patients.

The mortuary had capacity for 133 patients. Contingency plans were in place to increase capacity in the event of a major incident. The mortuary staff checked fridge space daily and escalated any concerns about capacity.

Is the service effective?

Evidence-based care and treatment

Staff completed individualised care plans for patients receiving end of life care. These care plans included individualised, holistic assessment, including assessment of spiritual and psychological needs. This was in line with national guidance including NICE guidelines on “Care of dying adults in the last days of life” (2015) and “Priorities of care for the dying patient” (2014) from the Leadership Alliance for the Care of Dying People. This was an improvement since our last inspection.

We reviewed 16 patient care records and found individualised care plans were well completed. Care plans included assessment of nutrition and hydration needs and discussion of spiritual and psychological needs with patients and their families.

The Leadership Alliance for Care of Dying People “Priorities for care of the dying patient” (2014) was included on the individualised care plan. The Leadership Alliance for the Care of Dying People promotes a consistent approach to end of life care through five key principles. This meant staff had access to evidence-based national guidance on end of life care when completing care plans.

Ward staff accessed guidance through the staff intranet. We asked five staff about end of life guidance and all could describe how to access this guidance using the palliative care ‘quick link’ on the intranet.

We reviewed four end of life clinical guidelines and found that they were version controlled, ratified and in date for review. For example, “Guidelines for use of the CME T34 Syringe Pump for adults” was dated May 2013 and was due for review in January 2018.

Staff at Aldeburgh community hospital had access to paper copies of “End of Life Guidelines” and “McKinley Syringe driver guidelines”. We reviewed both guidelines and found that they were version controlled, ratified and in date for review.

Specialist palliative care team (SPCT) staff had plans in place to trial the Supportive and Palliative Care Indicators Tool (SPICT) on Lavenham ward in October 2017. This is an evidence-based tool used to identify patients likely to be in the last 12 months of life.

The trust did not participate in any national accreditation schemes such as the Gold Standard Framework (GSF). The GSF provides training in relation to end of life care and an accreditation scheme for trusts.

SPCT staff completed local audits to monitor compliance with national guidelines. Staff told us about actions in place to support compliance with this guideline.
Ward staff referred patients to the SPCT through an online system. The SPCT received 941 referrals from 01 October 2016 to 30 September 2017, with 709 of these being for patients with a diagnosis of cancer.

Staff in the SPCT informally monitored their response times but did not formally audit this. Data provided by the SPCT showed that from April 2017 to June 2017 the percentage of patients assessed within 48 hours ranged from 78% to 90%.

**Nutrition and hydration**

Nutrition and hydration needs were included in patients’ individualised care plans. We saw evidence in patients’ records that nutrition and hydration needs for patients were met. The individualised care plan included prompts for nutrition and hydration assessment, mouth care and swallowing difficulties. Records we reviewed showed that staff completed the malnutritional universal screening tool for patients where appropriate.

Staff we spoke to understood nutrition and hydration requirements of patients receiving end of life care. Staff were aware of the importance of providing patients with mouth care to ensure their comfort in the last days of life.

Dieticians and speech and language therapists were available across wards to provide support with patients’ nutritional and hydration needs where required.

**Pain relief**

Staff had updated the ‘Symptom Control form’ since our last inspection. The form included a ‘Red, Amber, Green’ rating for pain and included prompts for staff to consider patients’ comfort and advice for staff on what action to take and how to escalate concerns around patients’ pain control.

The SPCT consultants and nurses had specialist knowledge and were able to provide guidance to staff on the most appropriate management of patients’ pain in the last days of life. We saw records of assessments carried out by the SPCT which included detailed assessments of patients’ pain.

We reviewed 16 patient care records for patients received end of life care and found that anticipatory medicines were prescribed appropriately to manage patients’ symptoms. Where appropriate, patients had syringe drivers, which delivered measured doses of drugs over 24 hours.

A specialist pain team was available from Monday to Saturday to provide additional advice and support for staff in managing patients’ pain.

We observed staff asking patients about pain and offering pain relief in a timely way. One patient told us that the staff response to requests for pain relief was good. A patient’s loved one told us staff were “on top of it” in relation to managing the patient’s pain.

**Patient outcomes**

**End of life care Audit: Dying in Hospital**

The trust participated in the End of life care Audit: Dying in Hospital 2016 and performed worse than the England average for all five of the five clinical indicators. The trust scored particularly poorly for the clinical indicator asking ‘Is there documented evidence that the needs of the
person(s) important to the patient were asked about?’

The trust answered yes to six of the eight organisational indicators

(Source: Royal College of Physicians)

In the latest “End of Life Care Audit: Dying in Hospital”, published in March 2016 by the Royal College of Physicians, the trust met none of the five clinical outcomes and achieved six of the eight organisational outcomes. The trust formulated an action plan following the audit which was signed off through the governance systems. This was monitored through the Patient Safety and Effectiveness Committee but later through the End of Life strategy programme and latterly through the End of Life programme board. We reviewed minutes of these meetings and found that the trust identified four work streams; fast track, improving communication, measurement and education and training through which the action plan was monitored.

Senior staff and SPCT staff told us that actions from this audit had been integrated into the new end of life strategy, which was monitored through the End of Life Programme Board. We saw the end of life care strategy, which included local priorities, outcomes and measures of success with defined timeframes.

Staff had taken action to make improvements following the audit. For example, the trust had not met the organisational outcomes “Is there a lay member on the trust board with a responsibility/role for end of life care” and “Access to face-to-face specialist palliative care for at least 9-5 Monday to Sunday.” In response to this, the trust had appointed a non-executive director for end of life care and had increased staffing in the SPCT, with a plan to extend working hours to Monday to Saturday and bank holidays in 2018 (although hours had not been extended at the time of our inspection).

The trust scored 29% for the clinical indicator “Is there documented evidence in the last 24 hours of life of a holistic assessment of the patient’s needs regarding an individual plan of care” compared to the national average of 66%. The trust had introduced an individualised end of life care plan and SPCT staff completed ad-hoc local audits, which showed improvements.

Results of a local audit of end of life care in March 2016, showed improvements in the quality of end of life care. Reported improvements included, end of life care plan use (70%), documentation of MDT involvement in recognition of dying (88%), involvement of patients with their plans for end of life care (60%), relative and patient involvement in discussing DNACPR (93% and 92%) and documentation of mouth care (83%).

The SPCT completed a ‘Brief assessment of compliance with completion of end of life care plans’ in July 2017. This looked at staff identification of patients in the last days of life and completion of end of life care plans for these patients. Results showed 75% of patients who required a formal end of life care plan, had one of these plans in place. Staff had an action plan to improve outcomes, including timescales and accountabilities.

Competent staff

SPCT staff had carried out “A baseline assessment of trust wide proactive identification of end of life care needs and non-specialist palliative care delivery (a service assessment)” in 2016. This was a baseline assessment focused on early identification of patients that might benefit from early intervention, discussion and planning. Staff had an action plan from this assessment, which included a trial of the Supportive and Palliative Care Indicators Tool (SPICT) to assist staff in
identifying patients likely to be in the last 12 months of life. A pilot of this tool was planned on Lavenham ward in October 2017.

SPCT staff told us they had reviewed job descriptions for all staff to identify what level of training in end of life care would be appropriate for each staff group. The annual report for end of life care training from July 2016 to August 2017 confirmed a training needs analysis had been completed and SPCT staff were monitoring staff compliance with end of life care training.

The annual report for end of life care training showed staff compliance with ‘level one’ end of life care training was 97% in June 2017. This training was delivered through e-learning and was part of the trust’s mandatory training booklet.

The annual report for end of life care training showed SPCT staff had delivered 13 sessions of ‘level two’ enhanced training to staff from October 2016 to August 2017. An overall figure for compliance with level two training was not provided. The report stated that a business case would be put forward to make level two face to face training mandatory for all key clinical staff. This was also included in the end of life care strategy, which stated “By June 2018, 80% of clinical staff will have received enhanced training.”

Junior doctors received end of life care training from the SPCT and bereavement team as part of their induction. Training from the bereavement team included guidance on completing death certificates for deceased patients. We saw an information handout created by the bereavement team to support this training.

Data provided by the trust showed 71% of SPCT staff had completed an appraisal in the last year. SPCT maintained their competency through attending training relevant to their speciality. For example, one specialist nurse had recently attended cognitive behavioural therapy training. SPCT staff had monthly supervision where they had the opportunity to de-brief with a trained counsellor.

Two nurses at Aldeburgh community hospital had recently undertaken a verification of death course, which enabled them to verify expected deaths.

All wards we visited had an end of life ‘ambassador’ who was responsible for updating staff with information on end of life care. This was in line with the trust’s end of life care strategy. SPCT staff told us any member of staff could become an ambassador, including nurses, health care assistants and allied health professionals. Staff were aware of the ambassadors for their wards.

Mortuary staff had monthly team meetings, where staff received feedback on incidents and updates on national guidance. Meeting minutes from July 2017 to September 2017 showed standing items on the agenda including discussion of incidents, complaints, national guidance and ‘topic of the month.’

SPCT staff offered regular study days and were available to support ward staff with end of life care teaching for two hours every Wednesday afternoon. This training was arranged with senior nurses depending on the needs of their staff. On the day of our inspection, the SPCT had completed end of life care training for staff on Woodbridge ward. A member of staff on Sprroughton ward told us about workshops they had received and a member of staff on Lavenham ward told us about future training sessions they had planned with the SPCT.

The SPCT offered drop in sessions for students twice a month on a Monday, to support students with learning around end of life care.

Staff had taken part in a series of educational activities as part of ‘Dying Matters’ week in May 2017. SPCT staff arranged a study day in partnership with the local hospice and chaplaincy staff organised activities such as creating a ‘bucket list’ to help break the taboo of talking about death...
and dying. Chaplaincy staff told us the week also included training from external partners such as funeral directors, to help improve awareness of their role in end of life care.

Chaplaincy staff developed a training programme to support volunteers in the hospital. This included topics such as working with patients living with dementia and listening skills. Staff in the chaplaincy had also arranged to provide teaching about end of life care for undergraduate nurses and paramedics at the local university in December 2017.

Porters completed a two day induction programme, which included training on end of life care. We viewed an example of the induction booklet, which included topics such as “Dignity at the centre of everything you do” and “Communicating with compassion.”

There were inconsistencies in syringe driver training across the trust. On Sproughton ward, staff told us that training on the use of syringe drivers was formally completed as a medical devices competency and that staff completed a three yearly self-assessment of competence. However, one member of staff on Kirton ward and two on Somersham ward told us that syringe driver training was not formally completed or monitored but staff were trained on an ad-hoc, one to one basis. Records dated October 2017 showed 53% of registered nurses, advanced clinical practitioners and operating department practitioners had completed medical devices training.

**Multidisciplinary working**

The SPCT received referrals from multiple sources, including nursing, medical and allied health professionals, patients and relatives. Nursing staff we spoke to felt confident to refer to the SPCT for advice and support.

SPCT staff and chaplaincy staff attended daily handover meetings to review referrals and discuss care of patients.

Chaplains, SPCT staff and ward staff told us they had good working relationships with each other. One doctor said the response from the SPCT was “very good” and a nurse said the SPCT was “available for support” when needed. Ward staff we spoke to were aware of the chaplaincy service and its role.

Staff discussed plans of care for patients at a weekly palliative care multidisciplinary team meeting. This was attended by the SPCT consultants and nurses, patient pathway coordinators, counsellors, chaplains and a specialist nurse from the local hospice.

Staff had effective working relationships with the local hospice. Chaplaincy staff told us they worked closely with chaplains at the local hospice and visited patients who were discharged to the local hospice to ensure continuity of care. There was an agreement in place with the local hospice to provide specialist palliative care support to ward staff outside the working hours of the SPCT.

SPCT staff worked with other providers to develop standardised practice in end of life care. We saw a policy for ‘Just in case medicines’ which staff had developed as part of the regional end of life care group.

The trust did not use the electronic palliative care co-ordination system (EPaCCS). SPCT staff told us this system had been trialled but there was limited uptake of the system by community providers.

SPCT staff and the executive lead for end of life care told us they were planning on rolling out the SPICT tool to assist staff across the hospital and community services in identifying patients in the last year of life. A pilot of this tool was planned to take place on Lavenham ward in October 2017 and roll out of the tool was included in the end of life strategy. However, this was not in place at the time of our inspection. This meant there was no clear system for the trust to coordinate end of
life care, including the preferences and wishes of patients, with other healthcare providers and services.

Seven-day services

The SPCT did not provide a seven-day service. The SPCT was available Monday to Friday 9am to 5pm. Staff could access specialist advice outside these hours from the local hospice. This advice was available via telephone or, if required, face to face. SPCT staff told us a consultation was underway to extend the SPCT service to include Saturdays and bank holidays in 2018.

The chaplaincy service was available 24 hours a day, seven days a week. Chaplains of all faiths could be accessed, through the chaplaincy staff employed at the trust. The chapel was open 24 hours a day, seven days a week for staff, patients and visitors to access.

Mortuary staff facilitated viewings for families 24 hours a day, seven days a week. This service was arranged via an on-call rota, outside the standard opening hours of 8am to 4.30pm Monday to Friday. The bereavement team was available from Monday to Friday, 8am to 4pm.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

The trust provided training data covering from June 2016 to June 2017. There are no records pertaining to Mental Capacity Act or Deprivation of Liberty training. At the time of writing this report no data was available.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

We reviewed 14 Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms and found that these included records of discussions with patients and relatives regarding DNACPR decisions. One form did not have a clearly documented assessment of the patient’s mental capacity and we raised this with ward staff at the time of inspection. An appropriate senior clinician had signed the DNACPR forms we reviewed.

Records of DNACPR audit results from January 2014 to September 2017 showed a general trend of improving compliance with DNACPR form completion. In January 2014, compliance was 38% and in September 2017 compliance was 92%. Wards with low compliance were highlighted so that ‘spot checks’ could be completed before the next audit.

We asked two patients about consent and both told us that staff gave an explanation and asked permission before carrying out procedures. Staff understood the importance of including patients and their families in discussions around escalation of care and resuscitation.

Three junior doctors raised concerns about the timeliness of consultants’ decision making around DNACPR and escalation of care in surgical specialities. We did not see evidence that patient safety had been impacted by this, however the junior doctors told us they were sometimes required to have sensitive discussions with patients and relatives while on call overnight because decisions had not been made during the day. We raised this with senior leaders at the time of inspection.

Is the service caring?

Compassionate care
Staff treated patients with compassion, dignity and respect. Medical and nursing staff we spoke to were aware of the importance of treating patients receiving end of life care and their visitors in a sensitive manner.

Staff worked to meet patients’ wishes and bring them comfort in the last days of life. Specialist palliative care team (SPCT) staff told us how arrangements were made to bring a patient’s dog to visit them on Somersham ward, in the last days of the patient’s life. SPCT staff told us that weddings were frequently arranged for patients receiving end of life care, who wished to get married.

Chaplaincy, bereavement and mortuary staff were passionate and committed to ensuring that patients were cared for with dignity and respect, both before and after death. Chaplaincy staff told us how they facilitated a ‘pause for thought’ for patients that died following attempted resuscitation in the emergency department. This was a time when staff would be asked to pause for a moment to acknowledge and respect the life of the deceased person.

A nurse on Sproughton ward told us how the porters acted with respect for the privacy of the deceased. For example, they would close all the doors on the ward as a mark of respect and to ensure maximum privacy when transporting the deceased patient to the mortuary. Porters used concealment trolleys to maintain the dignity of the deceased patient during transport to the mortuary.

A ward sister told us about a situation where the police were involved in an investigation relating to a patient receiving end of life care. The ward sister minimised the number of staff looking after the patient, which meant that the patient’s privacy was protected and the patient received continuity of care at the end of their life.

A senior member of staff told us about an instance where a patient’s family had arranged for their funeral procession to pass the hospital and staff had opened the doors and gathered to pay their respects.

All four patients we spoke to were positive about the care given by staff. One patient told us they felt safe and said staff respond “straight away” and another said staff were “always checking on me.” Another patient described staff as “Friendly, compassionate, helpful.” A patient’s loved one told us “Staff have been amazing” and told us they had received good communication from staff.

Staff on Shotley ward showed us cards and letters with positive feedback from patients’ relatives. One said “Thank everyone for the amazing care given….and the consideration to family. None of you could have been kinder” and another said “When it came to end of life care the sensitivity that was shown by all staff was greatly appreciated.”

**Emotional support**

The trust had a range of clinical nurse specialists to support patients with identified conditions, including cancer, respiratory disease and dementia.

The individualised care plan included assessment of psychological and spiritual needs. We reviewed 16 patient care records and found that the care plans were well completed.

The chaplaincy service provided emotional support for all patients, relatives and staff, of all faiths and none. Chaplaincy staff provided pastoral care before and after a patient’s death. For example, they told us about when they had supported patients’ families by conducting funerals for patients that had been under their care in the hospital.
Chaplaincy staff told us how they supported staff with breaking bad news and provided support to patients’ families during formal identification of deceased individuals.

Staff signposted bereaved relatives to emotional support services. The bereavement team gave bereaved families a guidance booklet. This outlined what to expect following the death of a loved one, and signposting to relevant information and support, including counselling services provided by external providers.

Staff on some wards, for example critical care, routinely provided a follow-up call to bereaved relatives. This did not take place on all wards. However, the executive lead for end of life care told us that they planned to roll this service out to all wards and we saw this was included in the end of life strategy.

Staff had access to a dedicated telephone line for emotional support. Staff could also access up to six sessions of formal counselling. One member of staff told us they had accessed this service and had found it helpful.

SPCT staff told us they could access a family support worker to provide support for patients and their relatives.

The chaplaincy service facilitated regular ‘Coffee and Catch up’ sessions for staff, where staff could discuss the emotional impact of providing end of life care. We saw an advert for one of these sessions on the chaplaincy noticeboard and chaplains gave us an example of a recent session they had organised for staff following a cardiac arrest. A nurse told us about how they had arranged for the chaplaincy staff to support staff on the ward following a distressing situation where a patient receiving end of life care was part of a police investigation.

Staff could book one to one sessions with the chaplains, however two chaplains told us that finding a private space to meet staff could sometimes be difficult. This had been raised with the estates team.

Understanding and involvement of patients and those close to them

Staff supported relatives to spend time with patients receiving end of life care. Visiting hours were open for relatives of patients receiving end of life care and ward staff made arrangements for relatives to stay overnight with patients if they wished to.

Staff in the SPCT told us how staff had arranged for a couple receiving care at the hospital to be cared for in a larger side room so that they could stay together. A nurse on Sproughton ward told us that after a patient’s death family were allowed to stay with the deceased patient for as long as they needed.

A ward clerk told us it was important to show empathy to the relatives of patients receiving end of life care. They described how they supported relatives and ensured that relatives were given time to ask questions when they called the ward.

Chaplains were passionate about supporting bereaved relatives. Two chaplains told us they provided impartial pastoral support to relatives and would accompany relatives to meetings with clinical staff if requested.

The trust had a ‘carer’s cabin’, which was run in partnership with a local charity. This cabin, situated outside the hospital, was open from Monday to Friday and offered carers free refreshments and the chance to drop in for emotional support and signposting to services.
The individualised care plan included prompts for discussing care with patients and relatives. Staff we spoke to understood the importance of including patients and relatives in discussions about care. One patient we spoke to said their family was involved in discussions “as much as they wanted.”

Mortuary staff had a visitors book which included an area for feedback to staff from visitors to the mortuary.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

There was no dedicated ward for end of life care. Patients receiving end of life care were cared for across all clinical areas and ward staff were supported by a specialist palliative care team (SPCT).

All staff we spoke with told us patients approaching the last days or hours of life were, wherever possible, given the option of being cared for a side room, to protect their privacy and dignity. Staff confirmed that side rooms could usually be accessed when required. One side room on Woodbridge ward included sensory equipment, which provided a calming environment for patients.

There were no visiting restrictions for visitors to patients receiving end of life care. Staff made arrangements for relatives to stay overnight if needed. On Lavenham ward and Woodbridge ward, recliner chairs were available in side rooms to allow relatives to stay with their loved ones.

The bereavement office had a dedicated relatives room, which was a quiet environment decorated in calming colours where relatives could meet bereavement officers following the death of a patient. There were two free parking spaces available for bereaved families to use when visiting the bereavement office.

Chaplaincy staff had daily handover meetings each morning to ensure that all patients requiring pastoral support were visited. The mortuary offered viewings 24 hours per day, seven days per week.

SPCT staff told us they had met with representatives from local Gypsy and Traveller communities and were taking part in a project aimed at providing better care to patients from these communities at the end of life. Staff told us regional funding had been approved to put together a DVD to support this project.

Three staff told us there were sometimes delays in completion of death certificates and cremation documentation. We saw a complaint relating to the length of time a relative had to wait for cremation documentation. Staff in the bereavement office had started an audit in July 2017 in response to delays. Audit results for August 2017 showed that out of 95 death certificates, 25 were completed within 24 hours, 23 were completed within 3 days and 27 took over 7 days to complete. Twenty records were not included due to insufficient documentation. Staff were aware of causes of delays and told us they escalated any delays to the medical director and tried to facilitate completion of certificates by taking the certificate to the ward to be signed when needed.

Senior leaders were aware of concerns around delays in completion of death certificates and cremation documentation. They told us analysis had been completed to identify reasons for delay and they had plans to improve efficiency of the system. Timely completion of death certificates
was included as an objective in the end of life care strategy and meeting minutes showed this was discussed at the end of life programme board on 22 August 2017.

**Meeting people’s individual needs**

Staff were passionate about meeting patients’ individual needs. A nurse on Sproughton ward told us about support they provided to a patient’s relative, who had learning disabilities. The nurse told us how they took time to explain to the patient’s relative what to expect when the patient reached the end of their life and how they organised a key worker to support the relative after the patient’s death.

The executive lead for end of life care confirmed that the hospital did not audit preferred place of death or care (PPD/PPC). This meant there was no way to measure how many patients had received care and died in their preferred place. However the local CCG monitored this information and shared this with the trust. The minutes of these meetings demonstrate that due to the IT systems used by the hospital they were unable to accurately identify all patients who were at the end of their life. The IT department was working with the system to review ways in which this could be accurately captured. The trust put in place paper based systems to try to capture this information whilst IT systems were developed.

The meeting preferred place of care at end of life work stream identified four areas where services could be improved. These revolved around the services provided by others which would impact upon the admission and discharge of end of life care patients. The trust sought to work with these groups of healthcare professionals to ensure that patients where possible were cared for in their preferred place of death. The director of nursing suggested that an audit be undertaken retrospectively to identify if patients were cared for in their preferred place of care following their death. The outcome of this audit is still awaited.

SPCT staff told us how they had allocated extra car parking spaces for visitors of a patient from the Traveller community who had a large number of relatives wishing to visit the patient at the end of their life.

There was a multi-faith chapel and a multi-faith garden called ‘The Oasis’, which patients and relatives could access. One patient told us they had requested to go to a service at the chapel and staff had facilitated this, with a nurse accompanying the patient and staying with them during the service to ensure their wellbeing. Chaplaincy staff provided communion for any patient that requested it each Sunday.

The chaplaincy noticeboard contained information on different religious beliefs and also contained information on how to contact faith and belief group leaders from the local community. Chaplaincy staff kept a list of contacts for leaders from a variety of faiths, so that they could be contacted to visit patients where required. A nurse on Sproughton ward told us about a time they had invited a local religious leader to perform last rites for a patient, in line with the patient’s wishes.

Staff were sensitive to the spiritual and religious needs and preferences of patients. A chaplain told us about an occasion when they arranged for a male chaplain to visit the patient, in line with the patient’s religious beliefs. A nurse on Sproughton ward told us how a patient’s bed had been moved to face in a certain direction, as this was important to the patient in terms of their religious belief.

Staff in the mortuary told us they would facilitate specific religious needs where requested. The mortuary had equipment appropriate for bariatric patients. A cold mattress was available to facilitate viewings of babies.
Staff provided information leaflets about end of life care to relatives. Information leaflets included “Care in the last days of life” and “Facilities available to those visiting a terminally ill patient.” After the death of a patient, staff gave relatives a bereavement pack, which included practical advice on obtaining a death certificate and registering a death, and also advice on support services.

Staff could access translation services for patients who did not speak English. One member of staff told us how they made boards of symbols with key words as an additional way of helping patients and family members communicate.

**Access and flow**

There were 941 referrals to the SPCT from 01 October 2016 to 30 September 2017. The service accepted referrals from any staff member, patient or relative. The fast track discharge of patients in the last days and weeks of life was coordinated by discharge coordinators.

Information provided by the trust showed that out of 112 requests for fast track (rapid discharge) care packages from 1 March 2017 to 25 September 2017, 104 were put in place, one request was rejected and seven packages were not arranged before the patient died. Staff told us that delays could be caused by difficulties in accessing care in the community.

The mortuary had 133 spaces. There were arrangements in place to increase this capacity if required. Information provided by the trust showing the four wards with the highest number of non-clinical bed moves from 01 March 2017 to 01 July 2017 stated that none of the patients moved were receiving end of life care.

**Learning from complaints and concerns**

**Summary of complaints**

Between June 2016 and June 2017 there were 16 complaints about end of life care. The trust took an average of 65 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be dealt with within 28 days of receipt of the complaint. Two of the complaints lack resolution dates.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

The chief executive of the trust wrote to all families of patients that died in the hospital to express their condolences and to ask for feedback in terms of any concerns. The trust received 16 complaints about end of life care from June 2016 to June 2017.

Staff in the SPCT reviewed all complaints relating to end of life care and identified themes in complaints. Staff told us themes included communication, DNACPR decisions and discharge of patients. Staff told us these themes had been incorporated into the new end of life care strategy.

All complaints relating to end of life care were discussed at the programme board for end of life care and shared with the patient and carer experience group. Programme board meeting minutes dated from November 2016 to August 2017 showed discussion of compliments and complaints was a standing item on the agenda.
Senior staff on Kirton ward and Lavenham ward told us about recent complaints relating to patients receiving end of life care and the actions taken relating to these, including sharing of learning.

We saw an incident and complaint file on Lavenham ward, with information on incidents and complaints received from July 2017 to September 2017. This included a summary of incidents, complaints and lessons learned.

**Is the service well-led?**

**Leadership**

The director of nursing was the executive lead for end of life care. The director of nursing chaired the programme board for end of life care, which met every month, and was responsible for oversight of the end of life care strategy.

There was a named non-executive director with responsibility for end of life care. This was an improvement since our last inspection and was in line with the “More Care, Less Pathway” report (2013) from the Department of Health (DH), which recommended that all healthcare organisations appoint a non-executive member of the board to oversee end of life care.

There was an established multidisciplinary specialist palliative care team (SPCT). The palliative care consultant and palliative care nurses demonstrated good leadership and ward staff we spoke to knew who they were and reported positive working relationships with the team.

Chaplaincy and mortuary services were well-led, with staff feeling supported and concerns escalated appropriately from managers to executive leads.

**Vision and strategy**

The trust had a clear vision and strategy for end of life care from 2017 to 2022, which was due to be formally launched to staff on 19 October 2017. The strategy was evidence based and included reference to key national guidance, including “One Chance to get it Right” (2014). Staff in the SPCT were clear about the end of life care strategy and understood their role in delivering it.

The end of life care strategy included defined local priorities, outcomes and measures of success. The executive lead for end of life care told us the strategy was based on results from the “End of Life Care Audit: Dying in Hospital” national audit, published in March 2016 by the Royal College of Physicians

The SPCT engaged staff in the development of the end of life care strategy by asking staff to describe how they thought end of life care at Ipswich hospital should be. The words used by staff were displayed on the front of the strategy document in the shape of a butterfly (the symbol used throughout the hospital to indicate end of life care). Words chosen by staff included “dignified” “comfortable” and “peaceful.”

Information provided by the trust stated “We recognise end of life care as a major challenge and so have set a target within our trust strategy to reduce significantly the number of patients who die in hospital.” Staff in the SPCT told us the chief executive considered end of life care to be a priority. Was saw records to show that end of life care was one of five “Quality Improvement Priorities” for the trust in 2017-2018.
Staff we spoke to were aware of the trust values, which were “Respect, Kindness, Listen and involve, Professional, Efficient and Improving together.” Three staff we spoke to told us about the trust values and the importance of these values in delivering end of life care.

Culture

Staff were passionate about delivering end of life care. Staff on Sproughton ward and Shotley ward told us they were proud of the end of life care they delivered. Staff described supportive working relationships between ward staff, chaplains and the SPCT.

Chaplaincy staff were highly dedicated to supporting patients, relatives and staff despite the limited number of staff in the chaplaincy team.

Governance

The hospital was part of a regional palliative and end of life care committee. This was a cross-sector committee, which met on a three monthly basis and was attended by the SPCT and representatives from the local hospice, GP out of hours service and clinical commissioning group among others. Minutes from this meeting dated from September 2016 to June 2017 showed representation from a variety of organisations involved in end of life care and included discussion of end of life guidance and policy.

A programme board for end of life care took place monthly. This was led by the director of nursing, who was the executive lead for end of life care. The programme board included representatives from staff across the hospital and included work streams focused on key priorities for end of life care, including ‘education and training’, and ‘sharing and measurement’. Complaints and compliments were discussed at the Programme board.

Senior leaders were aware of priorities for end of life care in the trust, including staff training, individualised care planning and meeting patients’ preferred place of care. Staff we spoke to were aware of the trust’s priorities around end of life care.

Management of risk, issues and performance

The portering manager showed us a risk assessment for the transportation of deceased patients. This included possible risks, including moving and handling and clear actions to mitigate risk.

We were not assured that senior staff had oversight of all incidents relating to end of life care. SPCT staff were unable to tell us how many incidents related to end of life care there had been in the last year, due to the way incidents were categorised. Meeting minutes from the end of life programme board dated from November 2016 to September 2017 showed discussion of incidents was not a standing item on the agenda. This meant opportunities for senior staff to identify and discuss themes relating to end of life care incidents could be missed. We raised this with senior staff at the time of inspection. After our inspection, the trust provided records of all incidents relating to end of life care in the last six months.

Staff recorded risks relating to end of life care on divisional risk registers and senior staff gave us examples of risks relating to end of life care. However, there was no risk register specific to end of life care, which meant senior staff did not have a single document to provide an overview of risks around end of life care across the trust. We raised this with senior staff at the time of inspection.

Information management
SPCT staff received referrals via an electronic referral system and could also be contacted via telephone. Staff across the trust could access information from the intranet, including policies and national guidance. Staff we spoke to knew how to access information on end of life care through the intranet and through paper documentation on the wards.

We saw end of life care packs on wards, which included documentation, such as symptom control forms, individualised care plans and information for relatives.

**Engagement**

Staff engaged patients and carers in the development of end of life care services. Meeting minutes from the end of life programme board dated June 2017 showed senior staff had arranged a patient forum to gain feedback on the end of life care strategy before it was launched.

Staff told us how they used “Dying matters” week as an opportunity to engage with patients and the public. For example, two chaplains told us how they had used this forum to engage people in talking about end of life care and tried to break taboos surrounding death by asking people to write their ‘bucket list.’ We saw a display of these ‘bucket lists’ in one of the main corridors in the hospital.

Staff in the SPCT told us about an open day, which was planned for 19 October 2017. Staff told us this would coincide with the launch of the new end of life care strategy and would include market stalls with information to engage and inform the public about end of life care at the hospital.

The trust met the organisational indicator “Did your trust seek bereaved relatives’ or friends’ views during the last two financial years?” in the “End of Life Care Audit: Dying in Hospital” national audit, published in March 2016 by the Royal College of Physicians. The chief executive sent a letter to the relatives of any patient that died, to express their condolences and ask for feedback on the service. However, there was no formal bereavement survey, to gather the views and experiences of bereaved relatives.

All the wards we visited had end of life care ambassadors, who assisted with sharing information on end of life care.

Mortuary staff were included in trust-wide discussions around end of life care. We reviewed meeting minutes for the end of life programme board and saw that the mortuary manager attended these meetings and contributed to discussions. This was an improvement since our last inspection.

**Learning, continuous improvement and innovation**

We saw evidence of staff in the SPCT using innovative approaches to improve staffing of the service. The team had recently supported a Band 6 ward nurse to develop into a Band 7 specialist palliative care nurse following difficulties in recruiting to the SPCT. Staff told us how they supported this staff member with a structured learning programme.

Staff in the mortuary told us that a three phase improvement was planned and a business case for this project had been approved. This plan included upgrades to the waiting area for family and the viewing area.
Community health services

Community health inpatient services

Facts and data about this service

Since October 2015, Ipswich Hospital NHS Trust has been registered to provide community inpatient services from three community hospitals across East Suffolk: Aldeburgh Community Hospital, Bluebird Lodge Community Hospital and Felixstowe Community Hospital.

Until 30 September 2017, the trust provided community inpatient services in partnership with two local NHS trusts and a GP federation. From 1 October 2017, Ipswich Hospital NHS Trust became the sole provider of community inpatient services.

The trust has 64 inpatient beds across the three community hospitals, providing rehabilitation and enablement care. The services are delivered by nurse-led multidisciplinary teams. All community hospitals accept both ‘step up’ patient admissions, transferred from primary care services, and ‘step down’ admissions, transferred from acute beds. The hospitals also provide palliative care placements for patients who are unable to be supported at home.

During the inspection, we visited all three community hospitals. We spoke with five patients and 21 members of staff including matrons, nursing staff, medical staff, pharmacy, administrative staff, therapy and domestic staff. We observed care and looked at 10 sets of medical records. We also looked at a wide range of documents including policies, standard operating procedures, meeting minutes, action plans, risk assessments and audit results. Before our inspection, we reviewed performance information from, and about, the trust.

We have not inspected community inpatient services since they registered with the provider. We announced our intention to inspect community services one day prior to our visit. We inspected the service on 21 September 2017, during an interim period, 10 days before the service became exclusively managed by Ipswich Hospital NHS Trust.

Is the service safe?

Mandatory training

At the time of our inspection, mandatory training was delivered in partnership with two local NHS trusts and a GP federation. In October 2017, Ipswich Hospital NHS Trust began managing the delivery of all mandatory training. The trust set up working groups to map out how the new training programme would look for community staff.

Staff completed a number of mandatory training modules as part of their induction and updated them in line with the training policy. Mandatory training included basic life support, equality and diversity, fire safety, moving and handling, prevent and conflict resolution. Training was mostly delivered through an online e-assessment, but there were also practical training days for staff to complete face to face training when needed.
Modern matrons monitored training and would notify staff when their training was due for renewal. Staff were positive about the training they received and were supported to attend additional training if relevant to their role.

As of September 2017, mandatory training compliance was 86.1% at Bluebird Lodge Community Hospital, 96.1% at Felixstowe Community and 90.8% at Aldeburgh Community Hospital. The trust target for mandatory training compliance was 95%. All nursing staff had received intermediate life support training. All healthcare assistants and administration staff had received basic life support training.

**Safeguarding**

Community inpatient services had safeguarding systems and processes in place to ensure that people were kept safe. Staff followed up-to-date safeguarding policies for adults and children, based on statutory guidance within the Care Act 2014. Safeguarding flow charts were displayed at each site, outlining the process to follow should staff have any safeguarding concerns.

Staff knew what the term safeguarding meant and how to recognise signs of abuse. They could explain the reporting process and knew how to seek support if needed. All staff could name the safeguarding lead and several could give examples of when the lead had specifically supported them. From October 2016 to April 2017, staff made 24 adult safeguarding referrals across their community services.

Safeguarding training was part of the mandatory training programme and included information on female genital mutilation and child sexual exploitation. As of September 2017, 94.3% of community staff had completed safeguarding vulnerable adults training and 98.2% had completed safeguarding children Level 1 and Level 2 training.

PREVENT is a government-led training programme, designed to identify and prevent the threat of terrorism. From September 2017, 73.5% of staff had completed PREVENT training at Bluebird Lodge and Felixstowe community hospitals. The trust sent no PREVENT training data for Aldeburgh Community Hospital.

**Cleanliness, infection control and hygiene**

Infection control practice was monitored through the infection control group, chaired by the Director of Nursing. The group discussed infection control audit results, such as hand hygiene audits, and recommendations were fed back to community staff.

All community areas, including the patient bays, clinical areas, day rooms and gymnasium, were visibly clean. Signed cleaning schedules were in place and housekeeping staff cleaned the departments daily. Staff labelled equipment with ‘I am clean’ stickers to indicate that it was ready for use.

All clinical areas had vinyl flooring, in line with best practice guidelines from the Department of Health. Some corridors and day rooms were carpeted. There was a process in place to ensure that all carpeted areas received a deep clean every six months (or when soiled), to minimise the risk of infection.

We observed staff to be complying with best practice with regard to infection prevention and control policies. All staff participated in infection control training as part of their annual mandatory training. As of September 2017, 87.9% of community staff had completed the training, against a trust target of 95%.
Domestic and clinical waste was disposed of correctly. We saw appropriate facilities for the disposal of clinical waste and sharps (such as needles) in clinical areas. The hospitals had different coloured bins to clearly identify categories of waste, in line with current legislation. Each inpatient unit had single room facilities in order to isolate patients deemed potentially infectious.

All infection cases were reported on the electronic reporting system. From October 2015 to September 2017, five cases of *C. difficile* were identified in community hospitals; one case at Aldeburgh Community Hospital and four cases at Felixstowe Community Hospital. Three of the cases at Felixstowe were identified to be of the same strain, indicating cross-contamination. The outbreak was reported as a serious incident and the hospital was closed for nine days. The Head of Infection Control formulated an action plan and as a result there have been changes in practice. For example, patient clothing was no longer laundered on site, reducing the risk of cross-contamination.

Staff followed the trust’s ‘bare below the elbow’ policy when providing care. Hand sanitiser points were widely available to encourage good hand hygiene practice. Personal protective equipment (PPE), such as gloves and aprons, was accessible for staff in all clinical areas to ensure their safety and reduce the risk of cross-infection when providing care. We saw staff using PPE appropriately.

**Environment and equipment**

The ward environments varied between community hospitals. Bluebird Lodge Community Hospital was a 28 bedded unit, spanning over three floors. Patients were risk assessed and those deemed more able were placed on the second floor.

Aldeburgh Community Hospital was a single-storey, 20 bedded unit, but could escalate to 24 beds if the trust needed to expand capacity. The Croydon Unit at Felixstowe Community Hospital provided 16 inpatient beds over two floors.

At the time of our inspection, an additional patient lift at Bluebird Lodge Community Hospital was being built to improve access and reliability. There had been a number of incidents, such as delayed discharges, caused by the broken lift. The renovation was due to be completed by December 2017.

There was sufficient space for therapeutic activity. Each community hospital had a well-equipped and spacious physiotherapy room, designed for one to one therapy sessions.

Access to clinical rooms, including the sluice, was secure and lockable. At Aldeburgh Community Hospital we found the sluice to be unlocked, posing a potential safety risk. We escalated this to the matron, who advised us that any hazardous substances were kept in the locked cupboards within the sluice.

There was enough equipment to meet the needs of patients, although storage was an issue at Felixstowe Community Hospital. Equipment, such as mattresses, was stored under the staircase and staff used one bathroom as an equipment store. We were told by the matron that there were plans in place to formally transform the bathroom into a storage room in 2018.

All hospitals had a resuscitation trolley, for staff to use in the event of a cardiac arrest. At Bluebird Lodge Community Hospital, patient beds dispersed over two floors. In an emergency, staff would use the resuscitation trolley on the first floor and a grab bag on the second floor. At Bluebird Lodge, we found both outdated Resuscitation Council (UK) guidelines in a resuscitation folder and up to date 2015 guidelines displayed on the wall. During the inspection we raised this with the
matron, who immediately removed the out-of-date guidelines, so as not to cause confusion amongst staff.

Each resuscitation trolley had tamper evident tags to alert staff if the trolley had been opened. Staff checked resuscitation equipment daily against an equipment checklist to ensure essential equipment was available and in working order. At each hospital, we found satisfactory checks completed from July 2017 to September 2017.

Sharp bins were used for the safe disposal of sharp medical items, such as needles and syringes. We checked the seals and dates of eight sharp bins and found two had not been dated. Disposable curtains and wipeable chairs were used in all community hospitals. We checked five disposable curtain tags and all had been renewed within the last six months.

Maintenance staff from the trust checked electrical medical equipment to ensure it was safe for use. On inspection, we found service and maintenance checks at Bluebird Lodge Community Hospital were not all up to date. For example, we found a blood pressure meter which was due for servicing June 2017, and a bladder scanner due for servicing July 2017. We were told by matron that the trust knew about the overdue equipment and had scheduled it to be serviced.

Staff told us the process for ordering equipment from an external contractor was efficient, as equipment needs were prioritised, based on risk. All community hospitals had ordered equipment specifically designed aid mobility and prevent patient falls. All sites had access to specialist equipment, such as bariatric equipment. Staff told us that additional equipment could be ordered prior to the patient’s arrival.

Patient-led Assessments of the Care Environment (PLACE) are a collection of assessments, used to measure the quality of the patient environment for NHS patients. The table below shows that all three community locations scored worse than the England average for the cleanliness score and the condition, appearance and maintenance score.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Cleanliness</th>
<th>Condition Appearance and Maintenance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aldeburgh Community Hospital</td>
<td>95.39%</td>
<td>86.22%</td>
</tr>
<tr>
<td>Blue Bird Lodge Community Hospital</td>
<td>92.01%</td>
<td>82.61%</td>
</tr>
<tr>
<td>Felixstowe Community Hospital</td>
<td>91.99%</td>
<td>85.38%</td>
</tr>
<tr>
<td>England Average</td>
<td>98.41%</td>
<td>94.01%</td>
</tr>
</tbody>
</table>

Assessing and responding to patient risk

Staff used the Modified Early Warning Score (MEWS) to assess patient deterioration. The MEWS is a tool, used by staff, to quickly determine the degree of patient illness, based upon six cardinal vital signs and a patient observation. Staff had a good understanding of how to use the MEWS charts and had received MEWS training prior to it being introduced on the wards.

If a patient deteriorated, nursing staff would seek medical support or contact the out of hours service. At Aldeburgh and Bluebird Lodge Community hospital, medical support was provided by the local GP services.

At Felixstowe Community Hospital, Ipswich Hospital provided medical support from 9am. The out of hours service closed at 8am. This meant there was limited medical support between 8am and 9am. If a patient deteriorated during this time, staff would need to contact the emergency services. If medical support was provided between 8am and 9am, deteriorating patients could be treated in
the hospital, reducing the strain on emergency services. The matron expressed that she had escalated this as a risk to the operational site manager.

The inpatient units did not provide acute care for patients. If a patient rapidly deteriorated or went into cardiac arrest, the emergency services would always be the first point of contact. There was a resuscitation trolley on each inpatient unit, in an easily accessible area. Staff had been trained so that they could respond to an emergency while awaiting the ambulance’s arrival.

Staff completed patient risk assessments on admission. Care plans were based on risk assessments and included nutrition, hydration, falls and mobility.

Patients were assessed by the therapy team within 24 hours of admission. Therapists used specific tests, designed to measure a patient’s performance in the activities of daily living. This allowed the team to tailor treatment and care to individual needs.

Staff told us that patient falls were their biggest risk. Patients who posed the highest falling risk were nursed close to the nurse’s station. A patient falls coordinator supported staff to complete fall assessments and procure suitable equipment. All community hospitals had ordered assisted technology to reduce the risk of patient falls.

Staff assessed patients for their risk of developing pressure ulcers on admission. For those deemed at risk, a care plan would be put into place and preventative measures, such as pressure relieving equipment, would be used.

The service could provide one to one care for patients who presented with challenging behaviour and required enhanced care. The patient call bell system monitored the time it took staff to respond to a patient call.

**Staffing**

Staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment. The service used a safe staffing tool to annually assess staffing establishments. On a shift by shift basis, staffing levels were adjusted depending on patient acuity. From what we observed, staffing levels met the needs of patients and the demands of the service. The modern matrons acted in a supernumerary capacity, to allow oversight of the unit. They were available to provide clinical support to their staff, when required.

The senior matron had overall responsibility for staffing levels and caseload at the three community hospitals. There were daily trust-wide bed meetings to discuss patient acuity and staffing. The senior matron dialled into the meeting each day to update the trust on the current community inpatient caseload.

Planned versus actual staffing levels were displayed at the entrance to each unit. During full capacity, planned staffing levels at Bluebird Lodge Community Hospital were four registered nurses and four healthcare assistants during the day, and three registered nurses and four healthcare assistants at night. At Felixstowe Community Hospital, the service planned two registered nurses and two healthcare assistants for both the day and night shift. Aldeburgh Community hospital planned two registered nurses and four healthcare assistants on a day shift and two registered nurses and two healthcare assistants on a night shift. At the time of our inspection, we saw evidence that the planned staffing levels were being met.

If a nursing shortage was identified, the community hospitals could either resource a nurse from another community hospital, or request a nurse from the bank/agency pool. Staff on all units told us that they tried to use the same bank and agency staff to promote continuity of care for patients.
From June 2016 to May 2017, 10.4% of qualified nursing staff shifts in the community were covered by bank staff, 3.9% were covered by agency staff and 3.9% were left unfilled. The chart below shows the proportion of qualified nursing staff shifts that were covered by bank staff, agency staff or went unfilled.

The chart below shows the proportion of nursing assistant staff shifts that were covered by bank staff, agency staff or went unfilled.

The table below shows that from July 2016 to June 2017 the trust reported an overall vacancy rate of 25% for all staff in community inpatient services. Of particular note, Aldeburgh Community Hospital had a vacancy rate of 47% for qualified nursing and health visiting staff, and 44% for non-medical staff. Bluebird Lodge Community Hospital had a vacancy rate of 54% for non-medical staff.

<table>
<thead>
<tr>
<th>Location</th>
<th>Staff group</th>
<th>Total % vacancies overall (excluding seconded staff)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>Staff Type</td>
<td>Percentage</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Aldeburgh Community Hospital</td>
<td>Other Non-Medical Staff</td>
<td>44%</td>
</tr>
<tr>
<td>Aldeburgh Community Hospital</td>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>47%</td>
</tr>
<tr>
<td>Aldeburgh Community Hospital</td>
<td>Support to Doctors and Nursing Staff</td>
<td>11%</td>
</tr>
<tr>
<td>Blue Bird Lodge Community Hospital</td>
<td>Other Non-Medical Staff</td>
<td>54%</td>
</tr>
<tr>
<td>Blue Bird Lodge Community Hospital</td>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>6%</td>
</tr>
<tr>
<td>Blue Bird Lodge Community Hospital</td>
<td>Support to Doctors and Nursing Staff</td>
<td>16%</td>
</tr>
<tr>
<td>Felixstowe Community Hospital</td>
<td>Other Non-Medical Staff</td>
<td>16%</td>
</tr>
<tr>
<td>Felixstowe Community Hospital</td>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>11%</td>
</tr>
</tbody>
</table>

At Aldeburgh and Bluebird Lodge Community Hospitals, daily medical cover was provided by the local GP. Ipswich Hospital NHS Trust provided daily medical cover at Felixstowe Community Hospital. The trust appointed a consultant geriatrician to run a weekly ward round at each site and be on-call to provide ad-hoc telephone advice.

Out of hours medical cover was provided by a primary care, out of hours service, commissioned by Ipswich and East Suffolk CCG.

At the time of our inspection, the therapy team were employed by another local trust. Physiotherapists and occupational therapists worked on each unit Monday to Friday, between 8.30am and 4.30pm. Generic workers supported the therapy teams at each site.

Other members of the multidisciplinary team visited patients on the units regularly, including a dietitian and tissue viability nurse.

From June 2016 to May 2017, staff recorded nine incidents related to staff shortages at night.

### Quality of records

Staff followed a records management policy, which set out responsibilities in the creation, storage and disposal of records. It also detailed standards for confidentiality and set out rights to access records.

All patient care records were in paper format. Staff stored patient care records securely in locked cabinets. Observation charts and care plans were kept in folders at the patient’s bedside.

As part of our inspection, we reviewed the records of 10 patients. We found them all to be clear, complete and up to date. All those reviewed included details of the patient’s admission and transfer information from the referring hospital.

Therapy records were thorough, comprehensive and completed in line with professional standards. Patient assessments were based on national guidelines. Assessments included a venous thromboembolism (VTE) risk assessment, a falls risk assessment and an early warning score, used to determine a patient’s degree of illness.

Records showed that staff completed appropriate risk assessments for patients at risk of developing a pressure ulcer. Staff used pressure relieving equipment, documented in patient records.
We saw an example of a detailed, individualised care plan, for staff to use in order to improve their own documentation. Record documentation was audited monthly via the accountability framework.

**Medicines**

Medicines were stored safely. At each hospital, staff stored all medicines in locked cupboards, in secure clinical rooms. Oxygen cylinders were also stored securely at each site.

Fridge temperatures were checked daily and logged to ensure medicines were stored at the correct temperature. We saw evidence that staff removed compromised medicines when an irregular temperature was recorded.

We checked 26 medicines across the three sites and found all were in date. At each community hospital we undertook a random check of controlled drugs (CD). Staff followed their internal procedures for the storage and administration of CDs which included two signatories following each administration. Our review of the CD log book at Felixstowe Community Hospital confirmed expired CDs were correctly recorded as due for destruction.

There was a policy for the safe maintenance and administration of CDs, including how to safely transport CDs in an emergency. The trust pharmacy team was piloting the use of secure transit bags for CD community transportation. The bags would be sealed and signed for when delivered.

At the time of our inspection, the operational site manager was responsible for destroying controlled drugs on site. However, we were told that from October 2017, this process would be taken over by the trust pharmacy team.

We were told by the matron that the service was looking to upskill senior nursing staff to be able to prescribe certain medicines. This would reduce patient wait times for prescribed medications.

There was no pharmacy on site. The Ipswich Hospital NHS Trust pharmacy team was available on call, Monday to Friday, 8.30am to 5.30pm. A pharmacist from the trust visited the community hospitals weekly to support medicine reconciliation, review and discharge. Two pharmacist technicians also supported the community teams weekly by monitoring medicine stock levels.

At Aldeburgh Community Hospital, nurses who were administering medicines wore a tabard reading 'do not disturb' to prevent administration errors.

The community hospitals had worked alongside the policy and pharmacy teams to amend policies so that they were more appropriate to a community setting.

**Safety performance**

Community inpatient services monitored safety performance using the NHS safety thermometer. The safety thermometer is a monthly snapshot audit, used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. The types of harm the trust monitored included falls, urinary tract infections (UTI) pressure ulcers and venous thromboembolism (VTE). VTE is a condition where a blood clot forms in a vein.

Safety thermometer data was displayed at each of the three community hospitals, allowing patients, visitors and staff to view safety performance on a monthly basis. Staff used a 'safety cross' system to record if there had been a fall or developed pressure ulcer that day.
The England average for harm free care is 95%. From September 2016 to September 2017, community hospitals achieved 89.5% harm free care in the safety thermometer audit results. Broken down, the trust reported 56 patients had developed a new pressure ulcer, 10 patients had a fall that resulted in harm, 15 patients had a catheter related UTI and three patients had developed VTE.

**Incident reporting, learning and improvement**

Staff followed an up-to-date incident reporting and management policy. Incidents were reported using the trust’s electronic recording system. Staff we spoke with knew how to report incidents and were aware of the types of incidents they needed to escalate. Clinical leads reviewed incidents on the recording system and graded them based on the level of harm.

From June 2016 to May 2017, community staff reported 1272 incidents, of which 2 were categorised as a serious incident. Serious incidents are adverse events, where the consequences are so significant or the potential for learning is so great, that a heightened level of response is justified. All serious incidents were results of either a slip, trip or fall or a developed pressure ulcer. All serious incidents were investigated by an appropriate clinical lead and the outcome of the investigation was reviewed by the senior matron.

Following an investigation, learning from incidents was disseminated amongst community staff. Incidents were discussed at senior management meetings and locally at team meetings and daily huddles.

Staff gave examples of changes in practice following an incident. For example, the matron described a photography incident at Felixstowe Community Hospital, that potentially compromised the privacy and dignity of patients. The matron contacted the safeguarding lead for support and was advised to place posters around the hospital advising relatives not to take photographs of patients. We were told that the posters had been successful in preventing further incidents.

From June 2016 to May 2017, there were no never events for community inpatients. Never events are a type of serious incident that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or relevant persons) of ‘certain notifiable safety incidents’ and provide reasonable support to the person.

Staff were aware of the principles of duty of candour and could give examples of when it would be triggered. The trust’s incident reporting system prompted staff to consider duty of candour when a moderate or severe harm incident was recorded. The trust had plans to adjust the reporting system so that staff would be prompted for all incidents, regardless of harm level.

From June 2016 to May 2017, there were 15 incidents graded as either moderate or severe. Within the same time period, community staff applied duty of candour 16 times. Monthly compliance of duty of candour was reported at divisional and trust level, through the trust’s accountability framework.

**Managing anticipated risks**

The trust maintained a community services risk register. During our inspection, we found service risks identified by staff but not recorded on the register, such as the building works at Bluebird Lodge Community Hospital.

The local clinical commissioning groups had developed a system-wide demand and capacity plan for Suffolk and the surrounding areas. It specified what escalation was expected from community inpatient services at each escalation level. For example, at escalation level red, community hospitals would lower their admission and discharge thresholds to alleviate pressure.
The trust had a business continuity plan, in the event that there was a specific threat such as loss of staff, loss of equipment or loss of location.

**Is the service effective?**

**Evidence-based care and treatment**

Community staff delivered care and treatment in line with evidence-based practice. Policies followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE) guidance. For example, staff followed NICE quality standards (QS6) when caring and treating for patients with diabetes.

Standard operating procedures (SOPs) were available for a range of procedures, for example the disposal of controlled drugs. At the time of our inspection, staff were following SOPs created by the trust, in partnership with two local NHS trusts and a GP federation. The SOPs we reviewed were all up to date and had clear dates for review.

Policies and guidelines were available on the trust intranet. However, at the time of our inspection, staff did not yet have access to the trust’s intranet pages. Policies ensured discriminatory factors including age, gender or disability, were protected when making care and treatment decisions.

Patients receiving rehabilitation had clear, personalised care plans which were up to date, in line with relevant good-practice guidance, and set out clear outcome goals. We spoke with physiotherapists and occupational therapists who could all describe the recognised assessment tools used for patients during their rehabilitation.

The trust, in partnership with two local NHS trusts and a GP federation, ran a programme of clinical audits for community inpatient services. The audits included infection control, pressure ulcers and falls resulting in harm. Action plans were developed to improve audit results.

**Nutrition and hydration**

Staff understood the importance of nutrition and hydration. Aids for drinking and eating were available and we observed patients using them. Staff used a specific tool designed to assess the dehydration risk of patients.

Nutritional risk was assessed using the 'Malnutrition Universal Screening Tool' (MUST). The tool is a five-step process, used to identify adults who are malnourished, at risk of malnutrition (undernutrition), or obese. All patients found to be at risk had a nutritional care plan in place.

A dietician attended the community hospitals weekly to support patient’s with specialist diets or swallowing difficulties.

Protected mealtimes were promoted. We observed a mealtime at each community hospital and saw assistance was given to patients who required it. Catering staff were able to accommodate special dietary needs, including food allergies.

In the 2017 PLACE assessment, patients assessed ward food to be better than the England average at Bluebird Lodge Community Hospital, and slightly below the England average at Felixstowe and Aldeburgh Community Hospitals.

**Pain relief**

Staff told us they regularly assessed and managed patient pain levels, and the patient records we reviewed supported this.

Staff used the national early warning score (NEWS) to assess patient deterioration. The tool includes a numerical scale to assess and record patient pain.
Patients told us their pain was well managed and that nursing staff administered pain relief in a timely manner.

**Patient outcomes**

Information about the outcomes of patient care and treatment was routinely collected and monitored. Modern matrons displayed quality performance data on each unit, allowing patients, visitors and staff to view their performance regularly. For example, at Felixstowe Community Hospital we saw information about the workforce, safety performance and patient feedback.

Local audit programmes, conducted in partnership with two local NHS trusts and a GP federation, were used to measure outcomes for patients and drive improvements to the service. For example, community inpatient services participated in a local audit that measured staff compliance with the World Health Organisation’s ‘five moments for hand hygiene’ approach. From October 2016 to March 2017, community inpatient services achieved 98.5% compliance, against a trust target of 100%.

The community hospitals also participated in national audit programmes to measure and promote improved outcomes for patients using the service. For example, the trust participated in the national Falls and Fragility Fractures Audit Programme. At the time of our inspection, results for the latest audit completed in May 2017 were not yet published.

We reviewed patient outcome data in relation to length of stay. The average length of stay in community inpatient services ranged between 18 and 38 days. Although the average length of stay was recorded, staff told us that there was no trust target for them to work towards. Longer hospital stays can impact negatively on patient welfare and well-being.

**Competent staff**

There were appropriate arrangements for staff supervision and appraisal. Staff followed an up-to-date clinical supervision policy, which provided a formalised framework for the development and implementation of clinical supervision for all staff and specified requirements of both the supervisor and supervisee.

Appraisals were yearly and based upon trust values. We reviewed a recently completed staff appraisal and found it to be individualised, with measurable goals for development. We requested data of appraisal compliance however this was not provided.

Nurses told us they had been supported with revalidation. This is the process where nurses renew their registration with the Nursing and Midwifery Council.

All healthcare assistants were to undertake the Care Certificate. The certificate aims to prepare health and social care support workers with the knowledge and skills to provide safe, compassionate care. The trust was currently in the process of rolling out Care Certificate training to all unregistered staff that have patient contact.

The service ensured staff had the necessary training to deliver effective care, support and treatment. Additional training opportunities were publicised on the intranet and on staff noticeboards. Staff told us they were supported to pursue any training opportunities relevant to their role. For example, the therapy team at Bluebird Lodge Community Hospital had enrolled on stroke rehabilitation training. Band 6 nursing staff were also receiving managerial training to support the matron with administrative tasks.

The therapy team at Felixstowe Community Hospital offered specific training sessions to patient relatives, to help improve their patient care.
All new members of staff completed a corporate and local induction. All agency and bank staff working on the units completed a local induction. The units supported nursing and therapy students on placement.

**Multidisciplinary working and coordinated care pathways**

There was effective multidisciplinary working across all community sites. Each community hospital held weekly multidisciplinary team (MDT) meetings to discuss in detail the needs of patients. An interface consultant geriatrician facilitated the MDT meetings, which focused on patient-centred rehabilitation goals. The weekly rounds included contribution from nursing staff, the therapy team and social services.

A daily ward round was conducted by a local GP at Aldeburgh and Bluebird Lodge Community Hospitals. The trust provided daily medical cover at Felixstowe Community Hospital.

Staff at the unit were able to make referrals to the wider multi-disciplinary team. A dietician attended the community hospitals weekly, following a staff referral. Staff could also refer patients to the trust psychiatric team. A tissue viability nurse visited the units to support staff with prevention and management of pressure ulcers and other lesions. The therapy team were employed by another local trust and support by generic workers.

The modern matrons encouraged staff to work shifts at the acute hospital to observe the beginning of the patient pathway. The matrons had also introduced ‘coffee and kit-kat’ sessions, inviting acute staff to the community hospitals.

The hospitals had strong working links with other services and agencies such as social services, the local hospices, league of friends and the voluntary sector.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

The Mental Capacity Act (MCA) is designed to protect patients who may lack capacity, to make certain decisions about their care and treatment. Information about the Mental Capacity Act (2005) and associated Deprivation of Liberty Safeguards (DoLS) was covered as part of staff mandatory training on dementia. Data provided by the trust showed that community staff had a compliance rate of 97.1% with this training.

From January 2017 to March 2017, the community hospitals submitted four DoLS applications. Staff were able to explain the process for submitting a DoLS application and ensured best interest decisions were made in accordance with legislation.

We observed staff seeking consent before starting treatment. There was evidence in patient records that consent had been obtained for certain treatments. We found Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms were completed to a good standard.

**Is the service caring?**

**Compassionate care**

Staff treated patients with dignity and respect. We saw that curtains were used effectively to protect the privacy and dignity of patients. There were dedicated male and female only bays, as well as side rooms, to help maintain patient dignity. Staff followed an up-to-date chaperone policy, protecting patients during intimate personal care.
We observed all staff to be courteous, professional and kind when interacting with patients. We observed staff greet patients appropriately, and introduce themselves by name.

Patient feedback was consistently positive. The patients and relatives we spoke with said that staff were “wonderful”, “kind” and “caring”. We were given good examples of staff going above and beyond what was expected of them. For example, staff used an online map as a therapy technique to build a patient’s confidence, when they became anxious of returning home. Staff had also personalised patient rooms.

Staff demonstrated an understanding of the religious needs of patients by arranging special events and wedding ceremonies for patients approaching the end of life.

The results of the Friends and Family Test (FFT) in April 2017, showed 100% of patients would be either ‘likely’ or ‘extremely likely’ to recommend community services to their friends and family.

Each community hospital displayed patient thank you cards. Comments from the cards showed patients felt they had been treated with compassion. Patients told us that staff were attentive and we observed that call bells were answered in a timely manner.

Patient-led Assessments of the Care Environment (PLACE) are a collection of assessments, used to measure the quality of the patient environment for NHS patients.

The table below shows that all three community hospitals scored worse than the England average. The trust had created an action plan to improve their PLACE scores.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Privacy, dignity and wellbeing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aldeburgh Hospital</td>
<td>80.23%</td>
</tr>
<tr>
<td>Bluebird Lodge</td>
<td>76.47%</td>
</tr>
<tr>
<td>Felixstowe Hospital</td>
<td>67.17%</td>
</tr>
<tr>
<td>England Average</td>
<td>85.87%</td>
</tr>
</tbody>
</table>

**Emotional support**

Staff showed a clear understanding of the importance of providing emotional support to patients. Patients described receiving emotional support from staff when they were anxious and our observations supported this. The therapy team helped patients develop their independence and regain confidence.

Each community hospital displayed information about the local support services available. For example, we saw information on how to safeguard people from abuse.

A chaplain from the trust visited the hospitals weekly and could be contacted 24 hours a day, 7 days a week to offer emotional support. Quiet rooms were available for staff to take patients and their relatives when they had received upsetting news.

**Understanding and involvement of patients and those close to them**

We saw staff communicate with patients about their care and treatment in a way they could understand. Patients knew what their therapy goals were. Staff provided patients with relevant information, both verbal and written, so they could make informed decisions about their care and treatment.

Staff used alternative ways to communicate with patients who had additional needs. For example, a hospital passport was used to help people with autism effectively communicate their needs to hospital staff.
Each community hospital had developed a patient information leaflet that included useful information on visiting hours, meal times, valuables and laundry services.

**Is the service responsive?**

**Planning and delivering services which meet people’s needs**

The trust planned and delivered community inpatient services to meet the needs and demands of local people. The hospitals worked with the local clinical commissioning groups and GP practices to improve patient access to services. Patients had appropriate information about other local health and support services available to them.

Each community hospital provided rehabilitation and enablement care, and palliative care for patients who could not be supported at home. The service was commissioned for people who lived in Suffolk and were registered with a Suffolk GP.

The service had developed clear admission criteria to ensure patients were only accepted if staff could meet their needs. Mixed sex breaches are defined by the CQC as a breach of same sex accommodation, as defined by the NHS Confederation definition. Also included is the need to provide gender sensitive care, which promotes privacy and dignity, applicable to all ages, and therefore includes children’s and adolescent units. The trust reported that they have had no mixed sex breaches for community inpatient services.

The facilities and premises at each community hospital met people’s rehabilitation needs, with adequate space for patients to mobilise. For example, at Aldeburgh Community Hospital staff were developing a sensory garden in partnership with a voluntary organisation, to meet the needs of patients with cognitive impairments and cognitive needs.

The hospitals had strong working links with other services and agencies such as social services, the local hospices, league of friends and the voluntary sector. Volunteers ran group activities and games for patients, and operated a library trolley service twice a week.

**Meeting the needs of people in vulnerable circumstances**

The community hospitals planned and delivered services to meet individual needs. Pre-admission screening was used effectively to ensure the hospitals only treated patients if they could meet their needs. For example, the service did not treat patients under 18 years old or patients needing daily medical intervention.

The trust patient record system identified which patients had additional needs, including patients with autism or patients who may be approaching the end of life.

At the time of our inspection, the community hospitals were being redecorated to be more suitable for people living with dementia. For example, contrasting colours were used to help identify key features and rooms. Community inpatient services had a nurse dementia link who had received additional training. The dementia link had created a dementia notice board containing useful information for patients and had organised a tea party during dementia awareness week.

All staff received dementia awareness training as part of their mandatory training. As of September 2017, dementia awareness training had been completed by 97.1% of community staff, against a trust target of 95%.
The trust had employed a specialist learning disability and autism liaison nurse who worked with both staff and patients to ensure reasonable adjustments were made to support patients with complex needs.

Patient-led Assessments of the Care Environment (PLACE) are a collection of assessments, used to measure the quality of the patient environment for NHS patients. All three hospitals performed better than the England average in relation to care given to patients living with dementia and learning disabilities.

Staff had created specially designed blister packs so that patients living with Parkinson’s disease could self-medicate, without the risk of dropping their medication. We saw evidence that staff involved patients in their rehabilitation goals and discharge planning.

Equality and diversity training was delivered to staff as part of their mandatory training. From September 2017, overall compliance for community staff was 88.4%, against a trust target of 95%.

Staff told us they had access to interpreting services for patients who did not speak English. The hospitals used the language line provided by the trust or could arrange a face to face interpreter if required. Patient surveys were available in various languages and formats.

Specific dietary needs were recorded on admission. Menu options were available for patients who required special diets, for religious or cultural reasons. There was specialist equipment available for patients with specialist needs, such as bariatric equipment and mobility aids.

The layout of the hospitals meant that all areas were accessible for people using a wheelchair or walking aids. The day room chairs were a mix of heights to help patients with mobility issues. The hospitals also had accessible bathrooms and lift access.

**Access to the right care at the right time**

All community hospitals provided ‘step up’ admission from primary care, and ‘step down’ admission from acute beds. They also offered palliative care placements for people who were unable to be supported at home. Community hospitals had clear admission criteria for the service they provided.

The trust actively monitored patient waiting times to identify trends and ensure services in high demand were managed appropriately to prevent patient pathway delays. The data provided by the trust indicated that community inpatients was not one of the services that reported long waiting times from referral to admission. Upon admission, all patients should receive a care plan agreed within 24 hours of arrival. We reviewed the April 2017 quality report to find community inpatient services were meeting this target 98.6% of the time.

Bed occupancy at all three locations ranged between around 95% and 99% between June 2016 and May 2017, with the exception of one month (August 2016) for Felixstowe Community Hospital where the bed occupancy was 90%. Within the same time period, the average length of stay was 28.9 days, ranging between 18 and 38 days.

From June 2016 to May 2017, staff recorded 561 incidents relating to patient access, admission, transfer and discharge (including missing patient incidents).

The trust were asked to let us know about any ward moves for a non-clinical reason during the last 12 months. For example if a patient has to move wards several times because there is no room in the speciality ward they should be on. The trust reported that they had 111 bed moves from April to September 2017.
Patient referrals arose through a number of routes including local GPs, the community health team, community matrons and the trust. The MDT reviewed each referral for suitability. Patients had to be over 18 years old, registered with a Suffolk GP, and medically suitable. Inappropriate referrals would be recorded as an incident. The operational site manager would try to find a more appropriate setting for the patient.

The hospitals avoided admitting patients at weekends and after 8pm, to ensure initial assessments were completed. From April to September 2017, 111 patients were admitted after 8pm across the three community hospitals.

Discharge planning started on admission. Patients were given an estimated discharge date, which was reviewed weekly. The average length of stay in community inpatient services ranged between 18 and 38 days. Although the average length of stay was recorded, staff told us that there was no trust target for them to work towards.

There were effective systems in place to ensure that patients were discharged appropriately, however all units reported incidents of delayed discharges. We were told by staff that the main reason for a delayed discharge was the lack of social care support available.

There was no discharge coordinator to support community inpatient services. Staff would explore alternative discharge arrangements with the patient, when returning home was not possible. Multiple services were involved in the planning of complex discharges.

Patient discharge summaries were electronic and a hard copy was given to the patient upon discharge. Staff sent a discharge summary to the patient's GP within three days of discharge. Therapy teams undertook home visits to facilitate safe transfer and ensure equipment requirements were met.

**Learning from complaints and concerns**

There were clear processes for staff to manage complaints and concerns. Staff logged all complaints and concerns onto the electronic recording system.

There were procedures for sharing and learning from complaints across the hospitals. Complaints were discussed locally at team meetings and at the monthly governance meeting. Trends would be identified and learning shared via the daily huddles. For example, following a patient complaint, staff attitude was reviewed.

Complaints leaflets, describing the complaints procedure, and complaints posters were available in all community hospitals. Patients told us they would be confident to raise a concern if necessary.

Complaint figures were low for community inpatient services. There had been four complaints recorded in the last two years. Staff told us they tried to resolve patient concerns before they escalated into a formal complaint.

**Is the service well-led?**

**Leadership**

Community inpatient services had clear lines of management responsibility and accountability. The service was overseen by a clinical director and an associate director of nursing. Each community hospital was led by a modern matron, supported by a senior matron and operational site manager.
At each hospital, we found the nursing team to be managed by a visible, experienced and enthusiastic leader. They were knowledgeable about their hospital and strived to continuously improve their service. For example, at Felixstowe Community Hospital, staff planned to move the daily board round to the patient bedside, allowing the patient to be more involved in decisions about their care.

All staff spoke positively about their local leadership. They described feeling valued and supported in their role. Local leaders said they too felt well supported by their line managers, specifically by the senior matron and associate director of nursing. Leadership study days were available for staff wanting to develop management skills.

**Vision and strategy**

The trust had a clear vision to be an outstanding provider of health services. The trust also wanted to develop integrated services so that patients could seamlessly transition from acute care to community and primary care settings. The vision of the trust was communicated to staff within the trust’s divisional business plan.

Community inpatients services were also discussed in the local Sustainability and Transformation Plan for Suffolk and North East Essex, which aims to deliver the significant system transformations needed to manage increasing demand. The plan identified investment in community services, along with redesign, would reduce the reliance on acute services.

We inspected the community inpatients service during an interim period, 10 days before the service became exclusively managed by Ipswich Hospital NHS Trust. Staff told us they were looking forward to the trust takeover, although felt that communication during the interim period could have been better. For example, staff described receiving emails from unknown members of the trust board.

Local leaders were clear on the vision and purpose of the service and their role within it. They were also clear on how the service fitted within the wider trust strategy.

**Culture**

The trust’s values and behaviours were created in collaboration with staff, patients and their families. They included respect, kindness and efficiency. Staff were aware of the trust values as appraisals were based upon them. Staff incorporated the values into their work and our observations supported this.

The culture within the service centred on the needs and experience of patients. Staff reported an open and honest culture. Staff felt able to raise a concern with their modern matron and we observed leaders had an open-door policy.

The trust had appointed a ‘freedom to speak up guardian’. Guardians promote an open culture, allowing staff to speak up about concerns easily. There was effective teamwork and professionalism in the way the service was managed.

The trust had a whistleblowing policy. Within the last 12 months, the CQC received one whistleblowing enquiry, relating to Aldeburgh Community Hospital. We raised the whistleblower’s concerns with the trust and the unit was visited by the associate director of nursing. We were provided with assurance by the trust that the service was being monitored.

Many staff we spoke with had worked in the community hospitals for a long time and said they were a great place to work. Although community staff did not work at the main hospital, staff described that they felt part of the trust as they received regular contact from them.
**Governance**

The local leads, along with the senior matron and operations site manager, attended a monthly governance meeting; these meetings then fed into the divisional governance meetings. We reviewed the meeting minutes of the monthly governance meeting and found incidents, risks, reports and staffing were all reviewed.

The trust used an accountability framework, designed to help the trust identify where support is needed. The framework was used to monitor the trust’s key performance indicators on a monthly basis. The senior matron fed into this framework by producing quality reports, presented to the board.

At local level, modern matrons ran team meetings with their local teams. The minutes of each team meeting were circulated to staff via email. Minute records showed incidents, risks, patient feedback and audits were all discussed at the meetings.

The trust also disseminated ‘five hot topics’ each day which staff discussed at their daily huddle.

**Management of risk, issues and performance**

At the time of our inspection, the community hospitals were preparing to adopt the trust’s risk management process and were in a state of transition. Thus, arrangements for identifying, recording and managing risks were not yet fully embedded.

Community inpatient services had an electronic local risk register, managed by the operations site manager. There was currently only one open risk identified on the local community risk register: the risk of transcribing errors when staff produced patient identification items, such as wristbands. The service was mitigating the risk and had invested in electronic requesting software to improve the process.

On our inspection staff told us about, additional service risks that had not been recorded on the local risk register. For example, the building work at Bluebird Lodge Community Hospital was not on the risk register, nor was the risk that Felixstowe Community Hospital had limited medical cover between 8am and 9am. As the risks were not recorded, the service did not have a clear oversight of their risks.

Any major risks identified within the local register would feed into the trust’s divisional risk register. However, as not all risks were recorded, this meant that risks may not be escalated appropriately.

The senior matron recognised that the community inpatient units were somewhat remote and that this could be a potential risk to staff. To combat this, staff had been given hand held radios to use at night and CCTV had been installed.

**Information management**

Community staff demonstrated how they could access the information they needed to deliver effective care and treatment. Patient records were paper based and easily accessible to staff. Daily shift handovers enabled patient information to be transferred to in-coming staff. We found no evidence that patients were admitted from acute settings without their appropriate records available to staff.

Community inpatients services had identified that there was a risk of transcribing error when staff produced patient identification items, such as wristbands. This risk had been rated as ‘critical’ on the service risk register and was regularly discussed at team meetings. The service had recently
acquired electronic requesting software, which would be used to print off patient identification labels and improve access to diagnostic test results. At the time of our inspection, staff had received training but were yet to start using the software, due to delays in equipment arrival. Staff told us that the new software would be implemented by the end of the year.

Important information such as safety alerts, audit results and key messages were displayed on staff notice boards to help keep staff up to date on current issues.

At the time of our inspection, community staff did not have access to Ipswich Hospital NHS Trust intranet services. We were told by staff that access would be granted in October 2017.

Discharge summaries were sent to the patient’s GP following discharge. This ensured that the GP understood what rehabilitation had taken place, and what follow-on care may be required. Care and discharge summaries were also given to patients on discharge.

**Engagement**

Patients were encouraged to leave feedback about their experience via the patient satisfaction survey and the Friends and Family Test. Results of the latest Friends and Family test showed 100% of community inpatients would be either ‘likely’ or ‘extremely likely’ to recommended the service to others.

The patient survey results in August 2017 revealed high scores in all areas, with one exception. Only 60% of patients reported that staff told them how to seek emotional support if needed. The matrons recognised this shortcoming and were looking at ways to improve their performance.

There was evidence that the trust acted upon patient feedback to help improve their service. In each community hospital a ‘you said, we did’ board displayed changes that had occurred, as a result of patient feedback. For example, following a patient concern that patients felt isolated in single rooms, staff now encouraged patients to spend time in the day room socialising with others.

The trust was actively looking to recruit patients to join a patient participation group. The group met every six weeks to provide a patient voice and escalate issues to board members. Staff were positively engaged with their hospital, and in their roles. The community hospitals had monthly team meetings in which staff were updated on new developments, clinical updates, staffing, changes in policy, as well as sharing other information of interest.

The trust held drop-in sessions to communicate the service strategy going forward, following the takeover of community services by the trust. The units held team building days, where staff were asked to discuss their responsibilities in their role with others. Staff described these days as a successful way to improve teamwork.

**Learning, continuous improvement and innovation**

The trust ran staff recognition awards for outstanding contributions to the service.

The community hospitals constantly reviewed their environments to ensure they were accessible to patients living with dementia.

The modern matron at Felixstowe Community Hospital planned to move the daily board round to the patient bedside, allowing the patient to be more involved in decisions about their care.