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**

West Suffolk NHS Foundation Trust provides acute hospital services from West Suffolk hospital, set in parkland on the outskirts of Bury St Edmunds. The hospital has an emergency department; obstetrics; maternity and neonatal services; a day surgery unit; eye unit; and children’s wards. It also provides the full range of secondary care services. The trust refers many patients who need more specialist care to a local hospital and many of the trust’s consultants work in both hospitals.

The trust trains doctors and provides the clinical base for a local university graduate medical course.

The trust provides outpatient services in the community giving convenient local access to consultants and other clinical staff. The trust also provides community services for the residents of West Suffolk as part of a partnership of providers.

(Source: Trust Website)

West Suffolk Hospital NHS Foundation Trust (WSFT) provides hospital and community healthcare services to people mainly in the west of Suffolk and is an associate teaching hospital of the University of Cambridge. WSFT was awarded foundation trust status in December 2011.

WSFT serves a predominantly rural geographical area of roughly 600 square miles with a population of around 242,000. The main catchment area for the Trust extends to Thetford in the north, Sudbury in the south, Newmarket to the west and Stowmarket to the east. Whilst mainly serving the population of Suffolk, WSFT also provides care for parts of the neighbouring counties of Essex, Cambridgeshire and Norfolk.

In October 2015 they were awarded the contract to provide community services for Suffolk in partnership with The Ipswich Hospital NHS Trust and other partners. They had their contract
extended beyond the original 12 months to provide these services. The community services cover a range of adult community services, specialist children’s services and community hospitals and:

- Delivers community-based services to people of all ages across Suffolk.
- Provides services to local clinical commissioning groups (CCGs), hospitals, community healthcare.
- Serves the population of Suffolk, with the exception of the Waveney area.
- Delivers services in a variety of settings including people’s own homes, care homes, community hospital inpatient units and clinics, day centres, schools, GP surgeries and health centres.
- Employs around 1,400 staff, including nurses, healthcare assistants, occupational therapists, physiotherapists, specialist clinicians, generic workers, technicians, administrators and support staff.

WSFT comprises of three locations registered with CQC.

- West Suffolk Hospital - There is a purpose-built Macmillan unit for the care of people with cancer, a dedicated eye treatment centre and a day surgery unit. WSH has a total of 477 beds (including day case and children’s beds) and 14 operating theatres, including three in day surgery and two in the eye treatment centre.
- Rosemary Ward at the Newmarket Community Hospital (NCH) is a 19 bedded reablement service.
- Glastonbury Court is a care home in Bury St Edmunds run by Care UK. WSFT has commissioned one of the 20 bedded units to provide ongoing assessment and reablement.

The trust employs 3,418 staff (March 2019 figures), including 378 medical, 824 nursing and 2216 ‘other’.

Previously CQC carried out a comprehensive inspection of two core services; end of life care and outpatients and a well led review at West Suffolk NHS Foundation trust between 09 November and 01 December 2017. Following this inspection, the trust was rated as outstanding. Safe, responsive and well led were rated as good, with effective and caring rated outstanding. Trust level leadership was rated outstanding.

We inspected the trust between the 24 September 2019 and 30 October 2019. This inspection was announced due to the number of core services inspected. The core service inspection took place on the 24 and 25 September 2019 and covered eight core services: urgent and emergency care, medical care, surgery, maternity, outpatients, community health services for children, young people and adults, community health services for adults and community health inpatient services.

Following this there were a number of unannounced inspections on the 8, 9 and 11 October 2019. A well led inspection at provider level took place between the 28 and 30 October 2019. We inspected the above services provided by this trust as part of our continual checks on the safety and quality of healthcare services

Following the well led inspection we undertook enforcement action, in relation to the maternity service, and told the trust it must improve. We issued a warning notice, on the 14 November 2019, under Section 29A of the Health and Social Care Act 2008. This identified specific areas that the trust must improve and set a date for compliance as 31 January 2020. The trust initiated an immediate action improvement plan.
Is this organisation well-led?

Leadership

The trust had an established, stable executive leadership team. Whilst priorities and issues were known and understood these were not always managed in a consistent way. The style of executive leadership did not represent or demonstrate an open and empowering culture. There was an evident disconnect between the executive team and several consultant specialties. Poor communication and fractured engagement of some of the consultant body had begun to impact on medical managers playing a full and effective role within the organisation.

The trust has an established experienced executive leadership team with only one executive being an interim appointment. The trust board consisted of six executive directors, chair and five non-executive directors. The team had remained stable since the previous inspection in 2017, with the only substantive change being the appointment of a new chair on 01 January 2018.

At the time of the inspection, there was an interim executive director of human resources (HR). The previous substantive director of HR, had accepted the interim position on 01 May 2019, on a part time basis following their retirement, until the next appointed director took up the position. Recruitment, and appointment, had taken place and the new director of HR was due to take up position with the trust on 04 November 2019. The chief executive officer (CEO) had been in post since 03 November 2014. The longest established member of the executive team was the director of resources, and deputy CEO, who had been in post since 01 December 2011.

The five non-executive directors (NED) were appointed between September 2013 and September 2018. There had been two changes of NED since we last inspected in 2017 due to previous individuals reaching the end of their tenure. Of the two most recent appointments, one NED held the responsibility as the audit committee chair, link to director of resources and health and wellbeing programme. The other held responsibilities for safeguarding adults, security and emergency preparedness, resilience and response (EPRR).

We found that the executive leadership team did not always support the delivery of high-quality person-centred care. The style of leadership amongst the executive directors did not represent or demonstrate an open and empowering culture. There was a failure by the executive team to step back from specific clinical safety concerns and consider organisational impact. We saw evidence that when staff had raised concerns they were not always taken seriously, appropriately supported or treated with respect. In some cases, responses to those raising concerns, were defensive in nature, individually focused rather than actively collaborating to seek solutions.

CQC received 10 whistleblowing concerns between September 2018 and September 2019, five of which were received in the three months leading up to inspection. Several of the whistleblowing concerns included factors around poor engagement, communication and leadership. There was a growing disconnect between the executive team and several clinical specialties which had impacted on consultant involvement with the running of services. Communication with some members of medical staff had broken down. We were not assured that the significance of this had been fully acknowledged by the executive directors, or board, or responded to in an effective, timely manner.

The medical staffing committee had been reinvigorated in June 2019, by the consultants, as an opportunity for clinicians to increase engagement collectively with the executive directors. We reviewed the minutes of the first two meetings. In the initial meeting the structure, format and
frequency of the MSC were outlined, with the CEO to have a regular 15 minute slot at each meeting. It was agreed that the medical director would attend but that the chair of the MSC could ask the medical director to leave should this be appropriate if discussions directly related to them. Matters arising were minuted, with actions, and it was agreed at that initial meeting the MSC would be held quarterly, with the next meeting set for September 2019.

The 10 September 2019 meeting minutes demonstrated that there had been discussion between the trust chair and the secretary of the MSC, around the morale and concerns of the consultant body. There was recognition that the board were aware of a degree of unhappiness among the consultants, and a feeling that concerns were not being recognised. It was noted that the increasing distance felt between the consultant body and the executive team had begun to impact on individuals withdrawing involvement in the running of the trust. As a result, it was agreed that one of the non-executive directors should be regularly invited to attend the MSC to update the consultants on the issues and concerns that the board was addressing and to gain an understanding of the consultants' views and concerns. It was agreed at this meeting that the MSC would meet monthly rather than quarterly.

During interview it was evident that the board were aware of the areas of concern and there were strong opinions as to the reasons that certain groups were unhappy, however actions to address and repair leadership relationships were less apparent. We discussed with the executive team during feedback, that certain staff felt the executives listened but did not hear. One example was Paediatrics where the trust and the consultants shared similar concerns but the communication between parties had not identified they were on the same page. Another example was Pathology, where there was an apparent disconnect between the view of the executive team and that of the consultants. The executive view was that staff at the trust were reluctant to work within the North East Essex and Suffolk Pathology Services (NEESPS) network however, we were informed by the consultants, and operations manager, that this was not the case. Their frustrations came from a lack of ability to provide the service they wanted to, due to ageing equipment and no control over the day to day management of the service they provided. Whilst the board had met with the senior team at the lead acute trust that host the NEESPS and received a commitment to deliver the required improvements, the consultants felt that this focused on the longer term and did nothing to address immediate concerns. They remained sceptical about the timeframe for change as NEESPS had been in place for two years with no significant improvement or responses to continued concerns. The Pathology team stated they felt the executives had stopped listening and believed the matter resolved.

All of the executive directors, NEDs and chair were collectively supportive and extremely positive of the CEO. They described the CEO as the driving force behind the organisation and specifically within the alliance partnership. Stating that by engagement, both locally and nationally, opportunities had opened up allowing investment and innovation. The board was a unitary board which meant that within the board the executive directors and NEDs made decisions as a single group and shared the same responsibility and liability.

There was a process for individual contribution, check and challenge through the internal governance framework, HR processes and various committees. Whilst there was an appropriate level of challenge seen in the various committee meetings we reviewed, we found that there was a potential risk that the board had become so driven behind a united decision there was a reluctance, perceived or actual, to take on board other perspectives and alternatives. For example, there was an ongoing complex, serious incident investigation at the time of inspection. The way this had been managed had impacted on the leadership, governance and culture across the organisation. We reviewed the approach taken by the executive leaders in regard to the investigation process that had occurred, alongside relevant information provided. Actions undertaken were unprecedented and concerning, such as the requirement for fingerprinting and handwriting analysis. These actions had not been disclosed to us until after the trust had undertaken them. Whilst there had been attempts to ensure impartiality, such as external
independent reviews and legal advice, we found that certain aspects of the process lent towards individual bias with potentially questionable conclusions and judgements made. We were not assured that, having made the decision to follow the course of action agreed by the board, that any subsequent information had been appropriately considered. We voiced this concern with the CEO and chair during the inspection.

Arrangements remained in place to ensure that directors were fit to carry out their responsibility in accordance with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust policy and procedure “Fit and Proper Person Requirements”, version two, dated May 2019 referenced the most recent CQC guidance document for providers and inspectors, January 2018. It included a standard to undertake, where a director meets the eligibility criteria, an enhanced Disclosure and Barring Service (DBS) check to establish whether the person is on the children and / or adults safeguarding barred list and whether they are prohibited from holding the office in question under other laws such as the Companies Act or Charities Act and this was also included within the self-declaration form. The policy and procedure outlined that a self-declaration form be completed as part of the appointment process and yearly as part of the annual appraisal process.

We reviewed the personnel files of all of the executive directors, the chair and four NEDs. The files demonstrated that appropriate FPPR checks had been undertaken and included records of the recruitment process, interview notes, reference checks, disclosure and barring service (DBS) check, employment history and self-declaration. All files detailed an annual appraisal with current objectives outlined, although those of the NEDs were extremely brief. The executive director appraisals included a mid-year appraisal check and closure of 2018/19 objectives which were rated as red (due date passed), amber (progress of trajectory), green (on trajectory) or black (completed).

We found that there were some inconsistencies in the record completion of all of the relevant checks and appraisals. For example, in three of the six executive directors' files detail was not recorded in relation to the recruitment and interview process or copies of references (although the checklist had been ticked to indicate these had been provided). Similarly, there was no evidence of recruitment, interview or actual references in three of the four NED files reviewed. Information provided after inspection identified references were held, however these were inconsistent. Out of the six files reviewed (the chair and NEDs) three had two references and three had only one, including that of the most recently appointed NED in September 2018. Details of another candidate were included in the chief nurses electronic file. The NED and chairs appraisals were not signed or dated by either the appraiser or appraisee, despite there being boxes for this to take place. We were able to note that these were current appraisals by the date they were electronically filed.

There were clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership. All executive and non-executive directors were clear of their areas of responsibility. We reviewed the trust strategic framework for the future which outlined the trusts one vision, three priorities and seven ambitions. One of the three priorities was to invest in quality, staff and clinical leadership. Outlined within this priority were a number of actions that included, but were not limited to, train and develop a modern workforce, build on teaching and research base, recognise the power of team and do more to invest in clinical leadership.

Leaders across the organisation had the skills and abilities to run services and there was support in place for any managers new in post. Investment in leadership development had taken place. Initiatives included leadership summit days, five o'clock club (a leadership forum with external speakers), West Suffolk Foundation Trust (WSFT) 2030 leaders programme and a variety of masterclasses and workshops. Leadership development also linked to other aspects of the organisation development agenda, for example health and wellbeing and quality and inclusion with leader training available in how to support staff's emotional and mental health. A session relating
to “Workplace wellbeing: handling stress at work”, for 25 staff on 20 September 2019, was advertised in the 16 August 2019 edition of The Green Sheet.

Staff were encouraged to participate in national and regional opportunities such as the NHS Executive, search executive talent career development workshops and mock interviews, and aspiring directors of nursing programme. The trust also collaborated with external stakeholders, with leaders from the West Suffolk clinical commissioning group (CCG) participating in the WSFT 2030 Leaders Programme and joint leadership development work with West Suffolk Alliance partners (the ‘One Clinical Community’ leadership development programme). The One Clinical Community leadership programme, running between September 2019 and March 2020, was externally facilitated and offered the opportunity to bring clinicians and managers from across the health economy together to work and develop solutions. The programme included four module activities; leadership, strategy and self, leading for outcomes, leading in partnership and leading locally.

Facilities available at the trust supported leadership and staff development. The Drummond education centre provided a centre for resources for learning and the Siklos centre for clinical skills and simulation provided the opportunity for scenario training and to practice skills.

There was a leadership and talent management strategy in place, that incorporated talent acquisition, development and career support and succession management, aligned with the trust’s seventh ambition to support all staff. The trust approach to succession planning was to develop capabilities rather than succession plans for posts. Between April 2018 and March 2019, 733 staff had participated in a leadership development programme out of 3990 that were eligible (18.3%).

We found that the executive team were visible throughout the organisation. Information provided stated that visibility of leadership remained an area of focus. We saw that regular and varied engagement was undertaken by all of the members of the trust board. These included weekly quality walkabouts, staff conversation sessions in the Time Out restaurant, senior core brief sessions, executive board round, area visits and back to the floor experiences where members of the board spent time with staff in specific areas to learn and understand various roles. Information provided demonstrated there had been eight back to the floor visits between June 2018 and May 2019, conducted by the CEO, chair and one of the NEDs, and included portering, housekeeping, volunteers, critical care outreach team, catering and pharmacy. The CEO presented at each corporate induction day. There had been two workshops for the council of governors and board, one in September 2018 and one in March 2019.

The 2018 NHS staff survey results demonstrated the trust had scored slightly above the average in respect of immediate managers consistently since 2015, with results remaining relatively static. The score achieved in 2018 was 7 against an average of 6.7 overall. Five of the six questions specifically related to immediate managers were just above the national average and had improved scores from 2017. The one question that had decreased was Q19g: My manager supported me to receive this training, learning or development. This had dipped from 54.8% in 2017 to 52% in 2018 which was below the national average of 54.1%. We saw that the trust had identified an action of further analysis to identify hot spots, with exploration if this linked to reduction in continual professional development (CPD) funding for non-medical clinical staff.

**Board Members**

Of the executive board members at the trust, 0% were Black and Minority Ethnic (BME) and 42.9% were female.

Of the non-executive board members, 0% were BME and 40.0% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0%</td>
<td>42.9%</td>
</tr>
</tbody>
</table>
**Non-executive directors** | 0% | 40.0%
---|---|---
**All board members** | 0% | 41.7%
*(Source: Routine Provider Information Request (RPIR) – Board Diversity tab)*

### Vision and strategy

The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had in place a clear vision, focused priorities and ambitions that were unchanged from our previous 2017 inspection. These identified quality and safety of existing services alongside the need to accelerate collaborative and integrated services in the community to ensure sustainability.

The trust’s one overarching five-year vision was to deliver the best quality and safest care for the community. This was underpinned by three priorities; deliver for today, invest in quality, staff and clinical leadership and build a joined-up future. The three priorities aimed to transform what services the hospital provided and recognised that to reduce unnecessary admissions collaborative working between primary and community care partners was required. The seven ambitions were centred around how the trust would achieve the vision and priorities. These were to; deliver personal care, deliver safe care, deliver joined up care, support a health start, support a healthy life, support ageing well and support all our staff. The trust values were; focused on patients, integrated, respectful, staff focused and two-way communication (FIRST).

The vision, values and strategy had been developed using a structured planning process in collaboration with staff, people who use services, and external partners, including governors, volunteers, Friends of West Suffolk Hospital groups, public members, NHS bodies and partner organisations. The trust’s operational plan was reviewed annually and engagement with local partners, including the clinical commissioning groups (CCG) and other members of the West Suffolk Alliance occurred to ensure the trust plans were consistent with those across the local health system and the wider Suffolk and North East Essex sustainability and transformation partnership (STP). The trust operational plan 2019-2020, dated April 2019, supported and aligned to the strategy, vision, priorities and STP. It included activity planning for current care delivery, quality and workforce planning, delivery of sustainable and joined up care through various initiatives within the integrated care programme. These included but were not limited to; integrated urgent care (IUC), rapid intervention vehicle (RIV), connect localities, responsive care, integrated respiratory service and paediatric physiotherapy joint working.

The focus within the STP was the design and mobilisation of local alliances to move from working as individual organisations towards a fully integrated system. The West Suffolk Alliance, formed in September 2016, brought Suffolk county council, the trust, the Suffolk GP federation and the acute mental health hospital together, working closely with the West Suffolk CCG, to form an integrated financial and management delivery framework to provide an improved service for people in West Suffolk and tackle sustainability issues across the system together. The West Suffolk Alliance Strategy 2019-2023 identified four interrelated ambitions; strengthening support for people to stay well and manage their wellbeing and health, focus on individual needs and goals, changing the way services are configured and work together and make effective use of resources. The chief
executive chaired the strategic digital investment assurance board for the STP as well as being the lead chief executive for the longitudinal health and care record.

As the trust held the contract for delivery of community services this was being used as a driver to support development of integrated locality teams. There was recognition of the benefits that closer alignment between the hospital, community and primary care would bring. Examples of initiatives being undertaken included the early intervention team (to help prevent people becoming ill), support to go home service which was helping break down barriers between acute and social care, social prescribing and enhanced services at Newmarket Hospital. Global digital excellence (GDE) funding had enabled the trust to continue building upon the electronic e-Care system, looking to wider system integration such as the population health package, with the aim to achieve seamless services across the health and social care system.

The trust’s dementia strategy dated October 2019, and the strategy for supporting patients who have a learning disability, dated August 2017, both identified partnership and engagement to improve care outcomes for these vulnerable groups. For example, the use of a health passport (a patient held record) to help reduce the need for patients to duplicate information to different care providers.

Staff across all core services were aware of the trust vision, values and strategy. Senior staff across the organisation understood their roles and responsibilities in helping to achieve them. Where individual service strategies were not in place, or fully aligned, work was underway to develop these, for example in community inpatient and children and young people’s services.

There was a pharmacy strategy in place for 2017 to 2020. The vision was that all people, irrespective of their care setting should have access from pharmacists in the management of their medicines. The four key themes were patient experience, patient safety through quality, efficiency and productivity and pharmacy workforce. The strategy supported the development of new technologies and an automated dispensing unit (robot) was in place along with an electronic prescribing and medicines administration (EPMA) system.

The progress against delivery of the strategy and local plans was monitored and reviewed. The trusts annual operational plan was approved at board and presented in public.

Culture

Not all staff felt respected, supported and valued or felt that they could raise concerns without fear. Communication and collaboration to seek solutions had not always been effectively undertaken. An open culture was not always demonstrated. However, staff were focused on the needs of patients receiving care. Equality and diversity and opportunities for career development were promoted.

Throughout the core service inspections, we found that the culture was centred on the needs and experience of people who used the service. Staff across the services were proud of the care they provided. Within the divisions staff were positive about the culture and felt supported by their colleagues and immediate line managers.
The trust felt that they promoted an open culture and had policies, procedure and processes in place to support staff, patients and relatives to raise concerns. The trust took assurance from the following mechanisms incident reporting, PALS, freedom to speak up (FTSU) guardian, trusted partners (volunteer members of staff), and guardian of safe working hours. To support staff directly there was an employee assist programme in place and the chaplaincy department was available to all. However, this did not align to the inspection findings. Staff did not feel listened to and saw others that had raised concerns be penalised. There was a focus on the individual raising concerns and response to issues were on occasion disproportionate. The executive leadership team failed to fully recognise the impact that this had on the safety culture within the organisation.

The trust was clear that behaviour inconsistent with the vision and values would be addressed and there were processes in place to manage behaviour and performance. In October 2018 the trust outlined via the green sheet that the trust executive group (TEG) was actively sponsoring action to make sure that anyone who believed they were being/or had been bullied or harassed or discriminated against had the confidence to report it formally and knew how to do this and that access to confidential support was available.

Despite these identified processes we found that some staff felt the culture did not encourage openness and honesty. Not all staff felt supported, respected or valued and some feared reprisals if they raised concerns. This impacted negatively on the ability of staff to challenge and discuss options for mitigating risk. Detail in the provider information request (PIR) was that, between April 2018 and March 2019, the trust had recorded one whistle blowing incidence. Incidences of whistleblowing were recorded in three main categories; patient care and patient safety, fraud, and workforce issues (including bullying culture). Additional PIR narrative then stated there had been six workforce incidents raised, no incidents of fraud and two patient care / patient safety incidents, thus giving a total of eight whistleblowing incidences, not one, within the same timeframe. The trust’s own analysis of theses noted that allegations of bullying and harassment, including lack of consideration and kindness to colleagues were key factors in a number of incidents. Other issues were around professional registration and staffing issues. These correlated to some of the results in the 2018 NHS staff survey and to our findings during inspection.

Six of the 10 whistle-blower contacts we received between September 2018 and September 2019 raised concerns that there was an apparent reluctance by the senior executive team to hear and accept feedback of a negative nature. Overarching themes included: the trust does not welcome feedback, a lack of robust investigation into employee relation matters and human resource (HR) process, poor support for staff with mental health concerns, poor culture, lack of engagement with FTSU guardian, poor communication, distrust of being able to raise concerns without breach of confidence or fear of repercussion. We heard examples from staff that information they had provided in confidence, to various individuals including the FTSU guardian, had become known. Across a number of specialties, including paediatrics, pathology, anaesthetics and vascular services, genuine concerns relating to clinical risk and safety had been raised. Staff directly involved felt communication and collaboration to seek solutions had not been effectively undertaken. Some staff, during interview, stated they felt this had resulted in specific areas and groups of staff being seen, by the executive team, as dysfunctional rather than believing that issues needed to be addressed and worked through with staff to improve services for patients. Some senior staff we spoke with felt that they had not been personally supported by the executive team when they had sought help and advice.
The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20 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. When we requested information around a serious incident in the vascular services, we were informed that duty of candour had not been undertaken as the level of harm was still unknown.

Whilst the duty of candour component 20(2) refers to notifiable incidents (death of a service user, severe harm, moderate harm or prolonged psychological harm), component 20(1) states that registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. Providers must promote culture that encourages candour, openness and honesty at all levels. This should be an integral part of a culture of safety that supports organisational and personal learning. There should also be a commitment to being open and transparent at board level or its equivalent, such as a governing body. We reviewed the trust local policy “Being open – The Duty of Candour” January 2018 where it was stated in the summary that the board set out a commitment to transparency and being open.

We requested copies of communication that were sent to vascular patients that required follow up and received only a draft letter for duty of candour. We were not provided with evidence of what communication had been made with the patients that had been affected by the incident, to be assured that the trust was openly communicating that there had been a failing in internal systems. It was also evident that this had not been acted upon or communicated in a timely manner. Therefore, we were not assured that the trust had acted in line with its own policy or taken reasonable steps to ensure duty of candour had been appropriately applied by being fully open and transparent.

There was a complex serious incident investigation ongoing at the time of inspection that encompassed aspects of alleged patient safety, incident reporting, risk management, breach of confidentiality and both personal and professional conduct. We found that the process of this investigation had far reaching effects across a number of staff, and the executive team, impacting on health and wellbeing, culture and morale of those involved. Whilst internal HR processes were being adhered to, some staff felt that the actions undertaken by the trust were questionable in purpose. Communications sent during the investigation were corporately worded, with direct legal reference, which meant that they lacked any personal element, and were seen by some as quite threatening in nature with a focus for apportioning blame.

On the 10 September 2019 the medical staffing committee (MSC) wrote a collective statement of concern to the chair. This stated that concerns had been raised by multiple departments in regard to the culture and behaviours of the executive body, on multiple occasions, that had not endorsed the trust values of freedom to speak up. The CEO and the chair attended the next meeting of the MSC in October 2019 to discuss and listen to the concerns being raised and reassure the consultant body that the executive directors lived the values. Whilst the meeting itself had been an attempt to address some of the concerns raised, we found that the subsequent response letter to the MSC chair, dated 14 October 2019, could be considered intimidating, and confirmed to us the continued disconnect around communication. The letter outlined that discussions were held around how matters of speaking up were dealt with and how the board sought to ensure balance and objectivity in their decision making. However, it also included a schematic, developed by trust lawyers, to set out the process followed when concerns were made about a professional's practice and stated that this was “assiduously followed”.

20190416 900885 Post-inspection Evidence appendix template v4
During the well led interviews, we found that the ongoing serious investigation was in the forefront of several of the executive directors’ minds. There was an understandable desire to bring the investigation to a closure as soon as possible however, we were concerned that the route the investigation had taken, and the commitment of the board of non-tolerance to poor behaviour, was potentially limiting their objectivity. CQC have no regulatory remit to investigate or intervene with individual complaints or incidents. Having looked at the process however, we were concerned that the incident focus had potentially impacted on the wider root cause analysis. Irrespective of the incident itself there was learning to be gained from understanding why established channels of raising concerns had not been taken, however the executive team appeared focused on the who, rather than the why and whether there were effective systems for staff to raise concerns to ensure patient safety. There was a level of acceptance, by the executive team, that there were simply two sides of the incident which was not helpful. In one meeting, the medical director described that certain staff were in “separate camps” and alluded to a “them and us” situation. There were wider ripples of impact in that disengagement of the consultant body was a real risk, yet following the concerns raised there had been no separate medical staff survey undertaken to explore the extent of concerns. We fed this back to the executive directors and there was an element of recognition that communication and engagement needed to improve.

The senior executive team did reflect and recognise that communication and handling of certain aspects of this incident, and others, could have been better. They also stressed that other incidents had been handled sensitively and had not been brought to the attention of others by those involved. They provided a separate example where wording around a question in relation to pay and annual leave for doctors had caused huge discontent and recognised that often language used can escalate an appropriate question out of proportion, that then takes a long time to repair. The trust had implemented a “lessons learned” process following a grievance or disciplinary to help to ensure any issues identified were not repeated going forward, but we were not provided with evidence that this had been implemented.

There was a better working lives group in place. We reviewed the minutes of the meeting on the 23 September 2019. Under agenda point 7, there was a discussion held in relation to improved support for staff in stressful situations such as coroner’s court, serious incident investigation, a never event, a complaint or after maternity or any long-term sickness absence. Included in this discussion were suggestions from the MSC. Options included ‘opt out’ rather than ‘opt in’ for support required. There was agreement that an exact process for support would be beneficial for all staff, not just doctors. It was noted that this would be a great quality improvement project but would be a huge piece of work. An action was identified that the deputy medical director would arrange a meeting with the head of patient safety and human resources to help take this forward.

Some staff told us that they felt that the executive team were so focused on maintaining outstanding status this impacted on the response received when concerns were raised and they “only wanted to hear the good”. We explored during the inspection whether there was added pressure on staff internally that was arising from the rating of outstanding. We noted that the theme of outstanding was used in various communications and formats. For example, the summer leadership summit had taken place on 19 June 2019 with outlined objectives and sessions based on creating a more inclusive culture and quality. There was an intense focus on understanding, developing and maintaining outstanding care and 70 staff attended. Session one focused on addressing and responding to priorities for improvement agreed from the 2018 national staff survey results. Session two focused on quality “keep calm and carry on being outstanding.” Minutes from the trust executive group on 2 September 2019 included a section on the CQC inspection and included text “the CQC don’t know we are outstanding, so we need to ensure we
tell them”. This message was reiterated by several staff throughout the core service and well led inspections.

**NHS Staff Survey 2018 results – Summary scores**

The following illustration shows how this provider compares with other similar providers on ten key themes from the survey. Possible scores range from one to ten – a higher score indicates a better result.

There were no themes where the trust’s scores were significantly higher (better) or significantly lower (worse) when compared to the 2017 staff survey.

*(Source: NHS Staff Survey 2018)*

The 2018 NHS staff survey was completed by staff during the period September 2018 to December 2018. A sample of 1250 staff was randomly selected, of which 601 responded. This meant a 48% response rate which was better than the average of 44%.

The 2018 national staff survey results showed that staff felt more supported than in the previous year. Ratings improved for staff getting support from their immediate manager (up 2.5%); getting clear feedback on their work (up 2.1%); being asked for their opinion before changes are made (up 2.9%); and for feeling like their manager values their work (up 1.4%). The percentage of staff that felt their role made a difference to patients had decreased from...
92.7% in 2017 to 91% but remained above the national average 89%. The percentage of staff satisfied with the quality of care they give was 84% against a national average of 80%, and 78% staff felt enthusiastic about their job (national average 74%).

The overview theme results, scored out of 10, for health and wellbeing, morale, safe environment (bullying and harassment) and safe environment (violence) were all above average at 6.4, 6.4, 8.1 and 9.4 respectively. Whilst the trust had a fairly consistent result between 2015 and 2018 in relation to safe environment (bullying and harassment and violence) there had been decline in several of the detailed results:

Q13b: In the last 12 months, how many times have you personally experienced bullying and harassment from managers: had increased from 9.1% in 2017 to 11.9% in 2018 (2.8% increase).
Q13c: In the last 12 months, how many times have you personally bullied and harassment from other colleagues: had increased from 14.9% in 2017 to 19.3% in 2018 (4.4% increase).
Q13d: The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it: reporting had dropped significantly from 51.2% to 37.9% which was in line with the worst rate for acute trusts.

A summary paper on the staff survey results went to board on 1st March 2019 and highlighted reporting, creating a compassionate and inclusive culture, being kind to each other and visible leadership as the top three priorities. We reviewed the trust action plan in response to the 2018 staff survey. Actions to address these results included further analysis to identify any ‘hot spots’ and reasons why staff may not be reporting. Additional actions included communication of the reporting process and importance of reporting via several means (core brief, Green sheet, and medical directors bulletin) alongside the re-promotion of staff support available, alongside setting of agreed behavioural standards and staff training on positive performance management and dealing with unacceptable behaviour. The introduction of an anonymous telephone reporting line had seen two contacts, one of which was to explore what the line was for. The lack of any high immediate response was seen by the executive directors we spoke with is as a positive sign.

The freedom to speak up (FTSU) guardian had been in post since 2017 and was directly employed by the trust. Prior to the role they had been a staff governor for nine years and had been approached by the director of HR to consider the role as there had been no expressions of interest. The FTSU guardian stated that they averaged approximately four hours a week but would flex this dependent on need. They could be contacted either directly by telephone or via email. The guardian had received initial training from the National Guardian Office (NGO) and they were involved in the Eastern Counties freedom to speak up network. The trust had hosted the network meeting on site on 26 June 2019.

During interview the FTSU guardian was extremely positive of the support provided by the executive directors. As well as direct support from the executive and non-executive leads for FTSU, they stated they could speak at any time to the CEO and chair and were confident that issues would be dealt with. They were proud of the role and stated they saw it as important and a privilege. They had monthly one-to-one meetings with the interim director of human resources and stated they met the nominated non-executive director (NED) every six months. They recognised that contact out in the community services needed to improve and stated they planned to work with the staff governor in the community to address this.

However, during interview we were not assured that the guardian had full understanding of the role. Their focus was on the support they were receiving from the executive team rather than support they were providing to staff across the organisation. They also stated they caught up fairly
frequently with the guardian of safe working hours (GOSW), however this was not confirmed by the GOSW. The GOSW had been in post since March 2019 and informed us that the FTSU guardian had not responded to their initial contact. Despite initial thoughts that contact between the two roles would be important, as time had passed this had lessened, however they confirmed that they knew who the FTSU guardian was.

The FTSU guardian produced two reports a year to board. We reviewed the FTSU reports to board, dated 26 April 2019 and 1 November 2019. We found that these reports lacked substance and were extremely limited in content. Both reports outlined the role of the guardian and ongoing engagement at staff events to promote role. There was no evidence of triangulation to other patient /staff experience data to identify potential emerging issues. There was no trend analysis of numbers, issues, type of worker speaking up or analysis of wider context such as potential risks, barriers and opportunities. Neither FTSU reports mentioned any analysis of the 2018 NHS staff survey results.

Data was submitted quarterly to the NGO as per the “Recording Cases and Reporting Data guidance”, July 2018. Data entry format was the total number of cases, number raised anonymously, number with a patient safety / quality element, number with a bullying or harassment element and number where people report they are suffering detriment. The FTSU report for board categorised the data into behaviour / attitude, trust procedure / practice, capacity / workload and miscellaneous. It was difficult to compare reported data to the NGO with the data reported to the trust board as timeframes and categories differed.

In the data submitted to the NGO for quarter four 2018/19 eight cases were reported, two under the patient safety element and six under bullying and harassment. The same total number overall was reported in the April 2019 board report, with time frame stated as “over the last six months”. Four were recorded under behaviour / attitude, with the status reported as zero resolved and four outstanding. We noted that the additional text did not correlate with the figures presented as it stated “these are two cases where I am either working with staff and HR or where I have been asked to support staff. To date one has been resolved and the other is outstanding with the member of staff awaiting closure”. One was recorded under trust procedure / practice (status outstanding), and three recorded as miscellaneous (all resolved). In the November 2019 report six concerns were documented as being reported in the five months prior to the report. Four as behaviour / attitude (status three resolved, one outstanding), and two as miscellaneous (both resolved). There was no update on any of the previous reports concerns that had remained outstanding in the November report. This limited the board’s ability to track and monitor progress.

We reviewed the board meeting minutes for April 2019 and whilst the agenda stated the FTSU report was submitted for the board to accept there was no documented comment in the minutes that this had taken place or evidence of any questions or challenge to the FTSU guardian. Therefore, we were not assured that there was sufficient data or content presented within the reports to provide any assurance to board. We noted that in an additional report to board in November 2019, in response to national FTSU guidance in NHS trusts it was documented that the trust would review the FTSU guardian report to ensure that the board received assurance through this reporting mechanism. In the same document was the commitment to produce a FTSU strategy to be presented to the board in January 2020.

The role of the guardian of safe working hours (GOSW) was to reassure junior doctors and employers that rotas and working conditions were safe for doctors and patients. They worked three days a week at the trust, reported into the medical director and produced a quarterly report.
to the board. Monthly junior doctors' forums were in place, that were held in two parts. The first being an open forum (un-minuted) and the second part being more formal, chaired by the GOSW and minuted. Attendance at the second part included the mess president, chief resident, British Medical Association (BMA) representatives, the director of medical education, the foundation programme director, members of human resources (HR), rota co-ordinators and BMA advisors. We reviewed the executive summary report for 31 July 2019 to September 2019. The report included summary data, including exception reporting broken down into month and department, work schedules, immediate safety concerns, staffing factors such as locum bookings and vacancies, and matters arising that detailed the concerns and actions taken to resolve them. The data reported was clearly documented with formats that provided monthly breakdown comparators.

**Staff Diversity**

The trust provided the following breakdowns of medical and dental staff, qualified nursing staff and midwifery staff, and qualified allied health professionals by ethnic group:

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Medical and dental staff (%)</th>
<th>Qualified nursing midwifery staff (%)</th>
<th>Qualified allied health professionals (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A White - British</td>
<td>46.3%</td>
<td>69.7%</td>
<td>82.3%</td>
</tr>
<tr>
<td>B White - Irish</td>
<td>1.8%</td>
<td>1.1%</td>
<td>0.8%</td>
</tr>
<tr>
<td>C White - any other White background</td>
<td>11.1%</td>
<td>7.6%</td>
<td>5.3%</td>
</tr>
<tr>
<td>C3 White unspecified</td>
<td>0.3%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>CA White English</td>
<td>0.0%</td>
<td>0.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>CQ White ex-USSR</td>
<td>0.3%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>CY White other European</td>
<td>0.3%</td>
<td>0.2%</td>
<td>0.0%</td>
</tr>
<tr>
<td>D Mixed - White &amp; Black Caribbean</td>
<td>0.5%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>E Mixed - White &amp; Black African</td>
<td>0.8%</td>
<td>0.2%</td>
<td>0.0%</td>
</tr>
<tr>
<td>F Mixed - White &amp; Asian</td>
<td>1.0%</td>
<td>0.3%</td>
<td>0.8%</td>
</tr>
<tr>
<td>G Mixed - any other mixed background</td>
<td>1.0%</td>
<td>0.4%</td>
<td>0.3%</td>
</tr>
<tr>
<td>GF Mixed - other/unspecified</td>
<td>0.0%</td>
<td>3.8%</td>
<td>0.0%</td>
</tr>
<tr>
<td>H Asian or Asian British - Indian</td>
<td>14.9%</td>
<td>0.1%</td>
<td>0.3%</td>
</tr>
<tr>
<td>J Asian or Asian British - Pakistani</td>
<td>4.1%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>K Asian or Asian British - Bangladeshi</td>
<td>1.0%</td>
<td>0.1%</td>
<td>0.6%</td>
</tr>
<tr>
<td>L Asian or Asian British - any other Asian background</td>
<td>3.6%</td>
<td>6.2%</td>
<td>0.6%</td>
</tr>
<tr>
<td>LJ Asian Caribbean</td>
<td>0.3%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>M Black or Black British - Caribbean</td>
<td>0.8%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>N Black or Black British - African</td>
<td>2.6%</td>
<td>0.4%</td>
<td>0.3%</td>
</tr>
<tr>
<td>P Black or Black British - any other Black background</td>
<td>0.3%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>PC Black Nigerian</td>
<td>0.3%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>R Chinese</td>
<td>3.3%</td>
<td>0.3%</td>
<td>0.6%</td>
</tr>
<tr>
<td>S Any other ethnic group</td>
<td>4.4%</td>
<td>0.7%</td>
<td>0.0%</td>
</tr>
<tr>
<td>SC Filipino</td>
<td>0.0%</td>
<td>0.5%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Z Not stated</td>
<td>1.3%</td>
<td>8.6%</td>
<td>8.3%</td>
</tr>
</tbody>
</table>
The trust promoted equality and diversity within and beyond the organisation. The trust had joined the NHS Rainbow badge scheme in June 2019. The trust had a lesbian, gay, bisexual and transgender plus (LGB&T+) network that met monthly. Membership included LGB&T+ people and allies employed across the acute and community services as well as from other health and public sector partners. The network was founded to support LGB&T+ staff and patients and to provide advice and guidance about LGB&T issues. The aim was to assure patients that they would be treated without discrimination, regardless of sexual orientation or gender identity, by staff that shares values of inclusion and support. The trust ran a trans awareness in healthcare workshop on 21 May 2019. Equality and diversity training was mandatory for all staff (repeated every three years). Training was provided face to face at trust induction and updates via e-learning.

The trust encouraged eligible staff to participate in development opportunities targeted at minority and under-represented groups, for example the NHS confederation network for black and minority ethnicity (BME) leaders, and sponsored leaders of the trusts LGB&T+ network to attend the Stonewall Workplace conference in April 2019. One member of staff was being supported to undertake the national workforce race equality standard (WRES) frontline forum coaching for improvement programme.

In addition, the trust had a disabled staff network, and held numerous workshops to improve communication and engagement. The three-tier strategy on recruitment and retention included staff from a diverse cultural background. The trust had a large number of staff that had been recruited from the Philippines. To encourage retention a second clinical practitioner had been appointed to support the career development needs specific to international employees with focus on aspects such as a social network and supporting families that have relocated either together, or support for staff where family has been left behind and flexible working.

The trust had a named lead for learning disabilities and autism and an equality, diversity and inclusion (EDI) group. The green light toolkit (GLT), from the national development team for inclusion was used to assess how the trust were meeting the needs of people with learning disabilities and / or autism. Assessments included accessible information, personal care, physical health and equalities. We reviewed a presentation on the GLT, that went to the EDI group, and saw evidence of actions in line with the GLT standards such as user involvement, working together, employment and reasonable adjustments. The learning disability (LD) and autistic spectrum disorders (ASD) strategy had five pathways based upon the GLT standards.

**Workforce race equality standard**

The workforce race equality standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts have to show progress against nine measures of equality in the workforce.

The scores presented below are indicators relating to the comparative experiences of white and black and minority ethnic (BME) staff, as required for the Workforce Race Equality Standard.

The data for indicators 1 to 4 and indicator 9 is supplied to CQC by NHS England, based on data from the Electronic Staff Record (ESR) or supplied by trusts to the NHS England WRES
team, while indicators 5 to 8 are included in the NHS Staff Survey.

Notes relating to the scores:
- These scores are un-weighted, or not adjusted.
- There are nine WRES metrics which we display as 10 indicators. However, not all indicators are available for all trusts; for example, if the trust has less than 11 responses for a staff survey question, then the score would not be published.
- Note that the questions are not all oriented the same way: for 1a, 1b, 2, 4 and 7, a higher percentage is better while for indicators 3, 5, 6 and 8 a higher percentage is worse.
- The presence of a statistically significant difference between the experiences of BME and White staff may be caused by a variety of factors. Whether such differences are of regulatory significance will depend on individual trusts' circumstances.

<table>
<thead>
<tr>
<th>WRES Indicators from ESR (HR data) (1)</th>
<th>BME Staff</th>
<th>White Staff</th>
<th>Are there statistically significant difference between</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>BE and White staff?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(BME staff)</td>
</tr>
<tr>
<td>1a. Proportion of clinical (nursing and midwifery) staff in senior roles, band 8+</td>
<td>1.8%</td>
<td>4.0%</td>
<td>-</td>
</tr>
<tr>
<td>1b. Proportion of non-clinical staff in senior roles, band 8+</td>
<td>5.7%</td>
<td>6.6%</td>
<td>-</td>
</tr>
<tr>
<td>2. Proportions of shortlisted candidates being appointed to positions</td>
<td>9.2%</td>
<td>14.7%</td>
<td></td>
</tr>
<tr>
<td>3. Proportion of staff entering formal disciplinary processes</td>
<td>0.2%</td>
<td>0.7%</td>
<td>-</td>
</tr>
<tr>
<td>4. Proportion of staff accessing non-mandatory training and CPD</td>
<td>92.7%</td>
<td>87.6%</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WRES Indicators from the NHS staff survey (1)</th>
<th>Proportion of respondents answering &quot;Yes&quot;</th>
<th>Are there significant differences between</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BME staff</td>
<td>White staff</td>
</tr>
<tr>
<td>5. Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months</td>
<td>Trust</td>
<td>26.5%</td>
</tr>
<tr>
<td>Peer group</td>
<td>29.9%</td>
<td>27.9%</td>
</tr>
<tr>
<td>6. Staff experiencing harassment, bullying or abuse from staff in the last 12 months</td>
<td>Trust</td>
<td>34.1%</td>
</tr>
<tr>
<td>Peer group</td>
<td>30.1%</td>
<td>26.0%</td>
</tr>
<tr>
<td>7. Staff believing that the trust provides equal opportunities for career progression or promotion</td>
<td>Trust</td>
<td>78.6%</td>
</tr>
<tr>
<td>Peer group</td>
<td>69.8%</td>
<td>86.3%</td>
</tr>
<tr>
<td>8. Staff experiencing discrimination at work from a manager/line leader or other colleague?</td>
<td>Trust</td>
<td>11.4%</td>
</tr>
<tr>
<td>Peer group</td>
<td>16.9%</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trust staffing numbers (1)</th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>[BME Voting Board Members] and Board compared to overall staff demographic</td>
<td>[0]</td>
<td>[0]</td>
</tr>
</tbody>
</table>

**Key**
- **Statistically significant or negative finding**
- **Not statistically significant**
- **Positive finding**
- **Statistical analysis not undertaken as less than 30 BME staff responded**
- **Statistically significant improvement**
- **No statistically significant change**
- **Statistically significant deterioration**

As of 2018, one of the ESR staffing indicators shown above (indicators 1a to 3) showed a statistically significant difference in score between White and BME staff:

2. In 2018, BME candidates were significantly less likely than White candidates to get jobs for which they had been shortlisted (9.2% of BME staff compared to 14.7% of White staff). This had significantly increased by 5.6% compared to the previous year, 2017.

Of the four indicators from the NHS staff survey 2018 shown above (indicators 5 to 8), none of
the indicators showed a statistically significant difference in score between White and BME staff. Please note that statistical analysis was not undertaken on indicator 7 (staff believing that the trust provides equal opportunities for career progression or promotion) as less than 30 BME staff responded.

There were no BME Voting Board Members at the trust, which was not significantly different to the number expected, based on the overall percentage of BME staff.

(Source: NHS Staff Survey 2018; NHS England)

Information provided ahead of the inspection was that the trust utilised reviews of performance against equality and diversity scheme (EDS) goals and outcomes, and reviews of equality impact assessment reports as part of their ambition to “support all our staff” (ambition seven).

The annual equality report, published on the trust website, included the workforce race equality scheme (WRES). The Trusts Workforce Strategy 2015 - 2020 outlined the trusts strategies and actions regarding workforce issues and included all the requirements for equality and diversity under the Equality Act.

We reviewed the trusts Inclusion strategy v02, that was in draft form for discussion. We saw that it outlined objectives for 2019 to 2021, for patients, service users and carers and staff. The objectives had been drawn from consultation with staff and users and review of the trust performance against the WRES, workforce disability equality standard (WDES), gender pay gap, trust strategic framework, national NHS staff survey feedback and equality delivery system (EDS2). The EDS2 is a toolkit designed to help NHS organisations in assessing and grading their equality performance each year. Progress would be reported to the equality and diversity steering group, and the patient experience committee for patient issues, with an annual report to board. We saw that the objectives had been developed into a single action plan covering all schemes.

We reviewed the annual equality, diversity and inclusion report 2018/19 to board that outlined the inclusion objectives for 2017 to 2019, standards and assurance, summary of progress since September 2017 and future developments. The workforce disability equality standards report 2019 was signed off by the trust board on 27 September 2019 and the report and associated action plan were available on the trust website.

The results of the 2018 National staff survey supported the work that was being undertaken in relation to equality, diversity and inclusion. In three of the four detailed results the trust had improved from 2017. These were related to fair career progression / promotion, a decrease in discrimination from patients / service users and adequate adjustments made to enable staff to carry out their work. The one question that had declined was Q28b: In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues? This scored 7.2%, an increase from 6.6% in 2017.

Additional data identified that whilst grounds for discrimination in relation to disability, religion and gender were all below the national average at 2.2%, 3.4% and 15.3% respectively. However, grounds for discrimination in relation to age (22.7%) and sexual orientation (4.7%) were both above the national average. It was recognised by the trust in the survey action plan that whilst gender discrimination remained below the national average (18.8%), 15.3% was still a high figure. Actions included a review of the mandatory equality, diversity and inclusion training,
publicising the results to all staff with emphasis on the unacceptability of all discrimination and ensure support and reporting mechanisms were understood and reviewed for suitability, continued organisational support for LGB&T+ network and exploring opportunities for organisational learning from any discrimination complaints.

Friends and Family test

The patient friends and family test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

The trust scored between 96.1% and 99.4% from July 2017 to June 2019. The data showed there had been a shift from February 2018 to September 2018 above the trust average. Two data points were unusually high, during April and May 2018, with two data points outside of the control limits and unusually low (November 2017 and May 2019) with a decline from April 2019 to May 2019. We discussed this during interview with the trusts patient experience manager They stated that some of the changes may have been related to the emergency department following the introduction of short message service (SMS) surveys being introduced in the emergency department, the previous system having been paper base. Actions were identified in response to some highlighted areas, for example customer care training and inclusion of patient experience as an agenda item at service team meetings.

West Suffolk NHS Foundation Trust – recommendation rates, July 2017 to June 2019

The chart below shows the response rates at the trust from July 2017 to June 2019:

West Suffolk NHS Foundation Trust – response rates, July 2017 to June 2019
Sickness absence rates

The trust’s sickness absence levels from May 2018 to April 2019 were consistently lower than the England averages.

(Source: NHS Digital)

General Medical Council – National Training Scheme Survey

In the 2018 General Medical Council Survey the trust performed the same as expected for all 18 indicators.

(Source: General Medical Council National Training Scheme Survey)


Governance

The trust had established governance processes throughout the organisation. The trust strategy and policy for risk management outlined clear roles and accountabilities at all levels throughout the organisation. Staff had regular opportunities to meet, discuss and learn from the performance of the services.

There were structures, processes and systems of accountability to support the delivery of the strategy and quality sustainable services. The council of governors, consisted of 25 governors, was the collective body that support and advise the executive and non-executive directors of the trust. As such the governors formed part of the governance structure and held the board of
directors to account. The governors had responsibility for appointing NEDs and could also challenge decisions of the trust board.

Since our previous inspection in 2017 the trust had finalised, aligned and integrated the governance structures for the community services. We reviewed the West Suffolk community service structures, dated 17 June 2019. The associate director of community and integrated services reported directly into the chief operating officer for operational activity. The head of nursing and senior matron for community and integrated services reported into the chief nurse for clinical activity. There was a separate defined structure for community paediatric services, community adult services and integrated therapies.

The trust strategy and policy for risk management ensured clinical governance and monitoring of compliance with best practice through a framework of committees and specialist groups. We reviewed the revised strategy dated August 2017 and noted this was overdue for review (July 2019). The strategy and policy supported the overall trust strategy, outlined the risk management procedures and identified roles and responsibilities at a corporate, divisional and local level down to individual staff responsibilities. Attached as appendices were the governance structure for managing risk, the risk escalation and feedback framework and the risk management development priorities.

Committees reporting into the trust board included the audit committee, trust executive group (TEG), quality and risk committee, charitable funds committee and the scrutiny committee. The clinical safety and effectiveness committee (CESC), patient experience committee (PEC) and corporate risk committee (CRC) reported directly into the quality and risk committee. Divisional executive performance meetings, divisional governance steering groups and ward / department governance groups formed part of the quality and performance monitoring and reported directly into TEG. Risk escalation to the board from TEG and the quality and risk committee were via monthly risk and governance reports.

We reviewed minutes from a variety of board, committee and subcommittee meetings. Board agendas and minutes, including those of the board's committees, aligned to the governance reporting structure and demonstrated consideration of risk. Minutes indicated appropriate levels of challenge across a range of these meetings. We reviewed minutes from the three quarterly quality and risk committees held between December 2018 and June 2019. The meetings had set agendas that incorporated approval of previous minutes and review of the matters arising action sheet, reports from sub-committees; such as the clinical safety and effectiveness committee (CSEC), corporate risk committee (CRC), patient experience committee, a quality group report, governance review and identification of issues for escalation or capture / review on the risk register. We were not provided with the action logs and accompanying papers and therefore could not comment specifically on the effectiveness of the oversight as tracking items through was not possible, however there appeared to be an adequate level of discussion and challenge documented.

Observational visits by board members and governors were undertaken as weekly quality walkabouts that covered both the hospital and community settings. During the core service inspection, we observed one of these quality visits on a medical ward. The team included the chief nurse, deputy chief nurse and head of patient safety and the chair. The format covered elements of quality checks, such as resuscitation equipment and medication fridge records, as well as
asking senior staff of their priorities, new innovations and ideas for improvements and speaking with patients. A programme of presentations and patient stories relating to the quality priorities and strategic/service developments was also delivered to the board and its subcommittees. We reviewed trust board meeting minutes, private and public, between 1 March 2019 and September 2019 and saw that patient stories were included at each meeting.

We reviewed the council of governors meeting minutes for 6 August 2019. The agenda outlined the general duties and statutory role of the governors. We saw this was well attended and agenda items included but were not limited to: reports from the chair and chief executive, governors issues, summary reports in relation to finance and workforce, quality and performance, alliance update, annual report and accounts 2018/19 and annual external audit review. The minutes were organised, detailed and evidenced challenge.

There were 26 governors in total, made up of staff and public members. The governors confirmed that they attended board meetings, quality walkarounds and undertook courtyard café surveys. They stated that they were often proof readers for strategies and could input comments through this process. Despite not being often embedded into the subcommittees of the board they felt they had the opportunity to scrutinise the board through the non-executive directors (NEDs) and that the NEDs took their views on board.

Across the core services regular governance meetings took place that had multidisciplinary attendance with staff having the opportunity to meet, discuss and learn. However, in maternity we found that governance needed to improve. Mortality and morbidity and leadership meetings were not minuted.

**Board Assurance Framework**

The board assurance framework (BAF) is a method of setting out the most important risks facing the organisation. It sets out the control framework used to manage them, any gaps in control and how the organisation satisfies itself that the controls are working as intended.

The trust provided their Board Assurance Framework, which details seven strategic objectives and the accompanying risks within each as of March 2019. The strategic objectives were:

1. Deliver personal care
2. Deliver safe care
3. Invest in staff
4. Deliver joined up care
5. Support a healthy start
6. Support a healthy life
7. Support to age well

(Source: Trust Board Assurance Framework – March 2019)

There were 11 risks identified against the strategic objectives, and these were rated as red (high), amber (medium), green (low) with detail of existing controls. The BAF included a summary of risk mapping, that included an inherent assessment, based on no controls in place, a residual assessment, based on existing controls, and a target, based on implementation of identified additional controls. Each of the 11 risks had an identified executive lead. Seven risks were rated red and four rated amber as of 29 March 2019.
The seven rated as red were related to quality, governance or service failure leading to reputation damage, reduced activity/income and/or regulatory action, management of emergency capacity and demand, including winter preparedness, delivery of cost improvement and transformational plans, provision of sustainable pathology services, delivery of workforce plan, external financial constraints and the development and delivery of the West Suffolk Alliance.

The four amber risks related to integration of community services, failure to deliver the national access standards, implementation of the estates strategy and digital adoption, transformation and benefits realisation.

The agenda of trust executive group (TEG) and board meetings were structured to ensure appropriate consideration of the key risks. TEG reviewed the top risks on a monthly basis along with red operational and corporate risks. A quarterly summary BAF report to board provided a high level summary of the key strategic risks and detailed identified additional controls to mitigate the risks. In addition, there was a six-monthly full review of the BAF that included consideration of risks, controls and assurances to ensure board oversight. Opportunities to undertake a ‘deep dive’ of the BAF risks was also undertaken by the audit committee.

We reviewed the BAF summary report, dated 29 March 2019. We saw that this included a review of the updated BAF, consideration of any gaps in assurance and identified topics for audit committee deep dives with proposed dates. These included global digital exemplar (GDE) digital roadmap, including community IT and HIMSS compliance (April 2019), winter planning, including workforce Internal audit findings (July 2019) and data quality (November 2019). We reviewed the minutes of the audit committee on 26 April 2019 and confirmed that the GDE deep dive had taken place.

The BAF and associated risk assessments and risk registers were all held and recorded electronically. Each of the 11 strategic risks had an electronic risk assessment that detailed an initial risk level and rating, devised from the likelihood and consequence of the risk, current risk level and rating once existing controls were in place, risk investigation and action plan.

Governance arrangements with partners and third-party providers were in place to encourage appropriate interaction and promote coordinated, person-centred care, however these were not always managed effectively. In relation to the development of a pathology network we remained concerned that the plans approved by both trust boards remained focused on the long term and did not address immediate ongoing safety concerns being raised by the team at the time of inspection, despite being identified by the trust, included as a corporate risk and included in the annual internal audit report 2018/19 and noted in the annual governance statement that the trust would continue to work with the host acute trust to address regulatory and accreditation concerns.

We reviewed the risk assessment for pathology that was provided after the inspection. The original assessment date was 10 June 2011 and many of the original hazards outlined correlated to the concerns the consultants continued to raise during this inspection. The latest date of review was 23 September 2019 with a risk rating of 16 (red). Outstanding actions, with timeframes identified as 31 December 2019, included evidence of operational implementation of the final pathology strategy, testing of the governance, demonstration of new governance arrangements and agreement of credible programme to achieve accreditation. The last action was for agreement and monitoring arrangements for the operational plan which was dated 31 March 2020.

The Medicines and Healthcare products Regulatory Agency (MHRA) had inspected the trust in February 2019 and found that urgent improvement was required in relation to a number of practices that fell short of best practice. The trust was required to respond with proposals and
timetable to address the concerns. Some of the concerns noted in the MHRA report echoed the ongoing concerns that were raised with us by the pathology consultants during the inspection.

We noted in the minutes from the closed board meeting on 1 March 2019, that the MHRA visit had been reported in the open board meeting. There were discussions about the ongoing concerns, that included identifying a local process to purchase essential items and claim reimbursement from the host acute trust. There was acknowledgment that this continued to be worked through and that progress was being made. In the minutes from the closed board in April 2019, it was noted that there was disappointment in the draft pathology strategy as none of the proposals made by the trust had been taken into account and that there was no recognition of the history of the quality and safety of services. In June 2019, it was noted under the scrutiny committee report that the pathology strategy had been considered by the executive team and would come back to the board with a recommendation. In the minutes of the meeting on 26 July 2019, it was noted that discussion of an alternative model, with the acute host trust and NHS Improvement, had not been successful. The board approved the recommendation to remain with the existing ownership model despite it being recognised that the view of the board differed from the view of the majority of the pathology consultant team.

The MHRA had re-inspected the trust on 17 September 2019 and the initial findings were included in the closed board papers for the meeting on 27 September 2019. In the ongoing actions section, it was documented that the chair recognised the importance of ongoing communications with the pathology team. The medical director reported that they had met with the consultant following the July board meeting and that they appeared to understand the reasons, some understood the national concept, and some accepted this, but others did not. It was noted that the pathology project board was meeting the following week and it was hoped that the strategy would be agreed and brought to board in November. There was appropriate level of challenge at board however we remained concerned that accurate reflections of current issues were not fully reported to enable complete board assurance. The feedback we received from the consultants and pathology managers during the well led inspection in October 2019 was not a misunderstanding around the network but remained focused on day to day safety issues and lent weight to the view that there remained a disconnect between the communication and understanding issues.

Management of risk, issues and performance

Risk, issues and poor performance was not always dealt with appropriately or undertaken in a timely manner. There was an inconsistent approach to risk management and processes. Service delivery and improvement was focused on short term issues. Clinical and internal audit processes were not always fully effective across all services.

The trusts risk management arrangements considered risk at three levels: strategic (risks to delivery of strategic objectives), corporate (risks with a wide organisational impact) and operational (risks local to an area or service), with both local risk registers and a corporate risk register in place. Processes were in place for identifying, recording, escalating and managing risks across the organisation, however these were not always fully effective or undertaken in a timely manner. There had been failures in the performance management and audit systems that had resulted in significant patient safety risk within the vascular service, and an extended period of time where potential risk across other specialties remained unknown.
Information provided prior to inspection was that ward to board assurance was through two-way communication between the board and operational areas across the organisation. The monthly integrated quality and performance report (IQPR) to the board provided an organisational dashboard. The information within the IQPR was underpinned by ward / service level metrics within the nurse staffing report and informed following divisional and service level review and action plans. Delivery of improvement at an operational level was monitored through the divisional performance review meetings.

We found that this structure was not fully effective across all of the core services inspected. Not all risks identified in the core service inspections had been highlighted by the local leadership teams. Recorded risks were not always aligned to what staff stated were on their worry list or contained sufficient information to determine how long risks had been on the register or if they were ready for removal. Not all staff were clear about their roles and accountabilities. Whilst there was a systematic programme of clinical and internal audit to monitor quality, operational and financial processes these were not always fully effective in identifying where action should be taken, for example within the urgent and emergency service the auditing of patient safety checklists did not lead to an improvement in performance. We found that there was a lack of pace in relation to change, including implementing actions from audits, and fed this back to the trust at the end of inspection.

We raised a number of significant concerns within the maternity service to which the trust partially responded. We issued a warning notice under section 29A of the Health and Social Care Act 2008, on 14 November 2018, outlining our remaining concerns. The trust is required to make the significant improvements identified regarding the quality of healthcare by 31 January 2020.

We received whistleblowing information, on 17 July 2019, that highlighted concerns in relation to vascular lost to follow up patients, an issue relating to the e-Care system removing prompts to review patient imaging and apparent reluctance by the trust to fully engage and explore this in a timely manner. Having contacted the trust for information on 19 July 2019 we were informed that this had been raised as a serious incident and that the trust would be taking action to address this, alongside any harm reviews that may be required and seeking information that no other specialties were affected. During the core service and well led inspections, we asked for details in relation to the progress of the investigation, wider review of any concern or impact for other specialties and how the trust was assured that the process for booking appointments for patients on surveillance and follow up appointments was robust.

Within the outpatient data flow process there was a clearly evident multifactorial risk of patients being subject to lost to follow-up. During the inspection there was clear information trends of patients not being seen in outpatients for their second or follow-up appointment in a timely manner or to a timescale prescribed by the managing clinician, this being due in part to capacity constraints. The management processes were described as being both electronic and paper based, giving risk to patient follow-up needs being lost within manual paper processes or not being subject to timely administration. Trust staff highlighted the follow-up work lists within the trust’s digital partner as a large directory of unvalidated data being a confusing risk. Whilst staff local to both outpatients and appointment access were able to describe their own work processes, both groups equally articulated the need to often escalate patient appointment needs to secretaries and consultant colleagues in order to secure future appointments, with no feedback that such appointments had then been booked.

A detailed investigatory review of loss to follow-up risk was undertaken within vascular services. There was clear evidence that technical systems at the time of go live: September 2016,
presented a definite lost to follow-up risk when considered in tandem with clinical routine work processes. Clinicians had highlighted, via the trust’s risk management system, evidence of patients dropping off individual consultant results work lists prior to the results being verified via the specific work list portal. Whilst all results were still retained within the data warehouse there was clear evidence to suggest patients results within vascular services may not have been reviewed giving rise to possible harm. This same technical risk could affect all clinical services across the trust but be particularly of concern to services operating a return surveillance service where test results could be processed annually. The inspecting team considered the trust’s own response to such highlighted risks to have been unsatisfactory.

It had taken several months from the initial incident report being raised by the vascular team in relation to the e-Care system and potential lost to follow up concerns to be recognised by the trust, with several incident forms rejected. Six incident reports had been submitted between November 2018 and May 2019 in relation to issues with reporting and viewing of images and e-Care. Incident reports submitted on the 25 January 2019 and 5 February 2019 had been rejected by the Chief Clinical Information Officer (CCIO). When we reviewed this during inspection the reason for rejection had been recorded as a non-system issue, but due to untimely review by consultants. The incident submitted on 28 May 2019 had been approved and prompted the beginning of the trust investigation. Therefore, there had been a significant delay in undertaking a root cause investigation to be assured there were no other contributory factors. It took until August for the trust to begin to communicate with other specialties to explore if the issue was more widespread.

In addition, we raised concerns that the non-executive directors and chair were not fully aware of the severity or length of time the issue of vascular lost to follow up had been identified (both groups stated awareness of some issue in summer and believed this related to a user error issue and not a system issue.) There had been no trust board meeting in August 2019, and the concern was not included in the September board, however we were informed that a report was going to the trust board on 01 November 19. We requested that report, however received the digital board update paper, dated 19 September 2019 and presented to board on 27 September 2019. Therefore, we remained unassured at that time, that the board had full sight of the issue to date.

We found that the trust had failed to respond in a timely manner to investigate and address concerns in relation to vascular lost to follow up patients and conduct relevant harm reviews. The initial information provided also failed to provide adequate assurance that wider risk to patients has been mitigated, that processes for booking patients for follow up appointments and ensuring surveillance pathways were effective or that the level of concern had been fully articulated to the board.

We issued a letter of intent on the 19 November 2019, informing the trust of possible urgent enforcement action under Section 31 of the Health and Social Care Act 2008. A letter of intent offers a provider the opportunity to put forward documentary evidence that risks have been removed or are immediately being removed. We were provided with evidence and assurance that immediate patient safety risks had been mitigated and harm reviews were being undertaken. The e-Care technical issue, relating to retention of information within the consultants work lists, had been resolved with the stipulated 90 day timeframe implemented. Surveillance pathways across specialties, and processes for follow up, were identified, reviewed and sample audits were undertaken to provide assurance that diagnostic interventions were happening as per pathway requirements. With regard to follow up patients we were informed that assurance was provided from reviews of incidents, complaints and GP issues.
The information gathering and deep dive into this had resulted in recognition by the trust that there were some inconsistencies across specialties and gaps in process that held potential risk. Steps were identified to strengthen governance process to ensure monitoring and oversight was appropriate and provide additional assurance to board planned. These included development of an e-Care report to identify patients and create a patient tracking list of patients for follow up. This would be reviewed at the specialties weekly tracking meeting, to provide consistency, and a programme of internal audit was being introduced. This would be monitored through the scrutiny committee and elements of the report added to the trust integrated quality performance report providing board oversight. In addition, the trust’s action plan identified plans to provide patients with more control to manage their own bookings through improved access to the electronic system. This meant we were more assured that the trust executive team were committed to learning from this and improving process to improve patient safety.

Staff responsibilities for risk management and supporting safe clinical practice include reporting incidents and near misses. Results in the NHS 2018 staff survey in relation to safety culture demonstrated that the trust overall had remained consistently above the England average since 2015. However, detailed responses were mixed. Between 2017 and 2018 three of the six specific questions demonstrated a continued improvement, whilst three demonstrated a decline, although all six remained above average.

Q17a: my organisation treats staff who are involved in an error, near miss or incident fairly had improved from 63% to 68.8%. Q17c: when errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again had improved from 76% to 77.4%. Q17d: we are given feedback about changes made in response to reported errors, near misses and incidents had improved from 61.6% to 65.3%.

We found that the three questions that had dipped echoed some of the themes highlighted to us from whistle-blowers, as follows: Q18b: I would feel secure raising concerns about unsafe clinical practice had decreased from 71.6% to 71.3%. Q18c: I am confident that my organisation would address my concern had decreased from 64.5% to 63.2%. Q21b: my organisation acts on concerns raised by patients / service users had decreased from 81.6% to 80.3%.

It was noted on the staff survey results action plan that action was needed to understand the issue of incident reporting and whether this was due to perceptions of the electronic incident system or fear of consequences of reporting, however the response to Q17a did not support this. We explored how the executive team were working to understand why levels of reporting were lower than other similar sized trusts. Information provided ahead of inspection identified that encouraging staff to report issues of concern; working to understand why levels of reporting were lower than other trusts and support for staff to speak up if they experienced poor behaviour were areas of focus.

The director of human resources and the chair confirmed that several actions had been undertaken, however it was stated that it remained a difficult question to pinpoint reasons why. From their own perspective, and informal view from speaking with staff when on quality walkabouts, the majority of staff would have no issue with reporting. Communication to ensure all staff and managers understood the reporting process and importance of reporting was sent via the core brief, green sheet, and medical directors bulletin. Promotion campaigns had occurred to ensure staff knew how to access support in the Time Out restaurant and via posters and leaflets. Training for trust staff on positive performance management and dealing with unacceptable behaviour was included as part of the leadership and management development programme and the leadership summit on 19 June 2019.
Clear structures and processes were in place for performance issues to be escalated appropriately, however not all staff groups felt these were always conducted suitably or quickly enough. As previously reported, the medical staff committee had been re-invigorated in June 2019. We reviewed the minutes from the MSC meetings in June, September and October 2019. Concerns identified within the minutes were supported by the consultants that attended the consultant focus group during the well led inspection. Examples were provided of the trust not listening when individuals were raising sensible, articulate concerns. Instead individual were reprimanded, went off through stress or were fearful for reprisals and positions. We fed back to the executive team the impact that the ongoing HR investigation was having in the organisation and the risk that this had on the wider safety culture. There was an acknowledgement that perhaps more could be done to pinpoint specific concerns.

We were also concerned that whilst audits were in place these were not always effective and not all investigation root cause analysis were extensive to encompass the wider risks. For example, a clinical pharmacy service was provided for inpatients alongside an outpatient dispensing service. One stop dispensing was in operation that allowed patients medicines to be kept in locked bedside storage labelled ready for discharge. There was a current audit programme in place which looked at safe and secure handling of medicines, use of antimicrobials and controlled drugs. However, the audit for the safe and secure storage of medicines did not cover bedside storage, and only the audit at ward level was overseen by pharmacy, not other specialist areas. The oversight of medicines in areas such as theatres was done at a divisional level both for risk assessment of storage and the reporting of omitted doses.

Following a serious incident, in November 2017, that involved member of staff self-administering medication, obtained from hospital supplies, whilst on duty we found that medications remained unlocked in the environment where this occurred. The risk assessment, that had been in place since 1 December 2015, had not been reviewed following the incident and was only updated on 29 October 2019, when we raised concerns.

At the time of inspection, the trust was not compliant with the falsified medicines directive (FMD) but we were informed that there was ongoing work with implementation, but this was dependent on the progress with Brexit. Pharmacy staffing was a risk to the provision of medicines reconciliation service to patients and the staffing of the aseptic unit which provided chemotherapy treatments. In order to mitigate these risks procurement, dispensary and production had taken precedence. This meant that clinical services had to focus on admission ward areas where patients were admitted for longer than 24 hours. The medicine reconciliation rate was 40% within 24 hours and 75% within 72 hours and remained on the divisional risk register alongside medication security.

### Finances Overview

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Previous Financial Year (2017/18)</td>
<td>Last Financial Year (2018/19)</td>
</tr>
<tr>
<td>Income</td>
<td>£253.4m</td>
<td>£241.7m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£0.3m)</td>
<td>(£9.9m)</td>
</tr>
<tr>
<td>Full costs</td>
<td>£253.7m</td>
<td>£251.6m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>(£5.9m)</td>
<td>(£10.2m)</td>
</tr>
</tbody>
</table>
The budget deficit reported in 2018/19 was higher than the previous year. At the time of reporting in June 2019, projections for 2019/20 indicated that the budget deficit would decrease to less than £0.1m.

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

Information provided prior to inspection was that the trust anticipated growth and inflation increase to turnover of 5% in 2020-21, resulting in a surplus of 2% of turnover overall. The trust had a block contract with two major commissioners that accounted for 85% of the clinical income. In addition, a seven-year contract was in place to provide community services in West Suffolk (this was an extension to the community services contract that had been running since October 2015). This meant that the trust considered the income plan as reasonably risk free.

The trust worked closely with the other members of the local alliance of health providers to agree an annual equitable division of system resources. We reviewed the cost improvement programme (CIP) information provided for May 2019 that indicated a target of £1,522k year to date (YTD) which represented 17% of the 2019-20 plan. There was a shortfall of £107k YTD against this plan.

There was no standalone finance committee as the board had taken the view retain full oversight of financial matters. Income and costs were part of the responsibilities held by the governance groups at both ward and divisional level. These reported into trust executive group, audit committee and trust board. We reviewed the audit committee meetings from January, April and May 2019. Financial reporting was a standard agenda item and had taken place in January. No financial reporting had been scheduled in the April meeting as the annual accounts sign off took place at the meeting on 23 May 2019. The audit committee was required to produce an annual report detailing work undertaken during a financial year. We reviewed the audit committee meeting minutes of 23 May 2019 that included the annual accounts sign off annual report to board, dated 27 July 2018, which covered the financial year ending 31 March 2019.

Finance reports were prepared by the deputy director of finance, overseen by the executive director of resources, and reported directly to the board. Members of the finance team were registered with various appropriate professional bodies, for example five with the association of chartered certified accountants (ACCA) and seven with the chartered institute of management accountants (CIMA). As noted by NHS Improvement ahead of the use of resources assessment there were no issues in respect of the capacity or capability of the trusts finance team.

We reviewed the finance and workforce reports for board and saw that these recorded a financial summary and executive summary, income and expenditure summary, overview of CIP, analysis on income and workforce planning, divisional positions, capital, balance sheet and cash and debit management. Included were key indicators to clearly define if performance was better or worse when compared against plan, against the previous month, and against target.

This meant the board had regular oversight of the financial status, any details in variance and summary sections from the divisions to allow for detailed analysis. Information provided following the inspection demonstrated that there was a process for clinical quality impact assessments (QIA) to ensure that any CIP or developments to services did not impact on patient care. We reviewed the terms of reference for the transformation steering group (TSG), v1 September 2018. This clearly outlined the governance and CIP decision making and approval process. All QIAs required approval by the medical and nursing director except for those that were under £10k and
a risk score below 12. This was confirmed in information we reviewed from the TSG meeting on 11 February 2019.

The non-executive directors (NED) presented a summary of the finance report and quality improvement report at the council of governors’ meetings. Various financial reports were produced for clinical teams, divisional and board analysis, such as CIP tables, model hospital report, presentation report for the transformation steering group and executive performance review meetings per division.

We reviewed the annual report and accounts 2018/19. This detailed an annual statement in remuneration and summary report from the renumeration committee. The aim of the remuneration committee was to make appropriate recommendations to the board on the trust’s remuneration policy and the specific remuneration and terms of service of the chief executive officer, executive directors and other staff as determined by the board. The committee comprised of the chairman and non-executive directors (NED) and was chaired by a NED. Three committee meetings took place during 2018/19.

The Use of Resources (UoR) assessment report, carried out by NHS Improvement, was undertaken on 30 September 2019. The aim of the UoR assessment is to improve understanding of how productively trusts are using their resources to provide high quality and sustainable care for patients. Findings of the UoR assessment were that the trust had consistently been able to deliver its control total (CT). It was part of the financial improvement programme (FIP2) and received support from a multinational professional services network in delivering savings in 17/18 and establishing systems and process around CIP monitoring going forward. These processes were now embedded within the organisation, which was shown as one of the most efficient trusts on Model Hospital. The Model Hospital is a free digital tool from NHS Improvement designed to help NHS providers improve their productivity and efficiency.

The current plan for 2019/20 was CT compliant, but required the delivery of a £8.9m CIP. The level of the CIP requirement was linked to challenges the trust had faced in delivering recurrent CIP savings in prior years. For 2018-19 the trust delivered an outturn £398k positive to control total (CT), with performance in line with plan for much of the year. For 2019-20 the trust had signed up to its CT with a planned deficit of £10,115k (excluding provider sustainability fund (PSF), financial recovery fund (FRF) and marginal weight emergency tariff (MRET)). It was noted that the current plan would be challenging and that the sustainability and transformation partnership (STP) had submitted a control total compliant plan which would require the system to work together to support delivery of all organisational plans.

信托企业风险登记

The trust provided a document detailing their nine highest profile corporate and operational risks as of June 2019. Each of these had a current risk level of amber or higher at the time of reporting.

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Risk level (current)</th>
<th>Risk level (target)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1680</td>
<td>Management of reporting and learning from incidents</td>
<td>Amber</td>
<td>Amber</td>
</tr>
<tr>
<td>1687</td>
<td>Prevention, identification and management of never events throughout the trust</td>
<td>Amber</td>
<td>Amber</td>
</tr>
</tbody>
</table>
As reported previously the board assurance framework (BAF) and trust wide risk registers were held and recorded electronically. The corporate risk register submitted as part of the provider information request (PIR), outlined in the table above, highlighted only one of the nine risks (European union (EU) exit risk assessment) with a red rating. We requested further information following the inspection that demonstrated there were 38 corporate risks rated as amber and seven rated as red. These reflected some, but not all, of the concerns we raised during inspection.

We reviewed the electronic risk assessment for each of the seven risks rated red. The seven highest risks related to exit from the EU, potential failure of the main building structure, pressure on radiologists to cope with 18 week process demand, severely reduced staffing in blood sciences, saving babies lives version two, issues around paediatric and obstetric staff and the ability to deal with contaminated self presenters. Each included an initial risk level and rating, devised from the likelihood and consequence of the risk, current risk level and rating once existing controls were in place, risk investigation and action plan. We found that these were not always detailed, and action plans were not fully robust. For example, the original assessment date for the risk related to radiologists capacity (305) was 18 June 2007. The action plan detailed seven actions ranging between March 2016 and July 2019. Six of the seven actions were to recruit. Risk 2987 related to the staffing in blood sciences (haematology, blood transfusion and biochemistry) and had been originally assessed on 26 September 2017. Documented text within the current controls referenced the demise of the previous pathology network however there had been no update recorded as to the new network NEESPS and how this may impact. Actions were centred around additional staff at weekends and locum use. The only mention to NEESPS was in the message section where it had been documented on 10 October 2017 that the actions added were for NEESPS staff to complete. Therefore, we were not assured that there was effective strategic oversight of the management of risk processes to ensure risks remained current and level of risk accurately reflected. There was a lack of clarity as to why risk processes differed across the trust, such as the security of medications within the theatre environment, and a failure to consider wider implications when undertaking risk and incident reviews.

The chief nurse and deputy chief nurse, as head of patient safety, were committed to raising concerns and challenging decisions to ensure that patient safety was forefront. As an example, the deputy chief nurse told us that they had to challenge over a learning from deaths / serious incident distinction to continue an investigation.

We were informed that there may have been elements of tension at times between the medical director and chief nurse in particular where the lines of accountability overlapped.

When we raised ongoing concerns within maternity services we found that the nominated executive lead for maternity and women and children’s services was the medical director, despite the chief nurse having a background in paediatrics. The professional responsibility for the head of midwifery and named nurse for safeguarding children remained with the chief nurse. It was suggested that staff preference was to speak with either the chief nurse or deputy chief nurse, as head of patient safety, but that the medical director was less likely to be approached by some.
We reviewed the annual internal audit report 2018/19 which was based on the overall adequacy and effectiveness of the organisations risk management, control and governance processes. The head of internal audit opinion was that there was an adequate and effective framework however further enhancements were identified to ensure that it remained adequate and effective. The scope and limitations of the internal audit were agreed with the management team and approved by the audit committee. Of the 19 reports issued, four had negative (partial) assurance opinions, 12 were positive (substantial or reasonable) assurance opinions and three were advisory in regard to three data quality reviews (deep dives into falls, pressure ulcers and information availability to support delivery of operational performance).

The 12 positive opinions from 2018/19 internal audit reports, where there was provision of assurance over the effectiveness of controls were: human factors approach review safer surgery, cost improvement plans, accident and emergency four hour waits, winter planning and preparedness, community services wheelchair service contract, integrated services – new services, red rated incidents, DSP toolkit and follow up GDPR preparedness review, divisional governance, BAF and risk management, creditors and payroll.

The four reports where only partial assurance was provided related to North East Essex and Suffolk Pathology Services (NEESPS) network, annual leave management, the Cambridge graduate course in medicine and data security and protection toolkit. The findings in relation to NEESPS supported the concerns voiced by whistle-blowers and our findings on inspection. Whilst there had been a lot of engagement and the approach to resolving issues and gaining accreditation had been approved by the trust board it did not taken account of how quality related risks, identified from a gap analysis, were being mitigated or that solutions would be delivered in a timely fashion. It also failed to make clear additional exposure to risk, alongside other factors such as the devolved decision making accountabilities, that could undermine efficient and effective progress and delay resolution of quality issues, until delivery was complete.

It was the view of the annual internal audit that there were no specific issues identified that needed to be identified as significant control issues within the trust's annual governance statement. However, it was stated that the trust should consider whether any of the control issues highlighted in the partial assurance reports for NEESPS and data security and protection toolkit should be included in the annual governance statement. We reviewed the annual governance statement that was included in the trust annual report 2018-19. We saw that three of the four partial assurance reports were included, the one not identified was data security and protection toolkit.

There were processes in place to take into account potential risks when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. The command, control and coordination (C3) plan outlined the arrangements in place across the trust (including the community) for patient flow business as usual and for escalation / de-escalation arrangements when responding to an incident. This plan was in date, due for review in December 2019, however we noted that version1.2 which was submitted prior to the inspection was a pre-approval working draft. There was a generic emergency and business continuity policy in place which outlined the requirement for the trust to have plans in place to ensure resilience of workforce and labour, infrastructure, utilities, technologies and supplies, developed at the lowest appropriate level, with clear escalation arrangements, matched with other plans, such as the major incident plan and C3 plan. The trust had sight of organisation readiness for Brexit through emergency planning reporting to the trust executive group and discussion at board meetings. We saw that there was a BAF deep dive in relation to exit from the European Union by the audit committee on 25 January 2019.

As part of winter planning based on predicted peaks in demand, the trust held a multi-agency discharge event (MADE) working with the wider health and social care system to find new ways to both recover and cope with demand.
Information management

Appropriate and accurate information was not always being effectively processed, which impacted on the reliability and analysis of data. Not all staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

We found that some of the information used to monitor performance and make decisions was inaccurate, invalid and unreliable. The combination of electronic and paper formats impacted on records reliability, ongoing issues with e-Care had impacted on the ability and accuracy to report service performance specifics, such as RTT and theatre utilisation. There were ongoing connectivity issues between the trust and the community services and we were concerned that there was a selective nature to the information being fed up to the board.

The trust had been a Global Digital Exemplar (GDE) site since 2017 and had received £20 million combined funding to invest in information technology across 2017 and 2018. This had enabled new developments in e-Care including theatres, anaesthetics, critical care, capacity management, emergency department dashboard (launch point), optimisation, integrated devices, open eyes, health information exchange, patient portal and population health platform.

Some of the identified new ways of working, through assisted technology, were aimed at giving staff time back to focus on caring for patients. These included voice recognition software for notes, the perfect ward app and replacing pagers with medic bleep. Information provided from the trust at inspection was that during the trial of medic bleep it saved junior doctors 48 minutes per shift and nurses 21 minutes per shift. However, the trust recognised that there was a need to balance the rate of technology to ensure it did not add to burnout and that there remained inherited issues that needed to be fixed, such as the community IT issues, where staff had to access a separate intranet system to the trust.

The performance dashboard in community children and young people’s service was under review to make it relevant to the service.

There were processes in place to monitor and report on performance, quality operations and finances such as the trust integrated quality and performance report. These included reports from ward to divisional level, up to corporate board level reporting. Information prior to inspection confirmed that data quality checks were performed by a number of information technology (IT), data quality and information system (IS) departments across the trust, alongside operational staff checking data as they process patients care. It was stated that IS checked the quality of the data as part of the routine report production.

However, we found that the information used to monitor, manage and report on quality and performance was not always reliable, or used effectively to monitor and improve the quality of care. The trust had an inpatient electronic prescribing and medicines administration (EPMA) system in place that also provided patients with information about their medicines at discharge. However, there were still some paper based systems in operation for certain prescribing and monitoring of certain antibiotics. Electronic prescribing of these was due to be completed at the next upgrade of the system. We found that missed or omitted doses were not overseen by the chief pharmacist but were reported on at a divisional level with data provided and monitored from e-Care which meant a disjointed approach and potential delay in specialist review.

An action relating to the vascular lost to follow up investigation was for the trust information technology (IT) team to identify a potential system logic to receive patient details however this had
only been requested approximately six weeks prior to the well led inspection (28 and 30 October 2019) despite the issue being known for several months. It remained as work in progress and became clear during inspection that the demands being placed on the internal IT teams outweighed their capacity.

There were continued concerns with the integration between the trust’s digital partner and several of the trust systems. The trust operates the digital product range for the management of its patient master index (PMI) and the recording of attending population data. The system is in itself linked to a data warehouse product also supported by the trust’s digital partner from which national access standard data and management reports are extracted. Throughout the inspection and during multiple triangulated interviews it was noted that the trust has had to introduce a substantial number of technical workarounds to data flow and reporting systems to allow for usable structured information output. Staff informed us during inspection that the contract agreement with the trust’s digital partner had failed to deliver as outlined. The trust internal information technology teams were continually required to seek alternative solutions to enable appropriate and accurate reporting, we were advised the number of workarounds totalled over 400. The situation was described such that the trust’s digital partner was now subordinate to the trust in sorting workarounds as the trust IT team had developed far greater ability, and knowledge, having responded and introduced so many. We recognised alongside the dedication, ability and competence of the IT teams the fact that this had put them under a tremendous amount of pressure. We were concerned for the morale and wellbeing of some staff that had been dealing with this pressure for a significant amount of time. For example, one member of staff described falling broken by it. We raised our concerns to the senior executive team, who were unaware of the full extent and impact this was having, despite the new initiative introduced around burnout.

At the time of inspection, the trust was underperforming across a large range of national access standards, in particular those related to the national 18 week referral to treatment (RTT) standard, the six week diagnostic standard and access standards related to suspected and confirmed cancer management. Whilst steps had been taken by the trust to introduce performance recovery plans at subspecialty level, there was very limited evidence that such plans were delivering the necessary traction of improvement. At a global trust level, the number of patients on the RTT waiting list was substantially higher than 12 months previously, reflecting a lack of systemic waiting list control.

We noted that in the annual governance statement 2018-19, section 2.6 of the annual report and accounts 2018/19, e-Care reporting and referral to treatment (RTT) performance were included. The launch of e-Care in May 2016 had impacted on the trust ability to report performance against a number of quality standards, including readmissions. The trust recognised that reporting challenges had continued and although the trust had delivered some improvements to reporting, control issues remained. The impact was noted specifically in relation to RTT with several “fixes” installed that had increased the number of patients on the patient tracking list (PTL). It was stated, as a cause of concern, that the trust had relied upon estimated reporting during 2018/19 for the national standard for ’18 week maximum wait from point of referral to treatment’ and that plans were being finalised to recover 90% performance against the RTT standard during 2019/20.

The trust was also unable to report data in 2016/17 and 2018/19 in relation to patients readmitted within 28 days of being discharged. It was stated that the trust would continue to review readmissions and identify themes and work with the trust’s digital partner to deliver further improvements.
We reviewed the Integrated quality and performance reports (IQPR) from May to August 2019. The report was colour coded using red, amber and green (RAG) to identify areas of risk. Referral to treatment (RTT) waiting list had been red since August 2018. The total number of patients on the waiting list had increased month on month from 16601 in August 2018 to 20942 at the end of August 2019, with two patients who breached the 52-week standard. The trust standard of 92% for the percentage of patients on an incomplete pathway within 18 weeks had also not been met for over 12 months. The trust had amber ratings between August and December 2018, but these had declined further and had been red since January 2019. The overall position had declined from 85.8% in May 2019, to 83.6% in August 2019.

With regard to cancer management, three areas failed the target for August 2019. These areas were cancer two week wait (breast symptoms) with performance at 90.3%, cancer 62-day GP referral, with performance at 79.6% and incomplete 104 day wait with three breaches reported in August 2019. Cancelled operations had missed the target standard (1%) in four out of the five months since April 2019. We found that whilst cancellations were reported as part of the IQPR, theatre utilisation was not. We were informed that this was due to a gap between the previous theatre system becoming obsolete and the introduction of the e-Care theatre module. This had been introduced in March 2019 and the theatre dashboard had been built. The team were in the process of testing the format and rules to ensure that the bespoke dashboard was capturing the information required and expected that complete reporting would start in a few months. In the interim between the two systems, a manual process was undertaken, and theatre productivity was discussed at various meetings including the weekly access meetings, performance review meeting and monthly theatre utilisation group. This meant the full visibility of theatre capability was disjointed and compromised.

It was noted, in the August 2019 IQPR, that there was an underachievement of the standard in general surgery, trauma and orthopaedics, ophthalmology, gastroenterology, thoracic medicine and gynaecology. Actions in place to recover performance included speciality action plans for recovery, monitoring long waiting patients at weekly access meetings, completion of a full action plan with options for out/in sourcing and additional internal activity, demand and capacity completion for cardiology and gastroenterology and root cause analysis, with clinical harm review, for patients breaching 52 week waits. The IQPR was reported at the trust executive group (TEG) meetings. We saw that in the TEG meeting on 2 September 2019 it was summarised that “The RTT performance had dipped but we have seen a reduction with the overall numbers on the waiting list. We are continuing to work through and review our capacity and what outsourcing capacity we have.”

We explored this further during the well led inspection. The deputy chief operating officer provided a detailed articulation of the trust’s weekly performance monitoring processes. Whilst the processes for review appeared on the surface to be robust, it was clear that applying material improvement at a subspecialty level was a constant challenge. The trust was being supported by national improvement colleagues to better understand and match capacity with demand. There was a description of a perpetual process of listing validation to support the weekly access meeting due directly to the trust’s digital partner information and data warehouse issues. Senior trust leaders reported not always being confident in the data they were receiving, and we were informed that it was suspected it would be a further 18 months before there was complete confidence in the accuracy of RTT data being reported.

This was also confirmed by the findings of the annual internal audit report 2018/19 where the opinion of partial assurance was found in relation to data security and protection toolkit. The
review tested a sample of three standards that included eight assertions over 26 elements. Based on the evidence available, at the time of the internal audit, the trust’s self-assessed status of all eight assertions was unsubstantiated. The internal audit report stated that actions were subsequently agreed to provide evidence to satisfy assertions, however in appendix B summary of internal audit work completed 2018/19 there were 19 actions agreed but these were not categorised.

There were arrangements in place for internal and external validation to ensure that availability, integrity and confidentiality of identifiable data management systems were in line with data security standards. The NHS Information governance toolkit is an online system which allows organisations to assess themselves or be assessed against Information Governance policies and standards. It also allows members of the public to view participating organisations’ IG Toolkit assessment. Information provided by NHS digital on 12 June 2019 was that the IG toolkit will be decommissioned and replaced by the data security protection toolkit within six months, with the deadline being no earlier than the end of October 2019. IG toolkit assessment for the trust, version 14.1 (2017-2018) was published on 29 March 2018. The trust received an overall score of 81% and grade of satisfactory.

Whilst there were assurance process for data validity in place we were not assured that these were fully effective, or that data produced was accurately reported or actions identified were followed through in the timeliest manner. For example, we found no evidence of any exception reporting in relation to the lost to follow up concerns in any of the board or subcommittee board minutes we reviewed before we issued the letter of intent. These included the trust executive group minutes, scrutiny committee and quality and risk committees as well as closed and public board papers. We subsequently received the minutes of the closed trust board, held on 1 November 2019. In these minutes it was stated that the starting point for the serious incident were green incidents reported in February and March 2019. However, evidence we received identified that the concern had initially been raised as an incident report on 25 January 2019 following contact from a family chasing a result (this incident was one that had been rejected). Therefore, the detail information provided for discussion, as documented, was not completely accurate. The final comment in the minutes was that a response should be sent to the CQC reflecting the discussions at the meeting and agreement that feedback to CQC should happen sooner rather than later, however this did not occur. Further discussions and information were only undertaken when we served the letter of intent.

We reviewed the independent auditors report to the council of governors in relation to the quality report. In the report it was stated that there was no evidence that would cause them to question that the quality report was prepared in line with criteria as specified in local trust policy, consistent with sources specified by NHS Improvement and that indicators, subject to limited assurance, had been reasonably stated in line with local policy. Therefore, governors were not fully sighted on the potential issues and current limitations with e-care integration and data production.

Senior leaders within the trust spoke about some of the considerations being reviewed with the clinical commissioning group (CCG) colleagues regarding capacity shortfalls and performance failings. Some exploratory work had been undertaken to consider insourcing, but it was felt such a work process could have a knock-on constraining affect to weekday routine working. Similarly, there was limited scope locally to outsource activity. There was very limited evidence presented to
the inspection team to suggest a shared system approach to referral management and assessment.

**Engagement**

Leaders across the organisation engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

There were several mechanisms in place to gather people’s views and experience to identify where services could be improved and how patients, and their representatives could engage and become involved in decision making to shape services. The “Your views matter” page on the trust website highlighted how people could be involved including, but not limited to: becoming a mystery shopper, patient representative, join the patient reader panel (reviewing patient information leaflets), completion of patient surveys and submitting a ‘patient story’ to help inform staff how individual patient experiences were.

Whilst consultation had occurred previously, for example in relation to the inclusion strategy, information provided prior to inspection was that there had been no public surveys or consultations undertaken in the 12 months leading up to the core service inspection in September 2019.

The experience of care strategy had been developed with the assistance of the patient vision, opportunity, insight, challenge, empower (VOICE) group to ensure that the trust focused on what mattered to the community. The trust had committed within its value “putting you first” and within its seven ambitions to deliver personal care to its community, with commitment to regular, high quality engagement outlined as part of the experience of care strategy. The strategy outlined a cycle of feedback, to listen and understand, engagement, to work together and improvement, to make changes that matter.

At the time of inspection, the experience of care strategy was in its second year. We reviewed the strategy document and saw that there were clearly outlined objectives for year one 2018/19 and year two 2019/20. It was stated that year three objectives would be agreed following engagement with relevant stakeholders and approved by the patient experience committee. There was a governance and assurance structure in place where information from several sources including the patient experience group, family carers group, end of life operational group, community paediatrics patient experience group fed into the quarterly patient experience committee that then reported to the quality and risk committee and up to trust board.

There was a patient experience manager in place and a nominated non-executive director for patient experience. The patient experience manager worked alongside the patient safety team and reported into the chief nurse. CQC utilises national surveys to find out about the experience of service users receiving care and treatment from healthcare organisations and mental healthcare providers. The inpatient survey for the trust was published on 20 June 2019. Between August 2018 and January 2019, a questionnaire was sent to 1,250 recent inpatients, with 594 responses received (47.5% response rate). There were 11 sections to the survey and all results were about the same when compared to other trusts. Each section was scored out of ten and the trust scored seven or above for 10 of the 11 sections. The one section that score lower was overall view of care and services (3.2/10). This was due to low scores in relation to patients being offered to take part in research (1.1/10), for being asked their vies about the quality of care during their stay (1.2/10) and for seeing or being given, information explaining how to complain (1.5/10).
As reported earlier the trust had taken steps towards becoming a more inclusive place to work, with staff support networks (LGBT+ and disability) and a better working lives group in place. Areas of focus identified by the trust included visibility of leadership, creating a more compassionate culture, recognising the importance of being kind to each other and encouraging staff to raise a concern.

The NHS staff survey results 2018, published on 26 February 2019, identified as an overall indicator of staff engagement that the trust score of 7.4 was above the average (7.0) when compared with trusts of a similar type. This figure had remained constant since 2016.

Detailed information in relation to staff engagement were mixed, although all none questions remained above average. The three questions related to motivation had either improved slightly or stayed the same as in 2017. In response to the three questions around ability to contribute to improvements, two had improved whilst Q4d: I am able to make improvements happen in my area of work had dropped from 59.2% in 2017 to 57.9%. All three responses related to recommendation as a place to work / receive treatment had worsened. Q21a: care of patients/service users organisation’s top priority had dropped from 87.1% in 2017 to 86.6% in 2018. Q21c: recommend the organisation as a place to work had dropped slightly from 74.4% in 2017 to 74.1% in 2018. Q21d: if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation fell from 85.3% in 2017 to 82.9% in 2018. The staff survey results action plan submitted prior to the inspection identified that further analysis would be needed to identify hot spots and for consideration of any other data that would supplement but no specific information was provided.

The trust engaged with external partners to build shared understanding of challenges within the system, the needs of the relevant population and how to deliver services to meet those needs. A joint based post of director of integration and partnerships had been established in January 2019 with West Suffolk clinical commissioning group. Healthwatch Suffolk were members of the quarterly patient and carer experience group and held a standing agenda item to discuss feedback that had been received in relation to services provided by the trust. Regular engagement meetings were scheduled with the acute mental health trust. Information provided ahead of inspection indicated that feedback from the mental health trust had been sought to shape the redesign of the emergency department and make changes to the psychiatric liaison service. Work being undertaken in relation to delivery of the West Suffolk Alliance meant collaboration and working jointly with other partners and stakeholders to create an integrated action plan and co-ordinated approach to increase capacity and redesign health and care services. Work was underway to establish a quarterly system quality and finance forums and joint posts were being explored for locality lead roles within the community.

The chief pharmacist engaged with other chief pharmacists within the sustainability and transformation partnership (STP) footprint including the STP wide area prescribing committee. At the time of inspection engagement with community pharmacists was targeted to patients most likely to benefit from a review of their medicines post discharge. The chief pharmacist attended the controlled drug local intelligence network (CDLIN), for wider sharing and learning around controlled drugs, on behalf of the accountable officer. The pharmacy team also worked in conjunction with other health partners and the University of East Anglia (UEA) with regard to de-prescribing and the provision of educational tools for general practitioners.

**Learning, continuous improvement and innovation**
Staff were committed to continually learning and improving services, however not all systems were fully embedded. Participation in and learning from internal and external reviews, including those related to mortality or the death of a person, were not fully established.

The trust had invested in building works and expanding clinical areas and pathways to improve patient experience. In December 2018 the cardiac centre opened bringing together the cardiology ward, cardiac care unit and the cardiac diagnostics unit. This enabled a fully integrated service and additional procedures such as angiography to be performed. The first phase of the acute assessment unit opened in December 2018 followed by phase two on 19 August 2019, and several additional services were launched to enable patients local access to specific care, such as the new tongue tie clinic in April 2019 and stroke pathway that included a repatriation service, allowing patients that lived locally to be treated closer to family and friends.

The trust had started recruiting partners of military personnel from the nearby airbase. The hospital and the base were working together to provide training on the differences between the NHS and the American healthcare system. The programme enabled military personnel to develop skill sets, through increased exposure, whilst supporting staffing levels at the trust. For example, information provided following the inspection indicated that the trust had benefitted from 2832 hours of technician support (1.6 WTE) and 1656 nurse hours (0.94 WTE). An example of one skill, intravenous (IV) cannulation had increased from 69 pre-placement for nurses to 541 post placements.

The programme also enabled the trust to tap into the pool of trained and skilled healthcare professionals among partners of military people on the base, enabling the United States (US) registered nurses to earn their UK nursing accreditation and go on to explore career opportunities in the UK. 15 registered nurse spouses had applied to start the training to convert to UK NMC registration of which 11 had been interviewed.

The trust also had five / six medical staff from the base covering the emergency department and several other specialties. We were informed the trust planned to apply to enter the HSJ awards category for NHS / non-NHS partnership working.

There were systems to support improvement and innovation work, including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work. The trust had several standardised improvement tools and methods in place. These included walkabouts and table-top reviews, GREATix (a new excellence reporting system to encourage staff to report good practice) and safety huddles. The trust undertook audit to measure performance and utilised the perfect ward app to review and report on several key indicators. For example, we reviewed a documentation inspection report, and observations inspection report, that highlighted key findings based on previous issues and whether they had been resolved, new issues and repeat issues, producing a separate score for records review and overall score result that was then shared with the ward/ area leaders to identify and action areas for improvement.

A quarterly shared learning bulletin had been introduced that included topics such as learning from clinical incidents and near misses, learning from deaths. The articles outlined the clinical aspects, identified learnings and how these would be shared across the trust. The bulletin also included details of quality improvement projects. The trust launched their own patient safety and learning strategy, following the publication of the national NHS patient safety strategy in July 2019.
Within the strategy the trust recognised areas of challenge and improvement, such as staff fear of blame and belief that incident reporting may be punitive, bureaucratic rather than responsive governance systems and some processes focusing on completion of an action rather than reduction of risk. The aim of the strategy was to reduce the instances of harm, improve engagement with patients and staff, support patients and staff through the investigation process and ensure learning was implemented. These translated into seven principles and the strategy included a three-year plan of objectives and quality assurance framework which provided a systematic approach to governance across the organisation.

The trust had produced several documents to inform staff and patients about improvement. For example, “The freedom to improve. Delivering high quality, safe care, together” outlining quality improvement tools and model for improvement. A summary of trust innovation and learning was provided within the document ‘Delivering high quality, safe care, together - Taking forward our Ambitions through innovation and improvement’. These were available as part of the open board meeting papers on the trust website.

We found examples across the core services of innovation and improvement. For example, digital integration and use of video consultations, medic bleep, continuity of carer team for specific cohorts of women and managers collaborating with staff in review of integrated community paediatric services.

However, whilst there were systems and processes in place for learning, continuous improvement and innovation these were not always fully effective. As reported earlier, we found that the impact from cultural issues and ongoing serious incident investigation processes were affecting the view of some staff that the trust was not promoting a learning, no blame organisation. Learning was not always shared effectively and used to make improvements. Team meetings were not routinely held within medical care.

Participation in and learning from internal and external reviews, including those related to mortality or the death of a person, were not fully established. At the time of inspection, the process for reviewing and investigating deaths was being reorganised, to make the learning more useful and disseminate a standard process across the organisation, the strategy was being drafted and there was no medical examiner in place. The consultant lead for learning from deaths had taken over the role in October 2018. They had instigated a process of review, resulting in the realisation that whilst every death was being looked at, and a huge amount of data produced, there was limited learning taking place from the individual reviews alone and no overview of themes / linking of these had been occurring. This led to a decision to use a targeted approach of reviewing areas of concern, either raised by members of staff or family members raising concerns with the bereavement office. The death would be reviewed using a structured judgement review (SJR) review methodology which was a nationally validated method where trained reviewers look at a medical record in a critical manner and comment on specific phases of clinical care. At the time of inspection there were three surgeons and one physician that undertook reviews.

The medical director and consultant lead confirmed that hospital standardised mortality ratio (HSMR) and summary hospital level mortality indicator (SHMI) were reviewed as part of hard number data indicators. However, as the trust were aware they were not situated within a deprived area and the narrative text made comparison difficult. They had identified that by using key words from concerns identified they could begin to extrapolate more meaningful data to identify trends.
The trust performed much better than compared nationally in relation to HSMR weekday and weekend. Dr Foster data demonstrated the trust had improved for mortality in low risk conditions and weekend between January and December 2018 when compared the same period in 2017. However, SHMI data had worsened slightly but remained similar to national comparators.

In April 2019 NHS Improvement announced the roll out of a new medical examiner system across England and Wales to provide greater scrutiny of deaths. The system will also offer a point of contact for bereaved families to raise concerns about the care provided prior to the death of a loved one. Acute trusts were asked to begin to set up medical examiner offices to initially focus on the certification of all deaths that occur in the organisation. At the time of inspection there was no medical examiner in place with the role yet to go to advert. We were informed during interview that currently the team consisted of a lead consultant and a senior member of staff that writes the reports and one administrator. A bereavement support officer was in place, with help from one other member of staff, to undertake the medical examiner administration role.

A monthly mortality group was in place, chaired by the non-executive director (NED) for quality and safety and attended by the medical director, as executive lead for mortality. Other attendees included the chief nurse, deputy chief nurse representing the community team and representation from primary care, reviewers, nursing, operations and a patient representative. The mortality group reported into the clinical safety and effectiveness committee and then to trust board. Monitoring was through a quarterly report and annual report to board. We confirmed that this occurred through review of the quality and learning reports to board and the annual report and accounts 2018/19.

We requested the minutes of the mortality meetings between June and September 2019. We received minutes from two meetings only, 20 May 2019 and 16 September 2019. According to the minutes there had been no meetings planned between these two dates, however dates were set for October and November (it was noted that due to annual leave the October meeting would have a reduced agenda). There was a standardised agenda that included a review of the previous minutes, status and update on actions, groups under focus, learning into action and reports (mortality dashboard and serious incident reports). We saw that there were multiple actions that had been identified however the quality of the minutes particularly in May were sparse, with no definitive timeline, which meant that progress was difficult to track. For example, in the May 2019 meeting minutes, action 23 related to the end of life improvement plan. It was noted that this action would be progressed once there was more resource within the quality improvement team. Action 28, learning into action was noted as ongoing. In both meeting minutes it was noted that the mortality dashboard was pre-circulated and not discussed. We saw that the learning from deaths strategy and implementation plan was in process and the consultation outcome and feedback was discussed at the September meeting.

We saw that learning from deaths was included in the trust annual report and accounts 2018/19 as part of the quality report. The annual report detailed the number of deaths, per quarter and specialist group, the number of case record reviews and investigations and actions taken as a consequence of what had been learnt in 2018/19 and actions proposed. The report noted that one case of maternal death for review by the Healthcare Safety Investigation Branch (HSIB) had occurred in 2018/19, which was ongoing at the time of our inspection. It was recognised in the annual report that whilst the trust records and reviews deaths of patients with learning disabilities it
did not receive feedback from external learning disabilities mortality review (LeDeR) and would be seeking to enhance wider learning in 2019/20.

There was evidence that leaders and staff at the trust participated in accredited recognition awards, such as finalist in the Health Service Journal (HSJ) awards 2018 ‘Using Technology to Improve Efficiency’ category, for piloting the new digital communications tool, medic bleep and finalist in the student Nursing Times awards 2019 ‘Student Placement of the Year: Hospital’ category, in recognition of the nursing student support programme. The trust charity was chosen as the regional winner in the Patient and Public Involvement award category of the NHS70 parliamentary awards.

**Complaints process overview**

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>25</td>
<td>86%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>25</td>
<td>86%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>June 2018 to May 2019</td>
<td>2,550</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

Our findings during the core service inspection were that trust response to complaints failed to meet trust standards. Trust complaints and compliments were reported and monitored as part of the integrated quality performance report (IQPR). We reviewed the IQPR between May and August 2019 and found the results confirmed our findings.

With regard to complaints being acknowledged in three working days the trust had dipped below the standard of 90% in May, June and August 2019, with results of 83%, 81% and 80% respectively. Complaint response within agreed timeframe overall had steadily declined each month from 77% in May 2019 to 44% in August 2019 against an internal standard of 90%. It was noted that increased demand had impacted on the acknowledgment timeframes however assistance from bank staff had been implemented to address and improve the performance in the short term.

A significant complaint had been identified and discussed, as a patient story, at the closed board meeting on 26 July 2019 in relation to care and discharge arrangement for a patient at end of life and the confrontational behaviour of a doctor once there had been PALS intervention. There had been challenge as to how the board would be made aware of this type of complaint and receive assurance that it had been dealt with sufficiently. Assurance was provided that one of the non-executive directors met monthly with the patient experience manager and reviewed the action points from the investigations reports for complaints to ensure these had been completed. There was a process in place that should the patient experience team experience problems with obtaining a response from individual clinicians this was escalated to either the chief nurse or medical director, whichever was appropriate. If a member of staff was mentioned in more than
one complaint this would trigger an escalation process. In addition, any doctor who had been mentioned in a complaint had to discuss this at their appraisal.

The chief nurse had proposed that a change should be made to how complaints were reported as part of the serious incidents, inquests, complaints and claims report that came to this meeting. We were informed that the trust had changed the way complaints were responded to. It was noted in the minutes from the quality and risk committee meeting, 29 March 2019, that the patient experience group had reported that the letters were too corporate in tone and it was agreed to reword the initial paragraph to be more personalised from the chief executive officer.

**Number of complaints made to the trust**

From June 2018 to May 2019, the trust received a total of 173 complaints. The highest number of complaints was for surgery, with 19.7% of the total complaints, followed by outpatients (18.5%) and medical care (15.0%).

A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>34</td>
<td>19.7%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>32</td>
<td>18.5%</td>
</tr>
<tr>
<td>Medical care (including older people’s care)</td>
<td>26</td>
<td>15.0%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>22</td>
<td>12.7%</td>
</tr>
<tr>
<td>Maternity</td>
<td>17</td>
<td>9.8%</td>
</tr>
<tr>
<td>Not core service specific</td>
<td>15</td>
<td>8.7%</td>
</tr>
<tr>
<td>Children, young people and families (community)</td>
<td>6</td>
<td>3.5%</td>
</tr>
<tr>
<td>Adults community</td>
<td>5</td>
<td>2.9%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>5</td>
<td>2.9%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>4</td>
<td>2.3%</td>
</tr>
<tr>
<td>Community inpatients</td>
<td>3</td>
<td>1.7%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>2</td>
<td>1.2%</td>
</tr>
<tr>
<td>Critical care</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>End of life care</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>173</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

**Compliments**

From June 2018 to May 2019, the trust received a total of 760 compliments. The highest number of compliments was for surgery, with 25.8% of the total compliments, followed by medical care (22.6%) and services for children and young people (9.5%).

A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>196</td>
<td>25.8%</td>
</tr>
<tr>
<td>Medical care (including older people’s care)</td>
<td>172</td>
<td>22.6%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>72</td>
<td>9.5%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>63</td>
<td>8.3%</td>
</tr>
<tr>
<td>Children, young people and families (community)</td>
<td>60</td>
<td>7.9%</td>
</tr>
<tr>
<td>Critical care</td>
<td>43</td>
<td>5.7%</td>
</tr>
<tr>
<td>Community inpatients</td>
<td>40</td>
<td>5.3%</td>
</tr>
<tr>
<td>Adults community</td>
<td>32</td>
<td>4.2%</td>
</tr>
<tr>
<td>Not core service specific</td>
<td>30</td>
<td>3.9%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>29</td>
<td>3.8%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>8</td>
<td>1.1%</td>
</tr>
<tr>
<td>Maternity</td>
<td>6</td>
<td>0.8%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>6</td>
<td>0.8%</td>
</tr>
<tr>
<td>End of life care</td>
<td>3</td>
<td>0.4%</td>
</tr>
<tr>
<td>Total</td>
<td>760</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments)

Accreditations

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust’s services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>• Endoscopy (first achieved in 2010 and renewed after site visit in 2018)</td>
</tr>
<tr>
<td>Anaesthesia Clinical Services Accreditation (ACSA)</td>
<td>• Anaesthetic department (April 2015 – due for re-accreditation in September 2019)</td>
</tr>
</tbody>
</table>
| Imaging Services Accreditation Scheme (ISAS) | • Radiology achieved in April 2011 and maintained since in annual cycles.  
• 2018 saw accreditation to version 3 of the ISAS standard, with additional successful accreditation of Newmarket radiology, the cardiology catheterisation lab and Thetford radiology  
• Haverhill ultrasound service is engaged with the scheme but has not yet achieved accreditation |
| Clinical Pathology Accreditation and it's successor Medical Laboratories ISO 15189 | • ISO 15189 was awarded to the histopathology laboratory, but a voluntary suspension was agreed by UKAS from 23/11/2018. UKAS inspection for re-accreditation is scheduled for September 2019.  
• The biochemistry, haematology, blood transfusion, and microbiology labs are all currently working towards ISO 15189 compliance and accreditation, following the cessation of clinical pathology accreditation in September 2018. |
Acute services

West Suffolk hospital
Hardwick Lane
Bury St Edmunds
Suffolk
IP33 2QZ

Tel: 01284713000
www.wsh.nhs.uk

Urgent and emergency care

Facts and data about this service

Details of emergency departments and other urgent and emergency care services

- West Suffolk Hospital accident and emergency department
- West Suffolk Hospital clinical decision unit

(Source: Routine Provider Information Request (RPIR) – Sites tab)

From April 2018 to March 2019, there were 74,400 attendances to the emergency department (ED) at West Suffolk Hospital. The highest attendance total for one day was 256 and the lowest was 141. Fifteen percent of the attendances were children.

The department includes two separate entrances for walk-ins and for ambulances. There are three separate waiting areas: one for GP streaming patients, one for the main emergency department and another for children.
Within the main treatment area there are: three bays for resuscitation (one for children); a high visibility bay; four bays for high dependency patients; one room for infection prevention; nine bays for low dependency patients; four see and treat bays; two paediatric rooms; one eye treatment room; and two triage rooms.

The clinical decisions unit (CDU) consists of two three bedded bays and four reclining chairs. There is a policy for identifying appropriate patients for placement in the CDU.

There is also a dedicated radiology room within the emergency department.  
(Source: Acute Routine Provider Information Request (RPIR) – Context acute tab)

Activity and patient throughput

From March 2018 to February 2019 there were 73,616 attendances at the trust’s urgent and emergency care services as indicated in the chart below.

Total number of urgent and emergency care attendances at West Suffolk NHS Foundation Trust compared to all acute trusts in England, March 2018 to February 2019

(Source: Hospital Episode Statistics)

Urgent and emergency care attendances resulting in an admission
The percentage of A&E attendances at this trust that resulted in an admission decreased in 2018/19 compared to 2017/18. In both years, the proportions were higher than the England averages.

(Source: NHS England)

**Urgent and emergency care attendances by disposal method, from March 2018 to February 2019**

- Admitted to hospital: 16,619
- Discharged*: 42,8
- Referred^: 8,851
- Transferred to other provider: 4,812
- Left department#: 227
- Other: 271
- Not known: 271

* Discharged includes: no follow-up needed and follow-up treatment by GP

^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional

# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)
Due to the number of core services inspected, our inspection of West Suffolk Hospital was announced. Prior to our inspection we reviewed data we held about the service along with information we requested from the service. The emergency and urgent care service was rated as good overall following its last inspection in March 2016.

During our inspection, we spoke with 39 members of staff including doctors, nurses, health care assistants, ambulance staff and non-clinical staff. We visited the adult and children’s emergency department, clinical decisions unit and the chaplaincy.

We spoke with seven patients including two children and reviewed 32 patient records and considered other pieces of information and evidence to come to our judgement and ratings.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Not all mandatory training compliance met trust target, particularly for medical staff. The service provided mandatory training in key skills including the highest level of life support training to all staff.

Mandatory training completion rates

The trust set a target of 90% for completion of all mandatory training with the exception of information governance which had a target of 95%.

West Suffolk Hospital

A breakdown of compliance for mandatory training courses as of June 2019 for qualified nursing staff in urgent and emergency care at West Suffolk Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Conflict resolution – e-learning</td>
<td>2</td>
</tr>
<tr>
<td>Basic life support (adult)</td>
<td>53</td>
</tr>
<tr>
<td>Medicine management (refresher)</td>
<td>49</td>
</tr>
<tr>
<td>Infection control - classroom</td>
<td>55</td>
</tr>
<tr>
<td>Blood borne viruses/inoculation incidents</td>
<td>52</td>
</tr>
<tr>
<td>Information governance</td>
<td>56</td>
</tr>
<tr>
<td>Training module name</td>
<td>As of June 2019</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Information governance</td>
<td>23</td>
</tr>
<tr>
<td>Fire safety training - classroom</td>
<td>21</td>
</tr>
<tr>
<td>Blood products &amp; transfusion processes (refresher)</td>
<td>18</td>
</tr>
<tr>
<td>Fire safety training - e-learning</td>
<td>20</td>
</tr>
<tr>
<td>Security awareness</td>
<td>19</td>
</tr>
<tr>
<td>Health &amp; safety / risk management</td>
<td>19</td>
</tr>
<tr>
<td>Basic life support (adult)</td>
<td>14</td>
</tr>
<tr>
<td>Medicine management (refresher)</td>
<td>18</td>
</tr>
<tr>
<td>MAJAX (Major accident)</td>
<td>18</td>
</tr>
<tr>
<td>Slips trips falls</td>
<td>18</td>
</tr>
<tr>
<td>Blood borne viruses/inoculation incidents</td>
<td>18</td>
</tr>
<tr>
<td>Conflict resolution – e-learning</td>
<td>18</td>
</tr>
<tr>
<td>Infection control – e-learning</td>
<td>18</td>
</tr>
</tbody>
</table>

In urgent and emergency care at West Suffolk Hospital, the targets were met for eight of the 17 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses as of June 2019 for medical staff in urgent and emergency care at West Suffolk Hospital is shown below:
In urgent and emergency care at West Suffolk Hospital, the targets were not met for any of the 16 mandatory training modules for which medical staff were eligible. Compliance rates ranged from 50.0% for conflict resolution to 92.0% for information governance.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The mandatory training was comprehensive and met the needs of patients and staff. Staff we spoke with said they completed training face-to-face and used on line training on the service’s intranet. Staff showed how they monitored their individual training needs on the services intranet page and could request additional training.

Nursing and medical staff did not keep up-to-date with their mandatory training. The service had had a clinical educator (CE) within the emergency department (ED) to respond to shortfalls in mandatory training and manage action plans to improve overall compliance. We observed the CE working alongside staff during our inspection, offering ongoing training and mentoring to the staff. The CE provided additional training on mandatory training days to cover any specific areas, or additional requests. For example, they had recently worked with the service’s sepsis lead nurse, to provide additional updates on neutropenic sepsis, and life support. Staff told us the role of the CE was extremely beneficial in terms of providing ongoing support and access to learning.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff we spoke with told us that managers monitored mandatory training and alerted staff when they needed to update their training. The staff could also access their own training record on the services intranet.

Staff we spoke with told us training was comprehensive, encouraged professional development and was monitored during supervision and appraisal.

Medical staff we spoke with told us that teaching and training for doctors was positive at the trust and teaching sessions were delivered on various clinical areas, and other core skills.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. The clinical staff we spoke with during our inspection told us they had access to additional training in order to meet patient’s needs. The providers intranet offered additional training sessions for medical staff and additional guidance.

ED reception staff completed training in conflict resolution. Data provided by the trust following inspection showed 93% staff compliance. The administrative and clerical staff within ED were not trained in first aid. They were given training to identify patients which need to be escalated immediately to the senior nurse on shift, this was in line with the services escalation of patients standard operating procedure.

Sepsis recognition and treatment for adults and paediatrics was included within the yearly ED mandatory training programme. Following our inspection, data provided by the service showed nursing staff achieved 98.1% compliance and medical staff achieved 100% compliance with sepsis training. The service had training plans in place to ensure the remaining nurses all staff were complaint.
The service provided bite-size sepsis sessions by the specialist sepsis nurse and delivered a presentation for the May 2019 ‘Topic of the Month’ board.

The senior operations manager contacted all medical staff with outstanding training requirements by email and informed them of the individual courses outstanding and reminded staff of their responsibilities. To improve training compliance the staff received a reminder email from the senior operations manager, who also met individually with staff with their supervising consultant to discuss current training compliance. They agreed an individual action plan for improvement and mandatory training was checked before any staff study leave was approved.

**Safeguarding**

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it, however compliance fell below trust target.**

**Safeguarding training completion rates**

The trust set a target of 90% for the completion of safeguarding training.

The tables below include Prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

**West Suffolk Hospital**

Nursing and medical staff received training specific for their role on how to recognise and report abuse.

A breakdown of compliance for safeguarding training courses as of June 2019 for qualified nursing staff in urgent and emergency care at West Suffolk Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>59</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>61</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2 (basic prevent awareness)</td>
<td>57</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>57</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>36</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5 (prevent awareness)</td>
<td>45</td>
</tr>
</tbody>
</table>

In urgent and emergency care the 90% target was met for four of the six safeguarding training modules for which qualified nursing staff at West Suffolk Hospital were eligible.
A breakdown of compliance for safeguarding training courses as of June 2019 for medical staff in urgent and emergency care at West Suffolk Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>23</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>22</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>21</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2 (basic prevent awareness)</td>
<td>20</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>20</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5 (prevent awareness)</td>
<td>15</td>
</tr>
</tbody>
</table>

In urgent and emergency care the 90% target was met for one of the six safeguarding training modules for which medical staff at West Suffolk Hospital were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. A service wide policy was in place for safeguarding adults alongside a further policy for children and staff we spoke with could easily access them. The policies were in date and included information about different types of abuse, female genital mutilation (FGM) as well as domestic violence and other key areas of safeguarding. Staff knew, and could explain, their responsibilities in relation to FGM, how to contact the safeguarding teams and make a safeguarding referral.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff we spoke with were clear about how to make a safeguarding referral or how to escalate concerns within the service. Staff within the adult ED completed a referral form or physically called the safeguarding teams for advice if they had a safeguarding concern.

The children’s ED team used a specific tab on the services electronic patient records to flag any child who may have a safeguarding concern, this alerted the services safeguarding lead of the concerns. Staff could call the safeguarding team for advice and make a referral, as well as use the out of hours safeguarding contact.

The patient record also showed any previous patient history, for example frequent attenders or children who may be known to the service or other agencies due to safeguarding concerns. The service had clear staff guidance for responding to unexplained injuries and staff we spoke to knew how to escalate concerns.

The service had a member of staff who specifically provided support regarding domestic violence concerns, training and advice. Staff were able to give good examples of safeguarding concerns and how they had dealt with them. The children’s team knew about county lines, FGM and the
signs of gang related or trafficking / modern slavery injuries. Guidance on safeguarding was displayed around the ED.

**Cleanliness, infection control and hygiene**

The service did not always control infection risk well. Records in relation to cleaning of children’s toys were not up to date and we observed some staff did not follow the trusts infection control procedures.

ED areas were clean and had suitable furnishings which were clean and well-maintained. All the disposable cubicle curtains we checked were clean and in date for renewal and disposal.

Clean linen was accessible and stored on covered trolleys. Staff told us that even in busy times they could replenish their linen stock. All the storerooms we observed were clean, tidy and well ordered.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. However, cleaning records were not up to date in relation to the toys in the children’s waiting area which posed a possible infection risk. Hand washing facilities, alcohol gel and hand conditioner were available throughout the department. Staff did not always follow, ‘Bare below the Elbow’ guidance, and wearing personal protective equipment (PPE) such as gloves and aprons whilst delivering care in line with the service’s policy.

Hand hygiene results for August 2019 showed 100% compliance with hand hygiene and 98.4% compliance with infection prevent control on the services perfect ward IT system. Staff did not always follow infection control principles including the use of personal protective equipment (PPE).

We observed one staff member who did not use appropriate personal protective clothing when supporting a patient, and three other staff who were not bare below the elbows or were wearing jewellery or watches. The ED, children’s ED and clinical decisions unit (CDU) had a plentiful supply of PPE and we observed staff restocking this as required.

Staff we spoke with could explain the protocol for isolating patients with a possible infectious condition. The ED was limited in its response to meeting the needs of infectious patients as it only had one cubicle that could be used for isolation, this was on the services risk register. The service did have equipment for dealing with major incidents, which included a pop-up tent. This could be used for dealing with larger groups of patients, or a serious biohazard.

**Environment and equipment**

The design, maintenance and use of facilities, premises, and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Since our last inspection in March 2016, the service had made several physical changes to its ED, CDU and children’s ED.

The design of the environment followed national guidance. Patients arrived at the ED either on foot, by ambulance or air ambulance. There was a dedicated reception area for walk-in patients, which had appropriate seating, vending machines for food and beverages as well as detailed signage explaining the patient’s possible care pathways within the department. This area was staffed until 1am, after this time the reception area closed, and patients were redirected by signage to a second reception area within the ED. Security staff were on duty 24 hrs a day in the
hospital and we routinely observed them monitoring the department throughout our inspection. The area was also covered by closed circuit television (CCTV).

The children’s ED now had a dedicated waiting area which was always accessed by a buzzer system and covered by CCTV. This was an improvement from our last inspection. The entrance to the children’s ED was adjacent to one of the two main ED reception areas, which was staffed 24 hours per day, giving good oversight of anyone entering or leaving this area.

This was a small children’s ED, with one triage room, and two treatment rooms. The waiting area within the children’s ED had dedicated seating and was equipped with toys and books that were age appropriate. Oversight of this area was from the nurse’s triage room, which did not have direct view of the children’s waiting area. This meant staff did not have direct view of the area at all times. We observed staff routinely checking the waiting area between treatments and staff were easily accessible. The trusts escalation policy dictated that at times of increased capacity, staff were to conduct physical checks in this area to monitor patient wellbeing. Access out of the children’s waiting area was by an electronic release button, which was high up on the wall, out of reach from small children and restricted anyone from leaving or opening the doors accidentally.

Treatment rooms within the children’s ED had slide projectors with colourful pictures projected onto the walls, large colourful murals and age appropriate equipment. Staff had a teddy bear placed on the ceiling and used this to distract children during treatment.

The service had suitable facilities to meet the needs of patients' families. The adult ED had a relative’s room, equipped with facilities for assessing drinks and comfortable seating.

The service had a dedicated assessment / interview room appropriately equipped for patients with mental health needs. This complied with the requirements of Health Building Note 15-01: accident & emergency departments 17.9 (2013) which states an interview room should be considered for use by staff for talking to disturbed and distressed patients and relatives. Due to the location of the room, one of the doors opened directly into the CDU. This area is used by the service to support patients following assessment and treatment who should spend less than 24 hours in the adult ED before being discharged home or admitted. The CDU often had patients who were elderly or frail, in open cubicles. We were concerned that a patient or relative could exit the mental health assessment / interview room directly into this area. The service had reported a previous incident where an agitated patient had left this room, entered the CDU and assaulted a member of staff. The provider had detailed risk assessments for the environment, which gave staff clear guidance on the risks and actions needed to protect staff and patients from any possible future incidents.

Staff had access to a ligature release grab bag which contained equipment that staff could use to release any one from a ligature. The department had detailed risk assessment for ligatures and actions to mitigate any risk of a ligature within the ED.

The general practitioner (GP) services had their own treatment rooms, alongside the emergency nurse practitioner rooms. Staff we spoke to explained this had a positive impact on patient flow as they were able to move patient to see and treat areas more quickly, and then discharge patients.

The service had submitted a business case and funding to build a new emergency department. During our inspection, we found the adult ED extremely cramped and all staff we spoke with explained that due to the volume of patients accessing the department it was becoming increasingly difficult to manage the space. The ED had dedicated treatment bays for patients with minor and major injuries, and two cubicles dedicated to rapid assessment and treatment.
Patients arriving at the main ED reception, who could sit and wait to be seen, sat in a dedicated triage area with oversight by nursing staff from the nurse’s treatment room. When patient volume increased, the staff turned this area into an escalation bay for patients arriving by ambulance. This meant that staff moved all the seating out of the triage area and into the main ED corridor and patients would then sit in the corridor waiting to be seen.

This meant reduced space in corridors, and increased the staff’s workload, as they had to move all the equipment and repurpose this area. The service did have a dedicated policy to support this and risk assessments in place. However, this demonstrated again the lack of space available at times of increased demand.

We reviewed over 20 pieces of equipment including blood pressure machines, defibrillators, pumps and air mattresses and found all of them to be up to date with electrical testing. Equipment that needed servicing was tracked and either returned to the manufacturer for servicing or serviced on site.

We checked a range of consumables in clean utility rooms including dressings, needles, syringes and sterilising solutions and found them all to be in date and stored correctly. The emergency department had a technician who specifically managed stock within the main emergency department and they took great pride in their ability to manage the stock and keep this fit for purpose at all times.

Staff carried out daily safety checks of specialist equipment, however these were not always consistent. The service had enough suitable equipment to help them to safely care for patients however not all equipment was replaced in a timely manner.

There was confusion in how checks on emergency equipment were completed by staff. For example, in the children’s ED staff had recorded in one set of records that equipment had been checked, but then not recorded in the overall check list that checks had been completed. In the main, checks on emergency equipment were completed, however there were gaps in some of the records. In the children’s ED, the resus trolley had no defibrillator as this was out for repair. Staff told us they accessed the resus trolley in majors, which was just a few paces away, whilst they waited for the equipment to be replaced.

Staff disposed of clinical waste safely. Throughout our inspection we noted that staff segregated waste appropriately, sharps bins were closed and signed. Staff had access to confidential waste bins for the disposal of confidential waste, and we always found these locked.

The service has incorporated mobile technology to overcome the traditional staff bleep system and has implemented the medic bleep system to improve communication across its services.

The service has up to date ultrasound technology and protocols to care for critically ill patients. Staff within the ED have access to the radiology picture archiving and communication system (PACS) so that the radiologist can provide extra support when needed.

**Assessing and responding to patient risk**

Staff did not complete risk assessments for each patient swiftly which meant a delay in removing or minimising risks and updating assessments.

**Emergency Department Survey 2018 – Type 1 A&E departments**
The trust scored better than other trusts for two of the five of the Emergency Department Survey questions relevant to safety and “about the same” as other trusts for the remaining three questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at A&amp;E, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>7.1</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a doctor or nurse and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the A&amp;E department?</td>
<td>9.2</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q34. While you were in A&amp;E, did you feel threatened by other patients or visitors?</td>
<td>9.8</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 2018)

**Median time from arrival to initial assessment (emergency ambulance cases only)**

The median time from arrival to initial assessment was worse than the overall England median in nine months over the 12 month period from July 2018 to June 2019. Performance at the trust was the same for two months (November 2018 and February 2019) and better in one month (December 2018).

In the most recent month, June 2019, the median time to initial assessment at the trust was nine minutes compared to the England average of eight minutes.

**Ambulance – Time to initial assessment from July 2018 to June 2019 at West Suffolk NHS**

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

Patients arriving by ambulance used a dedicated ambulance entrance for both adults and children. Adults would then proceed to the ED rapid assessment and treatment area, majors or minors, or resus areas. Children would either be taken into the children’s resus area or into the children’s ED waiting area.

The adult ED had dedicated treatment bays for patients with minor and major injuries, and two cubicles dedicated to rapid assessment and treatment. We observed the rapid assessment and treatment cubicles were routinely oversubscribed and patients who required rapid assessment and treatment were treated within the major’s cubicles. Staff still had clinical oversight of these
patients, however it demonstrated that the current space available was not meeting the demands of the department.

Hospital ambulance liaison officers (HALO) employed by a local NHS ambulance trust worked alongside the ED team to support patient flow. This gave the opportunity to pre-alert staff if a patient required additional support and increase patient flow through the department.

The Royal College of Emergency Medicine (RCEM) guidance says that streaming should be performed as soon as possible and ideally be within 15 minutes of the patient’s arrival in the ED and that all patients attending the ED should be registered within five minutes of arrival. We noted that patients were routinely registered by the hospital within five minutes of arrival, however service data showed the average time to initial assessment varied greatly.

Between Friday 20 September and Tuesday 24 September 2019, the service achieved an average of 13.3 minutes and 13.9 minutes on two days, both below the 15 minutes target. The remaining three days the times were 21.9 minutes, 24.4 minutes and 34 minutes, all above the 15 minutes target.

We carried out an announced follow up inspection on the 8 October 2019 and found the department at full capacity due to diverts arriving from another NHS trust. The communication between the emergency department coordinator and the HALO was exceptional. Staff were following the services ambulance escalation plan, utilising space efficiently and trying wherever possible to manage patient flow and get patients seen by speciality teams as soon as possible. Data seen within the department showed that on 4 October the initial time to triage averaged at 17.3 minutes, 12.6 minutes on the 5 October, 22.5 minutes on 6 October and 14.7 minutes on 7 October 2019.

**Percentage of ambulance journeys with turnaround times over 30 minutes for this trust**

From August 2018 to March 2019 there was a downward trend for monthly percentage of ambulance journeys with turnaround times over 30 minutes at West Suffolk Hospital. The percentage decreased month on month over this time period (from 69.6% to 53.8%) excluding October 2018 where it remained consistent. It then increased month on month from April 2018 to July 2019, with the highest proportion of turnaround times over 30 minutes in the most recent month (70.0%).

**Ambulance: Number of journeys with turnaround times over 30 minutes - West Suffolk Hospital**
Ambulance: Percentage of journeys with turnaround times over 30 minutes - West Suffolk Hospital

(Source: National Ambulance Information Group)

Number of black breaches for this trust

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. From April 2018 to March 2019 the trust reported 226 “black breaches”.

The number of black breaches fluctuated across the course of the 12 month period. There was a dramatic increase in January 2019 with 59 black breaches reported. The fewest breaches were reported in May, June and September 2018 with five or fewer, however black breach numbers were generally much higher than this across the period.

The trust reported that the main reason for the black breaches was lack of space in the department and increasing attendances.
Staff used a nationally recognised tool to identify deteriorating patients. The trust used the early warning score system (NEWS). An early warning score is a guide used by medical services to quickly determine the degree of illness of a patient. It is based on the vital signs of respiratory rate, oxygen saturation, temperature, blood pressure, pulse and heart rate.

Children were immediately directed to the children’s ED on arrival. All patients were triaged on arrival and transferred to the area best suited to provide treatment.

Staff did not complete risk assessments for each patient swiftly which meant a delay in removing or minimising risks and updating assessments. Staff were required to completed risk assessments for each patient on admission / arrival and update them when necessary using recognised tools. Staff did not routinely complete patient safety check lists. We reviewed 25 patient records and found in seven of the records either the risk assessments, for example falls risks, or the patient safety check list had not been completed. Staff explained this was due to the pressures within the department and staff prioritising patient care. We carried out a follow up inspection on the 8 October 2019 and looked at a further 12 patient records and found that staff were not routinely completing patient safety check lists or pain scores. The managers were aware of this issue and the hot topic following our inspection included completing the patient safety check list, patient observations, falls assessments and a focus on the deteriorating patients.

The IT based patient record system showed which patients required additional support and identified any patients with raised NEWS scores for staff to follow up on their care. The system was still under review and during our inspection the completion of patient risk assessments was escalated to the providers risk register.

The failure to manage and identity deteriorating patients was on the service risk register. Staff were aware of this risk and all staff knew how to escalate a patient who had a high NEWS score or where they had concerns over the patient’s physical signs. The service’s IT-based patient record system could generate data to support service audits called “Perfect Ward”. The perfect ward audit for August 2109 showed staff achieved 95% compliance with patient observations. The failure to complete the ongoing patient safety checklists could contribute to not identify patients who may deteriorate.

Staff knew about and dealt with any specific risk issues. Staff used the sepsis six bundle to identify any patient with a NEWS greater than four, alerting staff to follow the sepsis pathway and aimed to give the patient intravenous antibiotics (IV) within one hour often called “Door to needle time”. Staff accessed the ED neutropenic sepsis fast track pathway (NSFP) contained within a red folder displayed on the information board in the ED staff room. Performance against national standards
for door to needle time for neutropenic sepsis patients was 90% for the month of August 2019. Of the eight patients who were admitted through the ED, seven were treated within the hour (87.5%) and one breached the national standard. The service had an action plan in place to address the issues and improve performance against this standard.

Sepsis was a key focus of the services staff training programme and the service had a lead nurse who coordinated training and support. Hot topics contained sepsis updates, information and guidance and we noted sepsis training was a key element of the clinical educator role, who worked alongside the service’s sepsis lead to provides ongoing training and support for staff within the ED.

The service used a sepsis emergency cascade process calling “222” on its internal phone system to alert the outreach team to attend a septic patient. The children’s ED had a dedicated paediatric sepsis bundle, which enabled staff to identify any child at risk of sepsis.

Ambulance staff would call the ED to pre-alert staff to any patients with potential sepsis, including patients with possible neutropenic sepsis. Staff would complete the initial triage which would identify any patient with possible neutropenic sepsis and the adult ED had a dedicated area, called the sepsis corner. This is where staff managed medications in relation to sepsis and prepared syringe pumps and medication ready to treat septic patients with antibiotics. Audit data showed, in August 2019, 90% of neutropenic sepsis patients attending the ED received antibiotics within the hour and where the service breached this standard this was shared with the team to improve performance.

Data supplied by the service following inspection showed advanced care practitioners (ACPs) achieved 100% compliance with European paediatric advanced life support training (EPALS) and advanced life support training (ALS). Emergency nurse practitioners achieved 100% compliance with paediatric immediate life support (PILS) and immediate life support (ILS).

Ninety percent of adult registered nurses achieved compliance with PILS and 87% compliance with ILS. Sixty-nine percent of adult registered nurses achieved compliance with ALS training and 20% compliance with EPALS and 78% compliance with trauma immediate life support training (TILS).

Paediatric nurses achieved 100% compliance with PILS and 89% achieved compliance with TILS. Seventy-eight percent of paediatric nurses achieved compliance with EPALS, and 67% achieved compliance with ILS. The service had plans to ensure all staff reached 100% compliance with the appropriate life support training.

The services provided a stroke nurse Monday to Friday, 9am to 9pm who worked alongside the speciality doctors when a patient with a possible stroke entered the ED. Outside of these times staff could call for assistance from a nurse trained in thrombolysis on the stroke ward, or the registrar on duty.

We observed several occasions where patients with a suspected stroke came into the department, pre-alerted by ambulance crews. We noted the extremely professional way the teams worked together to provide initial lifesaving treatment and worked hard to identify treatment pathways or referrals to local neuroglial centres for ongoing treatment.

All areas where fully stocked with equipment, emergency trolleys and medicines to treat patients. Patients who were critically ill or required resuscitation were brought directly into the resuscitation area. This facility was appropriately equipped for the resuscitation of adults, children and babies. If
arriving by ambulance, the ambulance crew telephoned ahead, which allowed the department to prepare to receive the patients.

The service had 24-hour access to mental health liaison if staff were concerned about a patient’s mental health. In the children’s ED, staff could refer to the service for children aged up to 13 years, staff told us this service was responsive. Staff told us access to children’s mental health services for more complex and older children varied dependent on how busy this service was.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. The needs of patients were discussed at the staff safety huddles and handovers between shifts to identify any additional needs and mitigate any risks whilst in the department.

The ED staff focused on a hot topic, this included any issue that may affect patient safety or risk. The hot topic of the month varied based on feedback on incidents, complaint or clinical updates.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The table below shows a summary of the nursing staffing metrics within urgent and emergency care at West Suffolk Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Urgent and emergency care annual staffing metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2018 – March 2019</td>
</tr>
<tr>
<td><strong>Staff Group</strong></td>
</tr>
<tr>
<td>Target</td>
</tr>
<tr>
<td>All staff</td>
</tr>
<tr>
<td>Qualified nurses</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

At the time of our inspection the number of nurses and healthcare assistants on all shifts on each ward matched the planned numbers. The service had enough nursing staff of relevant grades to keep patients safe. At the time of our inspection the staffing levels reflected those planned for the departments. In the adult ED staffing levels were regular reviewed by the ward managers and staff were allocated based on their current skill and competency. The clinical educator role worked alongside the ward manager to identify staff who may need additional support and ensure only competent staff were delegated to set tasks.
The children’s ED had improved its staffing levels since our last inspection and there were two registered children’s nurses on duty between 10am and 10pm. However, the service did not meet the Royal College of Paediatrics and Child Health (RCPCH) standard of having two registered children’s nurses on every shift, as only one registered children’s nurse was on duty from 10pm, to 10am. The lead nurse for the children’s ED had put forward a business case to increase the number of children’s nurses on duty overnight. Staff could access the children’s ward for any additional advice regarding a child’s care.

The service appointed a full-time paediatric lead nurse in December 2018, to provide additional leadership and support in the children’s ED. This was an improvement from our last inspection. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The trust was actively participating in recruitment, including for overseas candidates.

The department manager could adjust staffing levels daily according to the needs of patients. During our inspection there had been an issue of staff sickness. The nurse in charge proactively managed staff allocation to ensure staff with the appropriate skills and knowledge provided support to patients.

Nurse staffing rates within urgent and emergency care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and agency use.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Vacancy rates

The service had reducing vacancy rates, below the trust target.

![Vacancy rate - qualified nurses, health visitors and midwives](image)

Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives showed a downward shift from October 2018 to March 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Sickness rates

The service had reducing sickness rates, below the trust target.
Monthly sickness rates over the last 12 months for qualified nurses, health visitors and midwives showed a downward shift from December 2018 to May 2019.
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank staff usage**

The service had low rates of bank nurses.

Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives were not stable and may be subject to ongoing change.
(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers we spoke with said it was important to ensure the right staff with appropriate skills worked within the department and they worked hard to manage this. Where staff from other areas or bank / agency staff did work within the department, managers made sure all bank and agency staff had a full induction and understood the service.

**Medical staffing**

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and
treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The table below shows a summary of the medical staffing metrics within urgent and emergency care at West Suffolk Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>6%</td>
<td>10%</td>
<td>3.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>126</td>
<td>5%</td>
<td>9%</td>
<td>3.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical staff</td>
<td>29</td>
<td>-15%</td>
<td>4%</td>
<td>3.0%</td>
<td>9,688 (10%)</td>
<td>6,096 (6%)</td>
<td>19,856 (20%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within urgent and emergency care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover and locum use.

Please note that the negative vacancy rate for medical staff in the table above indicates that the service was over-established.

At the time of our inspection, the medical staff matched the planned number on all shifts in each department. At the time of our inspection medical staffing was appropriate to the requirements of the department. The service provided an ED consultant in the department from 8am to 6pm, additional coverage from 1pm to 10pm, a consultant covering CDU 9am to 6pm and an on call consultant overnight seven-days per week. This met the 16 hours consultant cover per day recommended by the Royal College of Emergency Medicine (RCEM). Consultant medical staff managed care throughout the department as needed and one consultant acted as the emergency physician in charge of services.

We observed a “board round” where staff discussed key issues in relation to patient’s needs and safety and bed state. Staffing levels were discussed as well as identifying the patients at greatest risk of deterioration and how to utilise the departmental space to maximise patient discharge and flow.

The ED saw approximately 11,160 patients a year that were under 17 years of age. The RCEM recommends that emergency departments seeing more than 16,000 children per year should have at least one paediatric emergency consultant. The trust provided a paediatric consultant 9am to 8pm daily, with additional coverage between 1.30pm and 8.30pm and 12pm to 9pm. Outside of these hours the service provided 24-hour paediatric consultant cover through an on-call rota. This
met the RCEM standard despite the service seeing less than 16,000 patients a year that were under 17 years of age

**Sickness rates**

Sickness rates for medical staff were below the trust target at the time of our inspection and had reduced from September 2018.

[Graph showing sickness rate over time]

Monthly sickness rates over the last 12 months for medical staff were not stable and may be subject to ongoing change.

*(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

**Bank staff usage**

The service had an increase in bank hours. This was to cover short term vacancies until the service appointed new staff and cover some areas of sickness and did not show a prolonged increase in bank staff usage.

[Graph showing bank hours over time]

Monthly bank hours over the last 12 months for medical staff showed a shift from November 2018 to April 2019.

*(Source: Routine Provider Information Request (RPIR) – Medical locum tab)*

Managers could access locums when they needed additional medical staff. Managers we spoke with said they would aim to allocate shifts to the bank team based on their knowledge and experience to ensure a good fit within the department. Managers made sure locums had a full
induction to the service before they started work. All locum staff completed a detailed induction to the department prior to commencing duties.

**Staffing skill mix**

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

In April 2019, the proportion of consultant staff reported to be working at the trust was higher than the England averages and the proportion of junior (foundation year 1-2) staff was similar.

**Staffing skill mix for the 22 whole time equivalent staff working in urgent and emergency care at West Suffolk NHS Foundation Trust.**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>36%</td>
<td>30%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>6%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>35%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>23%</td>
<td>21%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty

~ Registrar Group = Specialist Registrar (StR) 1-6

* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

The service always had a consultant on call during evenings and weekends. Rotas we reviewed demonstrated that appropriate medical staffing was available throughout the ED. The service recognised that it had a lower percentage of middle grades, this was on the service’s risk register and they were actively recruiting to improve the number of middle grades.

**Records**

Staff did not always keep detailed records of patients’ care and treatment. However, records were stored securely and easily available to all staff providing care.

The service used a blend of IT based patient records and some manual records to support initial assessments. The IT based care records system gave staff access to a wide range of comprehensive risk assessments and care planning documents and all staff could access them easily. Records were stored securely, and staff kept records safe, we noted throughout our inspection that IT screens were locked or out of sight of patients.
Patient notes were not comprehensive; however, staff could access them easily. Staff were required to completed risk assessments for each patient on admission / arrival and update them when necessary using recognised tools. Staff did not routinely complete patient safety check lists. We reviewed 25 patient records and found in seven of the records either the risk assessments, for example falls risks, or the patient safety check list had not been completed. Staff explained this was due to the pressures within the department and staff prioritising patient care.

The service was aware that there were issues with staff completing patient records.

We carried out a follow up inspection on the 8 October 2019 and looked at a further 12 patient records and found that staff were not routinely completing patient safety check lists or pain scores. The managers were aware of this issue and the hot topic following our inspection included completing the patient safety check list, patient observations, falls assessments and a focus on the deteriorating patients.

All the records we reviewed contained details of patients' presenting conditions, medical history and current medication. Details of their GP and next of kin were also recorded.

When patients transferred to a new team, there were no delays in staff accessing their records as staff could easily access these on the IT based patient records. Information required to deliver care was available in a timely manner for example referring patients for X rays and blood results.

**Medicines**

**Records in relation to the storage and checking of medicines and refrigeration temperatures were not always up to date.**

Systems and processes for recording and storing medicines were not always followed. We reviewed the ED controlled drugs register in the adult and children’s ED and found gaps in daily checks. In the children’s ED we found checks not completed on the CD’s on the 6, 14 and 18th September 2019. In the adult ED we found checks not completed on the 15, 20 and 28 of September and again on the 26 and 27 August 2019. Checks on refrigeration temperatures were also missing during this period. This meant we were not assured staff were completing daily checks to ensure stocks were in place and refrigeration temperatures were within the required range. None of the gaps in the records had been escalated as a concern, which meant staff had not followed the services medication policy and raising concerns when checks had been missed.

Staff reviewed patients’ medicines regularly and provided specific advice to patients and carers about their medicines. Staff prescribed and administered medication in line with the medication policy. Patient records we reviewed showed that staff routinely checked patients’ medications to ensure that they received the right dose at the right time.

There were trust protocols, for the administration and supply of certain medicines by nurses under patient group directions (PGDs). PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. The process for administering medicines under PGDs was safe and effective and nurses received appropriate training for this.

Staff followed current national practice to check patients had the correct medicines. We noted in records where patients required pain relief that staff recorded analgesia appropriately, and patient allergies were completed in all the records we reviewed.
Staff stored and managed medicines and prescribing documents in line with the provider’s policy. The adult ED had a dedicated area, called the sepsis corner. This is where staff managed medications in relation to sepsis and prepared syringe pumps and medication ready to treat septic patients with antibiotics. This area promoted the safe administration of intravenous antibiotics (IV) in a hygienically clean environment.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff discussed any medication issues at handover and as part of the service’s hot topics.

**Incidents**

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

**Never Events**

The service reported no never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From August 2018 to July 2019, the trust did not report any never events for urgent and emergency care services.

*Source: Strategic Executive Information System (STEIS)*

**Breakdown of serious incidents reported to STEIS**

Staff reported serious incidents clearly and in line with trust policy.

In accordance with the Serious Incident Framework 2015, the trust reported six serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from August 2018 to July 2019. This represented 11.5% of all serious incidents reported by the trust as a whole.

A breakdown of the incident types reported is shown in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>3</td>
<td>50.0%</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI</td>
<td>1</td>
<td>16.7%</td>
</tr>
<tr>
<td>criteria (including failure to act on test results)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>1</td>
<td>16.7%</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI</td>
<td>1</td>
<td>16.7%</td>
</tr>
<tr>
<td>criteria (including failure to act on test results)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td>100.0%</td>
</tr>
<tr>
<td>-------</td>
<td>---</td>
<td>--------</td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

Staff knew what incidents to report and how to report them. Incidents were reported using a trust wide electronic system. All staff we spoke with understood their responsibilities to raise concerns and to report safety incidents internally and externally. Staff we spoke with told us they had received training and support on incident reporting and using the trust electronic reporting system to report incidents.

Staff told us that they had the opportunity on the incident reporting system to request feedback at the time of raising an incident.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers debriefed and supported staff after any serious incident. Staff met to discuss the feedback and look at improvements to patient care. The ED clinical leads attended governance meetings and cascaded learning back to the department. Staff told us that key learning from incidents was communicated at team huddles, staff handovers, through the services intranet, emails or face to face.

There was evidence that changes had been made because of feedback. For example, following a medication incident and learning from the incident review, staff implemented a new method of ensuring a specific type of medication was given to patients using an applicator to reduce any patient harm.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We reviewed three serious incident reports, these incidents were investigated by a multidisciplinary team, a full root cause analysis had been undertaken and recommendations identified.

Managers understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. We noted in the serious incident reviews that managers had apologised when things went wrong and given a full explanation to the patient or family where appropriate.

### Safety thermometer

**Staff collected safety information and shared it with staff, patients and visitors.**

During our inspection we noted safety thermometer data was publicly displayed for staff and patients to see. Staff used data from the safety thermometer to make improvements. Governance meeting notes from August 2109 showed staff discussed performance data and how to use this to make service improvements.

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 the suggested data collection date.
Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm or new urinary tract infections in patients with a catheter from July 2018 to July 2019 within urgent and emergency care.

(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff could access local policies, guidelines and procedures on the services intranet. Guidance for staff was also placed at key points throughout the department so staff could quickly find them, for example standards around sepsis and resuscitation.

There were a range of clinical care pathways that aligned with national standards and guidelines. We reviewed pathways for sepsis, asthma, stroke and fractured neck of femur and found them multidisciplinary and up to date.

Care and treatment for example, pain, feverish children and head injury in adults was delivered in line with the National Institute of Health and Clinical Excellence (NICE) and Royal College of Emergency Medicine clinical standards (2014).

Staff followed NICE guidance CG138. This guidance relates to the patient experience in adult NHS services and improving the experience of care for people using adult NHS services. Staff handovers routinely referred to the psychological and emotional needs of patients, as well as their relatives and carers.

The department used the “sepsis six-tool” interventions to treat patients and identify those at high risk. Staff used the sepsis six bundle to identify any patient with a NEWS greater than four, alerting staff to follow the sepsis pathway. The trust used a sepsis emergency cascade process to alert the outreach team to attend a septic patient. The children’s ED had a dedicated paediatric sepsis bundle, which enabled staff to identify any child at risk of sepsis.

The adult ED had a specific area dedicated to sharing information and guidance on patient care. This area contained up to date information on various subjects, for example dealing with early intervention of neck of femur injuries, NICE guidance, audit outcomes and clinical research.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.
The service adjusted for patients’ religious, cultural and other needs.

Emergency Department Survey 2018 – Type 1 A&E departments

In the CQC Emergency Department Survey, the trust scored 7.7 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.
Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff reviewed patient’s nutrition and hydration needs following the initial triage assessment. If it was safe for patients to eat and drink, staff offered food and drink to meet their needs.

We observed staff checking with patients and relatives if they needed food or drink and staff assisted patients who were unable to independently eat and drink. Patients we spoke with told us they had been offered food and drink whilst in the department.

The service had vending machines for snacks and drinks in the reception areas and patients and relatives could also access restaurants and food kiosks around the hospital site if they were visiting for long periods.

We noted in our records review that staff used a nationally recognised screening tool to monitor patients at risk of malnutrition and accurately completed patients’ fluid and nutrition charts where needed.

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

**Emergency Department Survey 2018 – Type 1 A&E departments**

In the CQC Emergency Department Survey, the trust 7.6 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.

(Source: Emergency Department Survey 2018)

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. The staff used a visual chart ranging from zero to ten, zero being the least pain with a happy face and ten the worst the pain could be with a very sad face. In the children’s ED we noted staff used a cartoon character face for assessing pain scores associated with the character smiling or being sad faced. This was useful to use for children and patients with learning disabilities or for those with impaired communication or cognitive impairment.

Patients received pain relief soon after it was identified they needed it, or they requested it. We noted throughout our inspection that staff routinely asked patients if they were in pain and when they were, staff responded promptly. We spoke with a child within the children’s emergency department, they told us that staff asked them about their pain, and if they would like some medicine.

Staff prescribed, administered and recorded pain relief accurately. Nurses were able to administer simple pain relief (paracetamol, anti-inflammatory, local anaesthetic) under a patient group direction (which permits suitably trained staff to supply prescription-only medicines to groups of patients, without individual prescriptions).
The staff used a dedicated area within the electronic patient record to record the patients pain score.

**Patient outcomes**

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in all relevant national clinical audits and managers carried out a comprehensive local audit programme.

Audit outcomes were shared with the staff team, on display within the emergency department (ED) and discussed at governance meetings.

**RCEM Audit: Moderate and acute severe asthma 2016/17**

In the 2016/17 Royal College of Emergency Medicine (RCEM) moderate and acute severe asthma audit, West Suffolk Hospital’s emergency department failed to meet any of the national standards.

The department was in the upper UK quartile for three standards:

- Standard 3: High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the ED. This department: 42.0%; UK: 25%.
- Standard 5: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV
- Standard 5a (fundamental): within 60 minutes of arrival (acute severe). This department: 42.9%; UK: 19%.
- Standard 5b (fundamental): within 4 hours (moderate). This department: 47.6%; UK: 28%.

The department was in the lower UK quartile for one standard:

- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 51.4%; UK: 77%.

The department’s results for the remaining three standards were all within the middle 50% of results:

- Standard 1a (fundamental): O2 should be given on arrival to maintain sats 94-98%. This department: 20.0%; UK: 19%.
- Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 34.0%; UK: 26%.
• Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
  o Adults 16 years and over: 40-50mg prednisolone for 5 days
  o Children 6-15 years: 30-40mg prednisolone for 3 days
  o Children 2-5 years: 20mg prednisolone for 3 days

• This department: 47.8%; UK: 52%.

(Source: Royal College of Emergency Medicine)

The provider had a dedicated action plan in place based on the audit results. All of the actions had been completed and additional recommendations made to support ongoing improvements.
RCEM Audit: Consultant sign-off 2016/17

In the 2016/17 Consultant sign-off audit, West Suffolk Hospital’s emergency department failed to meet any of the national standards.

The department was in the lower UK quartile for two standards:

- Standard 1 (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 4.4%; UK: 11%.
- Standard 3 (fundamental): Consultant reviewed: patients making an unscheduled return to the emergency department with the same condition within 72 hours of discharge. This department: 4.0%; UK: 12%.

The department’s results for the remaining two standards were both within the middle 50% of results:

- Standard 2 (developmental): Consultant reviewed: fever in children under 1 year of age. This department: 8.3%; UK: 8%.
- Standard 4 (developmental): Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 12.5%; UK: 10%.

(Source: Royal College of Emergency Medicine)

In response to the consultant sign off audit, the service developed the IT based patient record system to identify consultant sign off and flash up a tick box to say if the review was completed or alert staff that it needed completion. This helped to identify appropriate patients for consultant review, and reduce inappropriate patients being selected.

RCEM Audit: Severe sepsis and septic shock 2016/17

In the 2016/17 Severe sepsis and septic shock audit, West Suffolk Hospital’s emergency department failed to meet any of the national standards.

The department was in the lower UK quartile for three standards:

- Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 41.8%; UK: 69.1%.
- Standard 2: Review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 42.7%; UK: 64.9%.
- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 23.8%; UK: 43.2%.

The department’s results for the remaining five standards were within the middle 50% of results:

- Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to) within one hour of arrival. This department: 15.6%; UK: 30.4%.
- Standard 4: Serum lactate measured within one hour of arrival. This department: 39.8%; UK: 60.0%.
- Standard 5: Blood cultures obtained within one hour of arrival. This department: 42.2%; UK: 44.9%.
- Standard 7: Antibiotics administered: Within one hour of arrival. This department: 28.2%; UK: 44.4%.
- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 27.0%; UK: 18.4%.

(Source: Royal College of Emergency Medicine)

The provider had a dedicated action plan in place based on the audit results for severe sepsis and septic shock 2016/17. All the actions had been completed except for one which was for patient information being provided to all patients, and/or relatives, admitted with sepsis. This was partially met, and ongoing work was in progress.

Managers used information from the audits to improve care and treatment, shared and made sure staff understood information from the audits. The service routinely participated in local and national audits and used the details to improve performance within the service.

Local audits included completing patient observations, completion of patient documentation, staffing levels, patient satisfaction and infection prevention and control. Audit data was displayed across the ED and discussed at governance and staff meetings. Where there were shortfalls, action plans were in place and improvement was checked and monitored.

The ED staff focused on a hot topic, this included any issue that may affect patient safety or risk. The hot topic of the month varied based on feedback on incidents, complaint or clinical updates or audit outcomes.

At the time of our inspection the service was participating in RCEM audits in relation to mental health, assessing cognitive impairment in older people and care of children within the ED. It was too early to assess the impact of these audits within the service during our inspection.

The service had completed an audit in relation to procedural sedation of adults within the ED, this audit led to changes within the services medication policy and the introduction of new procedures to improve sedation for adults.

Trauma Audit and Research Network (TARN)

The table below summarises West Suffolk Hospital’s performance in the 2018 Trauma Audit and Research Network audit. The TARN audit captures any patient who is admitted to a nonmedical ward or transferred out to another hospital (e.g. for specialist care) whose initial complaint was trauma (including shootings, stabbings, falls, vehicle or sporting accidents, fires or assaults).

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit Rating</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Ascertainment (Proportion of eligible cases reported to TARN compared against Hospital Episode Statistics data)</td>
<td>71.7 - 82.1%</td>
<td>n/a</td>
<td>Did not meet</td>
</tr>
</tbody>
</table>
**Crude median time from arrival to CT scan of the head for patients with traumatic brain injury**

(Prompt diagnosis of the severity of traumatic brain injury from a CT scan is critical to allowing appropriate treatment which minimises further brain injury.)

| 34 minutes | Takes longer the TARN aggregate | Met |

**Crude proportion of eligible patients receiving Tranexamic Acid within 3 hours of injury**

(Prompt administration of tranexamic acid has been shown to significantly reduce the risk of death when given to trauma patients who are bleeding)

| 62.5% | Lower than the TARN aggregate | n/a |

**Crude proportion of patients with severe open lower limb fracture receiving appropriately timed urgent and emergency care** (Outcomes for this serious type of injury are optimised when urgent and emergency care is carried out in a timely fashion by appropriately trained specialists.)

| 0.0% | Lower than the TARN aggregate | Did not meet |

**Risk-adjusted in-hospital survival rate following injury**

(This metric uses case-mix adjustment to ensure that hospitals dealing with sicker patients are compared fairly against those with a less complex case mix.)

| 0.6 additional deaths | Similar to expected | Did not meet |

(Source: TARN)

**Unplanned re-attendance rate within seven days**

The service had a lower than expected risk of re-attendance than the England average. The ED participated in an audit to identify frequent attenders to the ED, including assessing their individual clinical and social needs. The team worked with other social care agencies to reduce frequent attendances and seek alternative care pathways to support patient outcomes, for example referral to alcohol or substance misuse services or charities for the homeless.

From July 2018 to June 2019, the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% in 10 of the 12 months, excluding November 2019 and March 2019 where performance met the national standard.

The trust performed consistently better than the England average across the 12 months. The trust’s performance was generally consistent, ranging from 5.0% to 6.0% compared to the England average of 7.9% to 8.5%.
Unplanned re-attendance rate within seven days - West Suffolk NHS Foundation Trust

(Source: NHS Digital – A&E quality indicators)

Competent staff
The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development. Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Appraisal rates
Managers supported staff to develop through yearly, constructive appraisals of their work.

West Suffolk Hospital
From April 2018 to March 2019, 84.6% of staff within the urgent and emergency care department at West Suffolk Hospital received an appraisal compared to a trust target of 90%. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>13</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>10</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>43</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>77</td>
</tr>
</tbody>
</table>
Medical and dental and administrative and clerical staff in urgent and emergency care services both met the 90% target. However, only 84.3% of registered nursing staff had received an appraisal.

Updated analysis for April 2019 to mid-June 2019 found that 25.3% of required staff in the urgent and emergency care department at West Suffolk Hospital received an appraisal compared to the trust target of 90%. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2019 to mid-June 2019</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
<td>Eligible staff</td>
<td>Completion rate</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>8</td>
<td>15</td>
<td>53.3%</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>4</td>
<td>11</td>
<td>36.4%</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>4</td>
<td>14</td>
<td>28.6%</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>7</td>
<td>51</td>
<td>13.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>23</strong></td>
<td><strong>91</strong></td>
<td><strong>25.3%</strong></td>
</tr>
</tbody>
</table>

None of the staff groups in urgent and emergency care at West Suffolk Hospital met the 90% target. However, this data only represents a partial year and so we would not expect a high appraisal completion rate.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Managers supported staff to develop through regular, constructive clinical supervision of their work. Nursing and health care assistants we spoke with told us they received appraisals and that these were an opportunity to discuss their future development and any training or mentoring needs. During our inspection we noted service data from August 2019 showed a 91.6% compliance rate with appraisals.

Staff we spoke with told us that managers identified any training needs during appraisals and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

New staff entering the department completed a dedicated competency framework based on the Royal College of Nursing Competency Framework and were allocated a staff member to act as a mentor within the ED. The clinical educators supported the learning and development needs of staff. The service had a clinical educator (CE) who worked in the emergency department (ED) and oversaw staff induction to the department. Staff we spoke with told us the CE role was beneficial in terms of providing ongoing support and access to learning. The CE provided additional competencies outside of mandatory training, for example dealing with a deteriorating patient and level three major haemorrhage.

Paediatric staff completed a dedicated competency pack based on the Core Competences for Nursing Children and Young People (Royal College of Nursing, 2012). Staff within the adult ED received training to achieve additional paediatric competencies, to improve their understanding of the needs of children. The ED held paediatric training scenarios, for example paediatric arrest,
chest pains and head injuries to encourage staff to use their new competencies to assess and treat the children.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. The ED had a specific area where it displayed meeting notes, governance records meeting records and training updates. Staff could access the services intranet for additional guidance and updates on training or clinical updates.

Managers made sure staff received any specialist training for their role. Medical staff had teaching sessions twice a week where specialty training could be accessed, for example airway management.

Managers recruited, trained and supported volunteers to support patients in the service. The ED used volunteers and worked closely with the services chaplaincy team to train volunteers to support patients in the ED.

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Staff worked across health care disciplines and with other agencies when required to care for patients. Throughout our inspection we noted positive multidisciplinary team working (MDT) across the ED. Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

We spoke with therapy staff, who were very positive about their relationships with the ED teams and explained how they worked together to improve patient outcomes. Staff used links with community-based staff and resources to coordinate patient care and where possible speed up safe patient discharge.

The ED had major incident continuity plans that used MDT working and drew together specialism from across the trust to deal with major incidents appropriately.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. The ED had good links with the psychiatric health liaison team, who provided support to ED and the clinical decisions unit. The teams had good working relationships and communicated together regularly to plan patient care and treatment. The team was based outside of the department, and at the time of our inspection we noted their attendance to support a patient within the ED and offer guidance to the staff caring for the patient.

The service held monthly mental health interagency meetings to review care plans for regular attenders to ED for mental health support. Staff included representatives from the service, mental health teams, local NHS ambulance service and police.

**Seven-day services**

**Key services were available seven days a week to support timely patient care.**

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week. The adult and children’s ED and the clinical decisions unit (CDU) were open 24 hours a day, seven days a week. Patients arrived by ambulance, air ambulance or on foot or as a referral from their general practitioner.
The service had 24-hour access to pathology, and diagnostic tests such as, blood tests, x-rays, computed tomography (CT) scans and magnetic resonance imaging (MRI) scans to provide staff with diagnostics to inform treatment.

The chaplaincy service was available 24 hours a day seven day a week to provide support for all faiths and none.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support within the ED. All the ED areas held leaflets that offered patients advice and guidance on issues such as diabetes, promoting healthy lifestyles and dealing with minor injuries.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. The staff had access to a range of external services, for example social services, smoking cessation and could refer patients back to their own general practitioner (GP) for ongoing care and treatment of health conditions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients’ liberty.

Mental Capacity Act and Deprivation of Liberty training completion

Not all staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.

The trust reported that Mental Health Act (MHA), Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) are covered in the safeguarding adults training.

The trust set a target of 90% for the completion of safeguarding adults training.

West Suffolk Hospital

A breakdown of compliance for safeguarding adults training as of June 2019 for qualified nurses and medical staff in urgent and emergency care at West Suffolk Hospital is shown below:

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing and midwifery registered</td>
<td>57</td>
<td>61</td>
<td>93.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>20</td>
<td>25</td>
<td>80.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In urgent and emergency care the 90% target for safeguarding adults training was met by qualified nursing staff, but not by medical staff, who had a completion rate of 80.0%.
Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff spoke with how to apply the MCA and when to apply for a DoLS where appropriate. Care planning was based on the least restrictive principals and staff explained they could access safeguarding and mental health team specialist staff for any additional guidance.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We routinely observed staff seeking patient consent prior to treatment during our inspection. Staff made sure patients consented to treatment based on all the information available and clearly recorded consent in the patients' records.

All staff we spoke with understood their roles and responsibilities in relation to MCA and DoLS. The trust had an up to date and version-controlled policy for MCA and DoLS and staff knew to access this on the trusts intranet.

Staff we spoke with understood their roles and responsibilities under the Children's Act (2004), the Mental Health Act (MHA) (1983) and knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Staff we spoke with in the children’s ED had a comprehensive understanding of the importance of the law relating to Fraser guidelines and Gillick competencies when caring for a patient under the age of 16. The Fraser guidelines refer specifically to consent for sexual health services and are an additional guideline to the Gillick competency framework that relates to consent for any healthcare intervention. There were no examples to review during our inspection.

### Is the service caring?

#### Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

#### Friends and Family test performance

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

Response rates for West Suffolk NHS Foundation Trust from June 2017 to May 2019 are shown below. The response rates ranged from 17.6% to 27.2%.

![Graph showing response rates for West Suffolk NHS Foundation Trust from June 2017 to May 2019](image)
The chart below shows the mean friends and family test scores, with upper and lower control limits. The width of the control limits is based on the response rates, therefore the higher the response rates (shown by narrower control limits) the more confidence we have in the data.

The trust scored between 96.1% and 99.4% from June 2017 to May 2019.

The data showed a shift between February and September 2018, which is an indication of change. Staff we spoke with explained this was during departmental renovation work which may have affected patients and public perception of their experiences.

There were two points outside of the control limits (November 2017 and May 2019).

The data also showed three unusually high data points (April, May and September 2019) and two unusually low data points (October 2018 and April 2019).

(Source: Friends and Family Test – NHS England)

We observed examples of staff responding with kindness when patients needed help and support, even during exceptionally busy periods. Staff offered reassurance to patients who were in pain or frightened and we observed staff promoting patients.

We observed reception staff were welcoming, kind and offered patients clear guidance on waiting times and who would be assessing them. All patients we spoke with told us staff were very helpful and caring and they were treated respectfully during the care and treatment.

Staff recognised patient’s individual needs and we noted in the children’s emergency department (ED) that children were treated with kindness and patience. We spoke with a child who told us that staff had been kind and nice. One parent told us that they were highly satisfied with the care provided to their child and would recommend the service to family and friends. We discreetly observed calm, kind conversations between staff, children and their parents during assessments and treatments.

Staff offered care that was kind and promoted dignity. Where patients were receiving care and treatment in cubicles, we observed staff closing curtains to protect people’s privacy and routinely asking for consent prior to undertaking examinations or treatment.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.
Staff in the ED could work with patients who presented with behaviours that staff might find challenging. We observed staff to be caring when patients were confused or shouting aggressively. In the clinical decisions unit (CDU) we observed a health care assistant dealing with a very verbally abusive patient. The staff member remained professional, non-judgemental and reassuring throughout the interaction. Following the event, the staff member went to reassure other patients in the area and ensure they were comfortable and not worried by the event.

**Emotional support**

**Staff provided emotional support to patients, families and carers to minimise their distress.**

Staff gave patients and those close to them help, emotional support and advice when they needed it. During our inspection we talked with a trust chaplain who visited the department to offer emotional support for patients and their families, as well as supporting families though trauma and loss of a loved one. The chaplaincy team were available 24 hours a day throughout the year to provide emotional support at times of need and signpost patients and families to other support and caring groups.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We observed staff supporting a patient living with dementia who had a minor injury. The patient was clearly very distressed and shouting. Staff remained calm and professional, reassuring other patients and ensuring the patient received treatment that was in their best interest.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. We spoke to a patient who attended the ED due to a specific concern, which then meant they were to be admitted to the ward for ongoing treatment. The patient was surprised by this and worried about what would happen next. Staff had spent time with the patient, reassuring them about their treatment plan and what the next steps would be.

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

**Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**

Throughout our inspection, we observed staff introducing themselves and their role to patients they were caring for within the ED. Staff made sure patients and those close to them understood their care and treatment.

Staff talked to patients in a way they could understand, using communication aids where necessary. We spoke with the parent of a child who told us they received clear guidance on how to look after an injury and how to seek further guidance should their condition worsened.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The chaplaincy team worked closely with the ED team and could offer ongoing support for families of staff who wanted to discuss any unresolved concerns or issues.

**Emergency Department Survey 2018 – Type 1 A&E departments**

The trust scored better than other trusts for five of the 26 of the Emergency Department Survey questions relevant to the caring domain and about the same for the remaining 21 questions.
<table>
<thead>
<tr>
<th>Question</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you informed how long you would have to wait to be examined?</td>
<td>5.5</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q11. While you were waiting, were you able to get help from a member of staff to ask a question?</td>
<td>8.8</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q13. Did you have enough time to discuss your condition with the doctor or nurse?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. While you were in A&amp;E, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. Did the doctors and nurses listen to what you had to say?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. If a family member, friend or carer wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. While you were in A&amp;E, how much information about your condition or treatment was given to you?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. Sometimes, a member of staff will say one thing and another will say something quite different. Did this happen to you?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q25. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Before you left A&amp;E, did you get the results of your tests?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q29. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q30. If you did not get the results of the tests when you were in A&amp;E, did a member of staff explain how you would receive them?</td>
<td>6.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. 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>9.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>6.3</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q40. 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>6.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving A&amp;E?</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what symptoms to watch for regarding your illness or treatment after you went home?</td>
<td>7.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left A&amp;E?</td>
<td>8.2</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q44. Did staff give you enough information to help you care for your condition at home?</td>
<td>8.1</td>
<td>Better than other trusts</td>
</tr>
</tbody>
</table>
Q46. Overall | 8.5 | About the same as other trusts

(Source: Emergency Department Survey 2018)

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The service knew that the facilities and premises within the ED were not always appropriate for the services being delivered. The service had a pending business case and plans to build a new emergency department at the hospital. Staff were openly engaged with this process and had opportunity to engage with senior staff and stakeholders to decide the shape of the new service model. Service managers told us that information about the needs of the local population was used to inform service planning and delivery. The trust was involved with local commissioners and other health care providers working together to provide urgent and emergency care to patients.

Managers planned and organised services, so they met the needs of the local population. Following our last inspection in March 2016, the service had updated its children’s emergency department and improved the physical environment for patients.

All ambulatory patients arrived at the front door of the ED and were triaged by staff who ensured patients were directed to the area of ED that met their needs. This ensured that patients moved to appropriate areas and were aware of where they needed to go to be seen.

Throughout the ED there was adequate seating available for patients and patients had access to vending machines for food and drink. Children had a range of play resources including a books, toys and TV.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Emergency Department Survey 2018 – Type 1 A&E departments

The trust scored about the same as other trusts for all three of the Emergency Department 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>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Overall, how long did your visit to the emergency department last?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Were you given enough privacy when being examined or treated?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 2018)
Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. There were processes in place to support patients with mental health needs, dementia or a learning disability. Staff told us they could request the support of the mental health team, the dementia nurse or learning disability nurse if required.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff we spoke with told us that translation services were offered to patients whose first language was not English.

The service had information leaflets available on a wide range of minor injuries and health care promotion. The leaflets on display were in English only, but staff said they could access alternative formats if required.

We observed during our inspection that patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff made reasonable adjustments according to patient’s needs, for example a range of specialist bariatric equipment was available should it be required.

**Access and flow**

People could access the service when they needed it and waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

**Median time from arrival to treatment (all patients)**

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust met the standard and performed better than the England average for 11 months over the 12 month period from July 2018 to June 2019. The exception was August 2018 when the median time to treat at the trust was 70 minutes compared to the England average of 56 minutes.

Waiting times were lowest in September 2018, at 46 minutes and performance remained under the standard and the England average in the final nine months of the period.

**Median time from arrival to treatment from April 2018 to March 2019 at West Suffolk NHS Foundation Trust**
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 emergency department. From August 2018 to April 2019 the service met the standard in two out of the nine applicable months (September 2018 and November 2018). The trust performed better than the England average in all months apart from August 2018 over this time.

Managers and staff worked to make sure patients did not stay longer than they needed to. The service did not submit any data for patients admitted, transferred or discharged within four hours in May, June and July 2019. This was due to the service participating in NHS England and NHS Improvement’s Clinical Review of Standards field test of revised access standards. Reporting against the four-hour standard is not required by NHS England and Improvement during the field testing, which started in May 2019. Performance against the revised standards is not publicly reported to prevent any misinterpretation. *(Source: Memorandum of Understanding relating to the arrangements regarding participation in the Clinical Review of Standards field testing of national urgent and emergency care access standards, NHS England & NHS Improvement).*
We discussed this process with the ED teams. The service was relying on their internal professional standards for specialities, for example surgery teams, responding to patients waiting to be seen following referral. The standard was an hour. Staff we spoke with said that response times to the internal standards was varied and relying on the internal standards meant patients were waiting longer to be seen by the specialities as they were not hitting their internal standards. This meant patients waited longer to be seen in the ED and restricted flow, when they could be referred and moved to other specificities in a timelier fashion. Managers we spoke with said that it was early to report on the new initiative regarding the four-hour standard, but initial results were positive.

**Percentage of patients waiting more than four hours from the decision to admit until being admitted**

From August 2018 to July 2019 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was consistently better than the England average. Performance against this metric generally deteriorated across the period but followed a similar trend to the England average.

**Percentage of patients waiting more than four hours from the decision to admit until being admitted - West Suffolk NHS Foundation Trust**

The table below shows the numbers of patients waiting more than four hours to admission from August 2018 to July 2019:

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug-18</td>
<td>15</td>
</tr>
<tr>
<td>Sep-18</td>
<td>9</td>
</tr>
<tr>
<td>Oct-18</td>
<td>47</td>
</tr>
<tr>
<td>Nov-18</td>
<td>24</td>
</tr>
<tr>
<td>Dec-18</td>
<td>51</td>
</tr>
</tbody>
</table>
Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from August 2018 to July 2019, no patients waited more than 12 hours from the decision to admit until being admitted.

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

During our inspection we noted that staff monitored patient waiting times and that no patients waited longer than 12 hours within the ED.

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

From July 2018 to June 2019, the trust reported that no patients left the urgent and emergency care services before being seen for treatment. This was consistently better than the England average.

Percentage of patient that left the trust’s urgent and emergency care services without being seen - West Suffolk NHS Foundation Trust

(Source: NHS Digital - A&E quality indicators)
Median total time in A&E per patient (all patients)

From July 2018 to June 2019 the trust’s monthly median total time in A&E for all patients was higher than the England average in 11 out of 12 months, excluding September 2018 where this was the same (154 minutes).

From July 2018 to June 2019 performance against this metric was generally consistent, with a peak in August 2018 (198 minutes).

In the most recent month, June 2019, the trust’s monthly median total time in A&E for all patients was 166 minutes compared to the England average of 163 minutes.

Median total time in A&E per patient - West Suffolk NHS Foundation Trust

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

The service had dedicated entrances for ambulance and air ambulance arrivals which led to the resuscitation and rapid assessment and treatment (RAT) areas which enabled critically ill patients to be triaged and transferred to the correct area in a timely manner. Hospital ambulance liaison officers (HALO) employed by a local NHS ambulance trust, worked alongside the ED team to support patient flow and help prioritise the sickest patients for treatment.

Ambulant patients accessed the ED through the main ED reception and children were immediately directed to the children’s ED on arrival. Patients were greeted by a qualified nurse who completed a triage assessment, directed the patient to the appropriate treatment pathway within the ED, for example general practitioner, emergency nurse practitioner or minor or major treatment areas. Staff had access to care pathways including supporting patients with a fractured neck of femur, stroke or sepsis. The pathways were based on best practice guidance.

Managers and staff worked to make sure that they started discharge planning as early as possible. We noted on several occasions that staff from the early intervention team worked alongside the ED staff to support early discharge and plan resources to maximise patient independence on leaving the department. This included working with social care and other health care providers to provide individualised support and equipment in their own home, supported living or care home.
Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service did not always complete complaint investigations on time in line with its policy.

Summary of complaints

From June 2018 to May 2019 the trust received 22 complaints in relation to urgent and emergency care (12.7% of the total complaints received by the trust). All the complaints related to care received at West Suffolk Hospital.

For the 18 complaints that had been closed at the time of data submission, the trust took an average of 32.7 days to investigate and close complaints. This was not in line with their complaints policy, which states complaints should be closed within 25 days.

The four complaints, that had not yet been closed, had been open for an average of 140.8 working days at the time of data submission.

A breakdown of complaints by type is shown below. However, please note that the trust attributed multiple subjects to some complaints and these are indicated in the table below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>11</td>
<td>50.0%</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>4</td>
<td>18.2%</td>
</tr>
<tr>
<td>Communications</td>
<td>2</td>
<td>9.1%</td>
</tr>
<tr>
<td>Clinical treatment, values &amp; behaviours</td>
<td>1</td>
<td>4.5%</td>
</tr>
<tr>
<td>Clinical treatment, patient care</td>
<td>1</td>
<td>4.5%</td>
</tr>
<tr>
<td>Clinical treatment, patient care, admissions, discharge &amp; transfers</td>
<td>1</td>
<td>4.5%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>1</td>
<td>4.5%</td>
</tr>
<tr>
<td>Clinical treatment, communications</td>
<td>1</td>
<td>4.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Patients, relatives and carers knew how to complain or raise concerns. The service had a complaints policy which ensured that systems and processes were in place to enable patients and relatives to make a complaint. Information about how to complain was available across the emergency departments we visited.

Staff we spoke with understood their responsibilities to support people to complain. The service clearly displayed information about how to raise a concern in patient areas. We noted guidance in relation to the patient advice and liaison service (PALS) on notice boards and placed around the various ED areas. All staff we spoke with were aware of the complaints process and where to direct patients and relatives to if they could not resolve the complaint within the department.
Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. Managers we spoke to told us if a formal complaint was made, they were managed in confidence, with a regular update for the complainant. Staff received feedback from any complaints at ward huddles and team meetings, learning was identified, and actions recognised and implemented. A summary of complaints and actions taken was displayed in the ED staff resource area.

**Number of compliments made to the trust**

From June 2018 to May 2019 there were 63 compliments about urgent and emergency care at West Suffolk Hospital. (10.0% of the total compliments received by West Suffolk Hospital and 8.3% of compliments received trust wide).

The trust noted that most compliments received trust-wide related to overall care along the whole pathway; and patients and relatives thanking staff for their kindness and compassion during difficult and stressful times.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

The service displayed thank you cards and compliments on display boards within the department. Staff celebrated successes and compliments were also used to improve performance if the feedback was positive regarding an area of the department or good practice.

**Is the service well-led?**

**Leadership**

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The emergency department had a clear leadership structure, with defined roles and responsibilities. The emergency department (ED) was led by the associate clinical director, clinical director, head of nursing and associate director of operations. Matrons, unit manager and service operations manager had day-to-day clinical and managerial oversight of the department.

Staff were motivated to provide care and individualised support that met the needs of people attending the service.

Local leaders were highly valued and respected by the staff team. The staff told us the chief executive officer was prominent in the service, often calling in to see patients and staff. Staff we spoke with said that local managers listened to concerns and were always willing to provide support and guidance.

Leadership within the service drove improvement and sought ways to embed new models of care. For example, the development of the sepsis corner to support patients with neutropenic sepsis in response to quality reviews of the sepsis pathway.

Staff within the children’s ED spoke highly of the new lead nurse within the service who had been in post since December 2018. This new role had brought new ideas and support into the team and the team felt valued and respected.
Vision and strategy

The service did not have a local strategy to turn it into action. Leaders and staff understood and knew how to apply the services wider values and monitor progress.

The emergency department did not have a specific vision or set of values. All staff we spoke with were focused on achieving the trust's wider vision and embedding the service values in their everyday practice.

Managers we spoke with were clear on the service’s wider vision and mission and were universally supportive of the development of the new emergency department facilities. The ED staff team were involved in the development of the proposed new ED services and developing the services future strategy and values.

Whilst the new emergency department was in its early planning stages, the staff team remained focused on the service wider vision and values aiming to provide care that met the needs of all patients attending the ED.

Culture

Staff we spoke with were universally proud to work for the service and there was a focus on collaboration to improve outcomes for patients.

Staff told us they felt very supported and valued in their roles, by staff of all grades and we noted consistent mutually respectful interactions between staff.

Staff described an open culture where they felt able to raise concerns and suggestions to managers who staff described as approachable, interested and willing to provide them with advice and support at any time.

Staff were very proud of the care they provided but recognised the emergency department needed substantial investment to meet the increased patient demand and were willing to work with the senior team to develop the new department.

There was a high level of enthusiasm and motivation for working in the ED teams. Staff knew they had shortfalls in the environment, but they knew plans were in place and were confident that the management team listened to their concerns and were supporting them to develop the new emergency department.

Governance

Leaders operated governance processes. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had an established governance system and managers we spoke with knew how the various quality and assurance groups fed into the governance structure. Governance meetings occurred monthly, with attendees from multidisciplinary staff across the services departments. The service held operational meetings monthly, where information from governance meetings could be distributed to various other working groups and committees and then cascaded to front line staff teams.
Governance meetings were comprehensive and covered a wide range of clinical and operational performance areas, for example risk management, mortality and morbidity, complaints, incidents and other key performance issues. Staff we spoke with said they received feedback from governance and operational meetings in team meetings, safety huddles or via the service’s hot topics process.

We reviewed governance meeting records from June, July and August 2019 and noted these covered key issues in relation to patient safety, risk, quality safety and performance.

Management of risk, issues and performance

Leaders and teams did not always use systems to effectively manage performance.

We reviewed the service risk register in relation to the emergency department and found this to be up to date, with named staff allotted to each risk and clear timescales for improvement, as well as mitigation to manage any risk.

Managers we spoke with understood the risks associated with their respective areas. Staff we spoke with knew that the service had risk registers, but not all staff understood how these risks affected the areas they worked within.

Risks on the risk register included failure to recognise deteriorating patients, this has been reviewed and the risk downgraded due to additional training being implemented and ongoing documentation audits. The service was aware that the completion of patient records was an ongoing issue. It had taken steps improve performance. During inspection we identified a theme of incomplete patient records specifically patient safety check lists. The service was auditing this process and seeking options to improve performance, for example additional training, working with other providers to establish best practice and using perfect ward round data. There remained a risk that staff may not recognise a deteriorating patient if staff were not completing the safety check lists and brought into question how effective the audit process was at driving improvement.

The service had an active recruitment process in place to address the shortfall in middle grade doctors, this was on the risk register. The service had specific risk assessments for the ED environment used to support patients with mental health needs, these were up to date, and showed mitigating actions to take to safeguard patients and staff.

Governance meetings discussed risks within the emergency department and operational meetings set out actions that would mitigate risks and ensure staff were aware of and minimised any impact on patients and staff. Service performance information was fed into a service wide dashboard, and we noted information from governance meetings displayed in emergency department for staff.

All the leaders and managers we spoke with were passionate about delivering quality care to patients, whilst supporting and leading operational staff to achieve this.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

The service had arrangements to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems and these were in line with data security standards.
The service had suitable arrangements to ensure that the information used to monitor, manage and report on quality and performance was accurate, valid, reliable, timely and relevant. Information was shared via team meetings, on the internal service dashboard, and at governance and mortality and morbidity meetings.

Senior staff we spoke with during our inspection understood key performance data and how this was used to drive improvement. Staff within the ED teams were aware of internal performance standards. The service was participating in NHS England and NHS Improvement’s Clinical Review of Standards field test of revised access standards. Reporting against the four-hour standard is not required by NHS England and Improvement during the field testing, which started in May 2019. The service was monitoring its internal performance standards, but it was too early during our inspection to report on how this change was affecting performance outcomes.

Nurses, health care assistants and medical staff had access to information technology systems to track patients through their journey within the emergency department.

Staff had access to policies, procedures and clinical guidance through the service’s intranet and staff could access these in a timely manner.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff attended team meetings and one to one meetings with managers to discuss their performance and ask questions regarding the service performance.

Staff attended a wide range of meetings to share and gather information. These included nursing staff meetings bi-monthly, ED paediatric meetings monthly and emergency nurse practitioner meetings monthly. There were weekly senior management meetings and bimonthly team meetings with staff representatives from across the ED.

Medical staff held bimonthly consultant meetings and registrars and junior teaching once a week (Tuesday for registrars and Friday for juniors). These included learning from incidents and hot topics in addition to teaching. Advanced Clinical Practitioners (ACPs) held six weekly ACP forums for all ACPs across the service and the ACPs attended junior doctor teaching.

The service worked closely with the public regarding configuring information technology services, holding open events and listening events to encourage the public to have their say on services.

The service produced newsletters with key information in relation to services, updates to staff and changes across the service.

The service had a wide range of volunteers supporting patients and staff across the service.

Staff responded to staff feedback using “You said” and “We did” framework. For example, staff had been unclear how results from local audits were shared amongst staff. The trust reviewed the existing process for sharing the audit data and used display boards to share audit outcomes and discuss these during hot topic meets and staff meetings.

Learning, continuous improvement and innovation
West Suffolk Hospital are one of 14 sites nationally to support NHS England’s pilot of new Urgent Care Standards. Healthwatch Suffolk approached the service with an offer of support to collect additional patient experience feedback whilst undertaking the Urgent Care Standards Pilot.

The service had incorporated mobile technology to overcome the traditional staff bleep system and had implemented the medic bleep system to improve communication across its services.

The service has incorporated the Colles fracture reduction by finger trapping method. A Colles fracture is a type of fracture of the distal forearm in which the broken end of the radius is bent backwards. The emergency nurse practitioner (ENP) team use Chinese finger trapping for the reduction of Colles fracture.

The service was incorporating innovative departmental working styles around the following topics, use of newer anticoagulant use for patients being discharged on lower limb plaster cast / walking boot and adults pain management ladder.
The trust provided the following information about their medical care services:

Medicine provides services within 13 ward/clinical areas at West Suffolk Hospital.

- Ward G8 is a unit specialising in care of the stroke patient. It consists of four hyperacute stroke beds, 24 acute beds and six medical beds.
- The cardiac centre opened in November 2018 and consists of seven coronary care unit beds, 15 cardiac beds, a catheterisation laboratory and six recovery beds.
- G4 is an acute medical ward (32 beds) including two side-rooms for patients requiring isolation. It has a sub-speciality in care of the elderly and provides a dementia friendly environment.
- G5 is an acute medical ward (33 beds) including three side-rooms for patients requiring isolation, with a sub speciality of diabetes and nephrology.
- G9 is a winter escalation ward and in the summer is used as part of a deep cleaning programme.
- F8 is an acute respiratory unit (25 beds) divided between the respiratory therapy unit (RTU) comprised of 10 beds and acute medical/respiratory beds, comprised of 15 inpatient beds. This also includes three side rooms for patients requiring isolation. There is capacity for one recovery trolley and a chaired area for patients being assessed/treated in the pleural clinic.

(Source: Routine Provider Information Request (RPIR) – Acute context)

The trust had 26,584 medical admissions from March 2018 to February 2019. Emergency admissions accounted for 14,883 (56.0%), 148 admissions (0.6%) were elective, and the remaining 11,553 admissions (43.5%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 11,734 admissions
- Gastroenterology: 4,814 admissions
- Dermatology: 2,107 admissions

(Source: Hospital Episode Statistics)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

The service provided mandatory training in key skills to all staff. However not all staff completed it and processes were not fully effective to ensure compliance targets were met.

Mandatory training completion rates

The trust set a target of 90% for the completion of all mandatory training, with the exception of information governance which had a target of 95%.

West Suffolk Hospital

Nursing staff did not always receive and were not kept up-to-date with their mandatory training.

A breakdown of compliance for mandatory training courses as of June 2019 for qualified nursing staff in medicine at West Suffolk Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Infection control - classroom</td>
<td>295</td>
</tr>
<tr>
<td>Medicine management (refresher)</td>
<td>268</td>
</tr>
<tr>
<td>Fire safety training - classroom</td>
<td>290</td>
</tr>
<tr>
<td>Blood borne viruses/inoculation incidents</td>
<td>259</td>
</tr>
<tr>
<td>Basic life support (adult)</td>
<td>261</td>
</tr>
<tr>
<td>Security awareness</td>
<td>282</td>
</tr>
<tr>
<td>Slips trips falls</td>
<td>277</td>
</tr>
<tr>
<td>MAJAX</td>
<td>276</td>
</tr>
<tr>
<td>Health &amp; safety / risk management</td>
<td>276</td>
</tr>
<tr>
<td>Fire safety training - e-learning</td>
<td>266</td>
</tr>
<tr>
<td>Moving and handling - clinical</td>
<td>261</td>
</tr>
<tr>
<td>Information governance</td>
<td>261</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>256</td>
</tr>
<tr>
<td>Conflict resolution – e-learning</td>
<td>47</td>
</tr>
<tr>
<td>Blood products &amp; transfusion processes (refresher)</td>
<td>196</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>161</td>
</tr>
</tbody>
</table>

In medicine, the training targets were met for nine of the 16 mandatory training modules for which qualified nursing staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)
Whilst we were onsite, we were given updated figures which showed that mandatory training overall compliance was at 87.8%. This was slightly below the trust’s target.

Medical staff did not receive and were not kept up-to-date with their mandatory training.

A breakdown of compliance for mandatory training courses as of June 2019 for medical staff in medicine at West Suffolk Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Fire safety training - classroom</td>
<td>55</td>
</tr>
<tr>
<td>Infection control – e-learning</td>
<td>51</td>
</tr>
<tr>
<td>Fire safety training - e-learning</td>
<td>51</td>
</tr>
<tr>
<td>Health &amp; safety / risk management</td>
<td>50</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>50</td>
</tr>
<tr>
<td>Security awareness</td>
<td>49</td>
</tr>
<tr>
<td>Blood borne viruses/inoculation incidents</td>
<td>49</td>
</tr>
<tr>
<td>Slips trips falls</td>
<td>48</td>
</tr>
<tr>
<td>MAJAX</td>
<td>48</td>
</tr>
<tr>
<td>Blood products &amp; transfusion processes (refresher)</td>
<td>28</td>
</tr>
<tr>
<td>Moving &amp; handling – e-learning</td>
<td>47</td>
</tr>
<tr>
<td>Medicine management (refresher)</td>
<td>47</td>
</tr>
<tr>
<td>Information governance</td>
<td>46</td>
</tr>
<tr>
<td>Basic life support (adult)</td>
<td>40</td>
</tr>
<tr>
<td>Conflict resolution – e-learning</td>
<td>15</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>5</td>
</tr>
</tbody>
</table>

In medicine, the training targets were met for one of the 16 mandatory training modules for which medical staff were eligible. Compliance rates for the remaining 15 training courses ranged from 62.5% for conflict resolution to 83.6% for infection control and fire safety e-learning.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Whilst we were onsite we were given updated figures which showed that mandatory training overall compliance was at 87.8%. This was slightly below the trust’s target.

The mandatory training was comprehensive and met the needs of patients and staff. The training covered a wide variety of topics and staff told us that it was helpful and thorough.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Extra training was provided on recognising patients living with a learning disability or dementia. This was not mandatory, but we saw strong positive uptake of the training on the wards we visited.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers were sent electronic reminders when staff were due to update their training. Some wards also had mandatory training champions who organised extra training sessions for staff. Training was given on Tuesdays and Wednesdays and were put into the rotas so that staff had time to complete it. Despite these processes, compliance targets were not met, however, improvement was being made.
Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Nursing staff had training on how to recognise and report abuse, and they knew how to apply it.

Safeguarding training completion rates

The trust set a target of 90% for the completion of safeguarding training.

The tables below include Prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

West Suffolk Hospital

Nursing staff received training specific for their role on how to recognise and report abuse.

A breakdown of compliance for safeguarding training courses as of June 2019 for qualified nursing staff in medicine at West Suffolk Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>290</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>289</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>288</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2 (basic prevent awareness)</td>
<td>283</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5 (prevent awareness)</td>
<td>236</td>
</tr>
</tbody>
</table>

In medicine the 90% target was met for four of the five safeguarding training modules for which qualified nursing staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Compliance for medical staff with training specific for their role on how to recognise and report abuse fell below trust targets.

A breakdown of compliance for safeguarding training courses as of June 2019 for medical staff in medicine at West Suffolk Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5 (prevent awareness)</td>
<td>55</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>51</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2 (basic prevent awareness)</td>
<td>51</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>49</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>49</td>
</tr>
</tbody>
</table>
In medicine the 90% target was met for one of the five safeguarding training modules for which medical staff were eligible. We requested an action plan for bringing staff up to compliance with safeguarding training but were only provided with a mandatory training recovery plan which did not have specific reference to safeguarding training. This included improving accuracy of training records and improving access to electronic learning. Medical staff we spoke with during the inspection knew how and what to report for safeguarding concerns.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. All staff we spoke with were familiar with the protected characteristics of the Equality Act, such as sex and race. Staff explained the process they would follow if they found a patient being harassed or discriminated against. Staff knew to contact the security at night team if they felt that a patient or staff member was being harassed out of hours. The security at night team also conducted nightly walkarounds all the wards.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff provided examples of situations where adults or children could be at risk of harm and were familiar with the safeguarding process to follow. Staff had taken action on one ward to safeguard a patient in a violent relationship.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

From 1 June 2018 to 31 May 2019 the department made 69 safeguarding referrals. The medical division’s safeguarding lead was visible, and staff knew who to raise concerns with.

Staff followed safe procedures for children visiting the ward. Children under the age of 12 were not allowed on the medical wards unless the patient was receiving palliative care, and they were accompanied by an adult. If patients were mobile staff encouraged them to meet with young relatives outside of the ward environment.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. However, hazardous cleaning chemicals were not always stored securely. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. All wards we visited were clean and tidy. Patients with infectious diseases or illnesses were nursed in side rooms. We saw side rooms being used for patients with infectious illnesses and saw that these were clearly identified.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning records we looked at were kept up to date and showed that the ward areas were cleaned regularly. Monthly audits were conducted through the ‘perfect ward’ application. This showed that the wards were achieving highly in hand hygiene.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff following infection control practices. All staff were ‘arms bare below the elbow’, had long hair tied back and used PPE such as aprons and gloves appropriately when needed. All patients we spoke with confirmed that staff cleaned their hands before every physical interaction.
Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw that cleaning wipes were used for hoists and standing aids after patient use. Staff informed us that this had been introduced following an outbreak of clostridium difficile in early 2019. On G4 ward (general medicine) we found COSHH chemicals (control of substances hazardous to health) which were not stored safely. The chemicals were stored in an unlocked room, in a locked cupboard. The key to the cupboard was kept unsecured nearby. We were particularly concerned about this due to the location of the room which was opposite two bays of vulnerable patients living with dementia or cognitive impairments and the risk that they could accidentally consume the hazardous cleaning chemicals. We raised this as a concern and staff removed the key immediately. However, when we returned on an unannounced inspection we found the key had been returned to the unsecure location, despite us raising this as a concern on our inspection. Following the unannounced inspection, we were told key lock safe were being introduced to mitigate the risk of patients ingesting hazardous chemicals.

Processes were in place in endoscopy to decontaminate endoscopes following use. This was in line with Health Technical Memorandum guidance. Decontamination occurred within the hospital site, so there was no need to transfer scopes off the facility.

Environment and equipment
The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. All patients we saw had call bells within their reach. Staff did not audit response times to call bells but whilst on inspection we saw staff responding quickly.

The design of the environment followed national guidance. All ward areas were wheelchair accessible and fire doors were kept clear. However, some wards were cluttered due to a lack of storage space. For example, G5 ward (geriatric medicine) stored equipment in the main corridor and F12 ward stored needles and syringes on an open shelf behind the reception area, as they had no equipment rooms. We raised concerns about the storage of sharps on F12 (infectious diseases) with staff and were told that no risk assessment had been completed for this. This meant a potential risk to patients or visitors as they could take sharps and syringes for personal use as they were not in a locked cupboard or room.

A new PICC line room had been built in the medical treatment unit (MTU). This met national guidance and had appropriate air flow to ensure the room was sterile.

A new acute assessment unit (AAU) had opened in December 2018. This included an ambulatory care unit for patients who were more mobile. Consideration had been given to the design of the unit and the suitability for patients with mental health concerns. For example, there was a specialist toilet available for patients who were suffering a mental health crisis which did not have any ligature (strangulation) points.

Staff carried out daily safety checks of specialist equipment. We checked the resuscitation trolleys on four wards and found all of them to be complete and in date. All resuscitation trolley record logs showed they were checked daily.

The service had suitable facilities to meet the needs of patients’ families. Chairs were available at the patients’ bedsides for families to visit. Some patients on G1 ward (oncology) were able to have their relatives stay overnight on pull-out beds.
The service had enough suitable equipment to help them to safely care for patients. All wards had sufficient equipment and all staff we spoke with said there was never an issue with obtaining new equipment if needed. We were told new equipment was provided either through trust investment or charitable funds.

Staff disposed of clinical waste safely. Clinical waste bins were clearly labelled. Sharps bins were kept closed and labelled appropriately. Arrangements were in place to dispose of cytotoxic waste on G1 (oncology). Cytotoxic medicines are those which kill cancer cells. Left over wastage of these medicines need to be disposed of safely as they can cause dangerous side effects to people if they are exposed inappropriately.

Assessing and responding to patient risk

**Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.**

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. All medical wards used the national early warning score (NEWS) to identify deteriorating patients. Staff took patients’ vital signs including blood pressure and temperature which was automatically put into their electronic patient records. This gave each patient a NEWS score. Depending on the patients’ score staff would escalate accordingly. We also observed on the cardiac centre nursing staff escalating a deteriorating patient to a consultant.

Staff completed risk assessments for each patient on admission / arrival and updated them when necessary and used recognised tools.

Internal audits found NEWS compliance to be mixed within the department. A 2018 audit found that 100% of patients (sample size 33), had NEWS recorded at initial presentation but that three patients had their observations repeated outside of the appropriate time frame. This equated to 9% of NEWS charts not being completed on time. We reviewed seven patient records and found the NEWS had been completed appropriately in all charts we looked at.

We saw that staff completed risk assessments, such as pressure ulcers and malnutrition assessments, usually in a timely fashion. However, we found one patient record where the patient was admitted to the ward with a grade 3 pressure ulcer but did not receive a pressure ulcer risk assessment for 11 days and did not receive a skin integrity risk assessment for three days. On the other six charts we reviewed pressure ulcer charts were completed appropriately, suggesting that this was not a recurring risk to other patients. However, we were not assured that all patients had the appropriate risk assessments completed in a timely fashion. When a patient sustained a hospital acquired pressure ulcer staff completed an electronic incident report. This was then referred to the tissue viability team who would visit the patient and give individualised advice. Equipment available for pressure area care included pressure relieving mattress, heel protectors and cushions.

An audit on completion of venous thromboembolism (VTE) risk assessments within the cardiology centre found that 85% of patients had a VTE risk assessment completed within 24 hours of admission.

Staff completed intentional rounding on patients on either a two hourly basis or four hourly basis, depending on the patient’s risk level. This included checking patients for pressure area care, mouth care and whether they needed assistance to the toilet.

Safety checklists were completed in endoscopy prior to procedures taking place.
Staff knew about and dealt with any specific risk issues. Staff were aware of the importance of identifying risks of sepsis, VTE, falls and pressure ulcers. Sepsis bundles were in place and the electronic record system alerted staff to a potential septic patient if their vital signs indicated they could be developing sepsis. Staff were aware that some of their patients were at high risk of falling and had completed falls risk assessments as required.

There had been one ‘red’ fall in August 2019 which involved a patient living with dementia falling, leading to them fracturing their neck of femur (broken hip). On review the fall was deemed to be unavoidable; the patient had been risk assessed and found to be independently mobile.

All patients aged over 65 years old had lying and standing blood pressure monitored to help assess their risk of falls. The service used signage above beds to indicate where a patient was at risk of falls and was looking to purchase red anti slip socks so that patients who were high risk of falls and were out of bed walking around the ward, could be easily monitored.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient’s mental health). A mental health team were onsite Monday to Friday, 9am to 5pm. Outside of these hours an on-call system was in place. Staff we spoke with knew how to access them and we were told they were quick to respond to requests for assistance.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. If staff had concerns about a patient’s risk of self-harm or suicide, they referred to the mental health team who completed the necessary assessments.

Staff shared key information to keep patients safe when handing over their care to others. We reviewed the proforma used when patients were moved between wards. This included information such as their resuscitation status, past medical history, the reason for their admission, their level of confusion and any intravenous (IVs) or controlled drugs (CDs) they were currently having.

Shift changes and handovers included all necessary key information to keep patients safe. Nursing handovers occurred twice a day. Information shared at handover included the patient’s status, any investigations waiting to be completed and any pending results.

**Nurse staffing**

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a corporate induction. However, there was no formal record of local induction for bank and agency staff.

At the time of our inspection, the service had enough nursing staff of relevant grades to keep patients safe. The medical division had recently recruited a large number of overseas nurses, alongside some newly qualified nursing staff. This had improved their nursing levels, which prior to this recruitment had been low and was supported by agency staff.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The medical division did not use a specific tool to manage their staffing levels but decided staffing
levels based on patient acuity and available resources. Due to lower levels of nursing staff, the
division had been changing the skill mix on the wards, by increasing the number of healthcare
assistants to supplement the lower numbers of registered nurses.

West Suffolk Hospital

The table below shows a summary of the nursing staffing metrics in medicine at West Suffolk
Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Medicine annual staffing metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2018 to March 2019</td>
</tr>
<tr>
<td>Staff group</td>
</tr>
<tr>
<td>Target</td>
</tr>
<tr>
<td>All staff</td>
</tr>
<tr>
<td>Qualified nurses</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

The ward manager could adjust staffing levels daily according to the needs of patients. Every day
a specific matron was assigned as ‘matron of the day’ and was responsible for the staffing rotas
and flexing staff where needed. We were told that staff were moved between wards when needed
to cover for staff sickness, or during the winter escalation months.

The number of nurses and healthcare assistants on all shifts on each ward matched the planned
numbers. Data was submitted by the trust which showed that in June 2019 the average fill rate
for nurses was 84% during the day and 92% at night. The average fill date for healthcare
assistants in June 2019 was 95% during the day and overfilled at 120% at night. Figures for July
and August 2019 showed a similar but improving picture, with higher fill rates for nurses during
the day.

Nurse staffing rates within medicine were analysed for the past 12 months and no indications of
improvement, deterioration or change were identified in monthly rates for turnover, sickness and
agency use.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Vacancy rates

The service had reducing vacancy rates, although still above target.
Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives in medicine showed a shift from October 2018 to March 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

The service had low turnover rates. The trust’s target was 10% and nursing staff had 7% turnover from June 2018 to May 2019.

The service had on target sickness rates. The trust’s target was 3.5% and nursing staff had 3.1% sickness from June 2018 to May 2019.

The service had reducing rates of bank and agency nurses used on the wards. The trust did not set a target for bank and agency staff. From June 2018 to May 2019, 2% of shifts were covered by bank and 4% by agency staff. We were told by staff on the ward that since the recruitment of overseas nurses there was less reliance on bank and agency staff.

Bank staff usage

Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives in medicine showed a shift from November 2018 to April 2019.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Managers limited their use of bank and agency staff and requested staff familiar with the service. We saw that many bank shifts were covered by substantive staff undertaking extra shifts. We were also told that when agency staff were going to be needed on a long-term basis, for example to
cover winter escalation areas, agency staff were block booked so that the same agency staff were used consistently. This helped make them familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service. All agency staff had a corporate induction, but we were told that there was no formalised local induction to the ward. We were told that substantive staff would show agency staff around the ward and ensure they knew about fire doors and resuscitation trolleys, however, this was not documented anywhere and therefore, there was no evidence of this. As such, we were not assured that the relevant checks had been carried out.

**Medical staffing**

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. Medical rotas were planned to ensure adequate numbers of medical staff. Medical staff we spoke with told us that there were sufficient staffing levels.

The medical staff did not always match the planned number on all shifts in each department. We saw the figures for actual staffing levels from June to August 2019. This showed that for two of the three months medical staffing was below planned numbers; 185 actual whole-time equivalents (WTE) vs 196 planned WTE for June and 185 actual WTE vs 196 planned WTE for July. In August we saw there was more staff than planned; 216 actual WTE vs 197 planned WTE. This was due to recent recruitment.

**Trust level**

The table below shows a summary of the medical staffing metrics in medicine at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Medical annual staffing metrics</th>
<th>April 2018 to March 2019</th>
<th>June 2018 to May 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff group</strong></td>
<td><strong>Annual average establishment</strong></td>
<td><strong>Annual vacancy rate</strong></td>
</tr>
<tr>
<td>Target</td>
<td></td>
<td>6%</td>
</tr>
<tr>
<td>All staff</td>
<td>881</td>
<td>9%</td>
</tr>
<tr>
<td>Medical staff</td>
<td>74</td>
<td>8%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)
The service had higher than target vacancy rates for medical staff. From April 2018 to March 2019 medical staff had a vacancy rate of 8%, higher than the target rate of 6%.

The service had low turnover rates for medical staff. From June 2018 to May 2019 medical staff had 2% vacancy rates, better than the target of 10%.

Sickness rates for medical staff were low. From June 2018 to May 2019 medical staff had a 1% sickness rate, better than the target of 3.5%.

The service had low rates of bank and locum staff used on the wards. The trust did not set a target for the number of bank and locum staff used on the wards. From June 2018 to May 2019 5% of shifts were covered by bank staff and 3% filled by locum staff.

Medical staffing rates within medicine were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness, bank use and locum use.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Managers could access locums when they needed additional medical staff. We saw locum staff were used when needed, especially during the winter escalation months.

Managers made sure locums had a full induction to the service before they started work. Staff confirmed locums received full inductions when starting to work for the division.

**Staffing skill mix**

The service had a good skill mix of medical staff on each shift and reviewed this regularly. In April 2019, the proportion of consultants reported to be working in medical care at the trust was the same as the England average. The trust had a higher proportion of junior (foundation year 1-2) medical staff working in medical care compared to the England average, whereas the proportion of registrars working at the trust was lower.

**Staffing skill mix for the 105 whole time equivalent staff working in medicine at West Suffolk NHS Foundation Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>45%</td>
<td>45%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>16%</td>
<td>28%</td>
</tr>
<tr>
<td>Junior*</td>
<td>34%</td>
<td>20%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital - Workforce Statistics - Medical (01/04/2019 - 31/04/2019))
The service always had a consultant on call during evenings and weekends. Rotas confirmed that there was always a consultant on call during evenings and weekends. Staff we spoke with confirmed they were easy to contact and came in if needed.

**Records**

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. We reviewed seven records and found all were completed. Most records were stored electronically, with staff requiring log in details to access them. Paper records were used for blood transfusions, two types of antibiotics and a blood thinning medication. These were stored on paper due to the nature of the treatment plans.

When patients transferred to a new team, there were no delays in staff accessing their records. The majority of patient notes were stored electronically, therefore, there was no delay when patients were transferred to a new ward or team.

Records were stored securely. Electronic records were stored securely as we saw computers were locked when not in use. Paper records were kept at the patients’ bedside with a clipboard cover stating that they were confidential. These were only minimal records that were in constant use by the nursing team.

**Medicines**

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines. We found that safe processes were not being followed in relation to the storage and recording of medicines. We found patients’ own medications were being stored on two wards (AAU and F8) in plastic bags on a counter inside the locked drugs room. All medications should be inside a locked cupboard or inside a locked room with controlled access. Untrained staff such as the care coordinator and clerk had access to the drugs room and therefore, potentially to the patients’ own medications. We saw student nurses accessing the drugs room on G1 and were told that they were sometimes given the medication cupboard keys to access medications. This was not in line with best practice.

We also found that the controlled drug (CD) book was not always being completed when staff were administering CDs. CDs are medicines that are highly addictive if taken in excess quantities. As such, stringent legal requirements are in place to ensure that they are not abused. We found four occasions on G4 and two occasions on G5 where there were gaps in the recording of either the administrator or the witness.

We also found that the drug room on G5 did not monitor ambient room temperatures despite the room being very hot during our inspection. We were told that the staff on the ward were aware the drug room was not appropriate as it was also very small, and that they had submitted a business case for a new drugs room. There was no risk assessment in place in the interim period. As such, we were not assured that effective processes were in place to ensure medications were stored at the correct temperature to maintain efficacy.
Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Patients' medications were reviewed daily during the ward rounds. Pharmacy staff visited the wards daily to review new patients, complete medication reconciliation and to arrange TTOs (medication to take home).

Patients were provided with advice and information about their medications. We were told that if a patient was receiving a blood thinning medication for the first time, pharmacy staff came and explained what they were and what lifestyle changes the patient may need to undertake, such as avoiding alcohol.

Staff did not always store and manage medicines and prescribing documents in line with the provider’s policy. The provider’s policy stated that in the administration of controlled drugs two staff should oversee the process and sign the controlled drugs book, which as noted above, did not always occur. However, in all the records we reviewed the prescription charts were legible, and the dosage and frequency of medications were signed and dated. All medication charts we looked at showed that medication was administered as prescribed.

Staff followed current national practice to check patients had the correct medicines. Staff ensured that the right patient had the right medications. All patients had barcodes on their wrist bands that were scanned prior to administration to ensure that the right patient was getting the right medicine.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Safety alerts were shared at clinical governance meetings, with the information shared through the hospital’s new ‘medic bleep’ system.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff ensured that patients’ behaviour was not being controlled by inappropriate use of medicines. All medications administered were recorded, including those that could be taken PRN ‘as needed’, to ensure no patients were taking excessive amounts. If patients were given potentially addictive medications, such as some forms of pain relief, to take home, they were only given three days’ supply so as to avoid any overdosing. Patients were advised to see their GP if they required further medication.

**Incidents**

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and there were several ways in which learning from incidents was shared. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff we spoke with gave us a variety of examples of the types of incidents to report and were familiar with the electronic reporting system. The trust also had a mechanism for reporting examples of good patient care so that positive events could also be shared.

Staff reported all incidents that they should report. Staff raised concerns and reported incidents and near misses in line with trust/provider policy.

**Never Events**

The service had no never events on any wards.
Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From August 2018 to July 2019, the trust did not report any incidents that were classified as a never event in medicine.

(Source: Strategic Executive Information System (STEIS))

Managers did not always share learning about never events with their staff and across the trust or share learning about never events that happened elsewhere. Some staff we spoke with were unaware if there had been any never events within the trust and did not have a clear understanding of what a never event was. Staff we spoke with were not aware of never events that had occurred in other NHS trusts.

Breakdown of serious incidents reported to STEIS

Staff reported serious incidents clearly and in line with trust policy.

In accordance with the Serious Incident Framework 2015, the trust reported 15 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from August 2018 to July 2019. This represented 28.8% of all serious incidents reported by the trust as a whole.

A breakdown of the incident types reported is shown in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>10</td>
<td>66.7%</td>
</tr>
<tr>
<td>HCAI/Infection control incident meeting SI criteria</td>
<td>4</td>
<td>26.7%</td>
</tr>
<tr>
<td>Major incident/ emergency preparedness, resilience and response/ suspension of services</td>
<td>1</td>
<td>6.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. From 1 May 2018 to 30 April 2019 duty of candour was applied 45 times. Staff we spoke with had a strong understanding of the duty of candour and explained how this was used in practice.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff received feedback from incidents through the ‘matron’s message’ which was displayed in staff areas on the ward. The oncology ward also produced a monthly newsletter which shared incidents. Medical and operational staff had a new mobile application ‘app’ on their mobile phones which allowed them to share information, including feedback from incidents.

Staff met to discuss the feedback and look at improvements to patient care. Feedback from incidents and improvements to patient care were discussed at clinical governance meeting. Individual staff members involved in incidents were met with to ensure that they were fed back any improvements they could have made to their practice. However, we were not assured that junior staff were fully aware of improvements to patient care as they did not attend the clinical governance meetings and did not have regular team meetings.

There was evidence that changes had been made as a result of feedback. The medical wards had recently introduced red tabards for staff undertaking medication rounds, as a result of an increase
in medication errors. Following this there had been zero medication errors on ward G4. We also saw on G8 that following a patient fall handover was changed to occur outside bays so that staff could observe patients during handover.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We reviewed the last three serious incident root cause analysis reports and saw that they were investigated thoroughly with clear root causes identified. We also saw duty of candour was met and families were kept informed during investigations.

Managers debriefed and supported staff after any serious incident. Staff who had been involved in incidents told us they were supported by senior leadership. The human resources (HR) department also held ‘tea and chat’ sessions where staff feeling like they needed help could go and speak to an HR officer. We saw pastoral support was also offered by the occupational health teams and chaplaincy.

**Safety thermometer**

**The service collected data for monitoring, but this was not fully utilised to improve safety.**

Safety thermometer data was not displayed on wards for staff and patients to see. Some information, such as falls were displayed, but not the entire safety thermometer data.

The Safety Thermometer was 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 was intended to focus attention on patient harms and their elimination.

Staff did not use the safety thermometer data to further improve services. Most staff we spoke with were unfamiliar with the term ‘safety thermometer’ and did not use it to improve their services. However, they were aware of patient falls and the need to try and reduce the number of patient falls.

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

Data from the Patient Safety Thermometer showed that the trust reported 42 new pressure ulcers, 14 falls with harm and 16 new urinary tract infections in patients with a catheter from July 2018 to July 2019 for medical services.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at West Suffolk NHS Foundation Trust**

1

2
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed policies to plan and deliver high quality care according to best practice and national guidance. We reviewed 10 policies and they were all up to date. However, we also reviewed six guidelines in cardiology and found four of these to be out of date for review. Although these guidelines were out of date, they still referenced current best practice, and therefore, there was no impact on patient care.

The service had adapted guidance on quality standard for conditions such as chronic kidney disease and acute kidney injury. Sepsis screening and management was completed effectively, and patients were seen by consultants appropriately. Staff followed National Institute for Health and Care Excellence (NICE) clinical guideline CG42 for supporting people living with dementia, through their use of a memory walk and interactive therapies.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff were aware of patients’ rights under the Mental Health Act and knew how to reach the mental health team to ensure patients’ care was being given appropriately.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We saw that patients’ emotional and psychological needs were discussed during handover. This ensured that appropriate referrals were put in place when needed.

Nutrition and hydration
Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients had protected meal times on the wards to ensure that they had time to eat and drink. We saw staff helping patients to eat when they were unable to do so on their own. Patients on specialist diets had this highlighted on the board above their bed. A variety of menu choices were available for patients who had specific religious or cultural requirements.

Staff fully and accurately completed patients’ fluid and nutrition charts where needed. Out of the seven records we reviewed all had completed fluid and nutrition charts, although one patient did not get a nutrition assessment until four days after their admission. Whilst we did not see evidence of impact due to this delay, there was the potential that the patient could have been at risk of malnutrition.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The department used the malnutrition universal screening tool (MUST) to assess and monitor patients at risk of malnutrition.

Specialist support from staff such as dieticians and speech and language therapists was available for patients who needed it. Dieticians and speech and language therapists visited the medical wards on a daily basis. Staff made referrals to the teams if they needed an in-depth consultation.

**Pain relief**

**Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used a smiley face tool to assess pain levels for patients with limited communication and gave pain relief as required to patients. The hospital had a specialist pain team which staff could refer to, for patients suffering with a lot of pain or chronic (long term) pain.

Patients received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately. Patients we spoke with told us they received pain relief quickly, however, the service did not audit the length of time between requests and administration. From the seven records we reviewed we saw pain relief was prescribed, administered and recorded appropriately.

**Patient outcomes**

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes. However, not all action plans detailed all areas of improvement.**

The service participated in all relevant national clinical audits. The service performed well in national clinical outcome audits and managers use the results to improve services further. Details of the national audits the service participated in can be found below.
Relative risk of readmission

From February 2018 to January 2019, patients at West Suffolk Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.

- Patients in gastroenterology had a similar to expected risk of readmission for elective admissions
- Patients in clinical haematology and medical oncology had higher than expected risks of readmission for elective admissions

Elective Admissions

![Bar chart showing relative risk of readmission for elective admissions across different specialties.](chart)

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 represents the opposite. Top three specialties for specific site based on count of activity.

From February 2018 to January 2019, patients at West Suffolk Hospital had a similar to expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in general medicine, geriatric medicine and respiratory medicine had similar to expected risks of readmission for non-elective admissions

The service had a similar to expected risk of readmission for non-elective care compared to the England average. From February 2018 to January 2019, patients at West Suffolk Hospital had a similar to expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in general medicine, geriatric medicine and respiratory medicine had similar to expected risks of readmission for non-elective admissions

![Bar chart showing relative risk of readmission for non-elective admissions across different specialties.](chart)

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 represents the opposite. Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

Managers carried out a comprehensive audit programme. The medical care division contributed to audits for a variety of specialities, including stroke care, cancer care and diabetes care. Details
of these can be found below.

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

West Suffolk Hospital took part in the Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade A in the latest audit, covering the period from January to March 2019. Over the last four audits the trust consistently achieved grade A.

<table>
<thead>
<tr>
<th>Overall Scores</th>
<th>Apr 18 - Jun 18</th>
<th>Jul 18 - Sep 18</th>
<th>Oct 18 - Dec 18</th>
<th>Jan 19 - Mar 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Combined total key indicator level</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
</tbody>
</table>

For patient and team centred performance, the rating for thrombolysis (domain 3) fell from grade B to D for the most recent time period, and two domains (specialist assessments and speech and language therapy) fell from grade A to B. However, the rating for four domains remained at grade A and two domains (standards by discharge and discharge processes) improved.

<table>
<thead>
<tr>
<th>Patient centred performance</th>
<th>Apr 18 - Jun 18</th>
<th>Jul 18 - Sep 18</th>
<th>Oct 18 - Dec 18</th>
<th>Jan 19 - Mar 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>C</td>
<td>C</td>
<td>B↑</td>
<td>D↓↓</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
<td>B↓</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>B↓</td>
</tr>
<tr>
<td>Domain 8: Multi-disciplinary team working</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
<td>C↑</td>
<td>C</td>
<td>D↓</td>
<td>B↑↑</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
<td>A↑</td>
<td>B↓</td>
<td>B</td>
<td>A↑</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Team centred performance</th>
<th>Apr 18 - Jun 18</th>
<th>Jul 18 - Sep 18</th>
<th>Oct 18 - Dec 18</th>
<th>Jan 19 - Mar 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>C</td>
<td>C</td>
<td>B↑</td>
<td>D↓↓</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
<td>B↓</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>B↓</td>
</tr>
<tr>
<td>Domain 8: Multi-disciplinary team working</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
<td>C↑</td>
<td>C</td>
<td>D↓</td>
<td>B↑↑</td>
</tr>
</tbody>
</table>
Lung Cancer Audit

The table below summarises West Suffolk NHS Foundation Trusts' performance in the 2018 National Lung Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude proportion of patients seen by a cancer nurse specialist (Access to a cancer nurse specialist is associated with increased receipt of anticancer treatment)</td>
<td>93.7%</td>
<td>Meets the audit aspirational standard</td>
<td>Met</td>
</tr>
<tr>
<td>Case-mix adjusted one-year survival rate (Adjusted scores take into account the differences in the case-mix of patients treated)</td>
<td>39.5%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Case-mix adjusted percentage of patients with Non-Small Cell Lung Cancer (NSCLC) receiving surgery (Surgery remains the preferred treatment for early-stage lung cancer; adjusted scores take into account the differences in the case-mix of patients treated)</td>
<td>15.8%</td>
<td>Within expected range</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Case-mix adjusted percentage of fit patients with advanced NSCLC receiving systemic anti-cancer treatment (For fitter patients with incurable NSCLC anti-cancer treatment is known to extend life expectancy and improve quality of life; adjusted scores take into account the differences in the case-mix of patients seen)</td>
<td>77.0%</td>
<td>Within expected range</td>
<td>Met</td>
</tr>
<tr>
<td>Case-mix adjusted percentage of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy (SCLC tumours are sensitive to chemotherapy which can improve survival and quality of life; adjusted scores take into account the differences in the case-mix of patients seen)</td>
<td>76.9%</td>
<td>Within expected range</td>
<td>Met</td>
</tr>
</tbody>
</table>
(Source: National Lung Cancer Audit)

This showed that the division was within the expected range or met the aspirational standard for all five indicators. However, it did not meet the national standard for one indicator; the case mix adjusted percentage of patients with non-small cell lung cancer receiving surgery.

Oncologists followed best practice in treating lung cancer. An internal audit completed in 2019 found that 100% of patients with EGFR+ T790M mutations (a type of mutated lung cancer) were treated with Osimertinib (a medication used to treat non-small-cell lung carcinomas with a specific mutation). The same audit also found that 100% of patients received liquid biopsies before tissue biopsies to look for T790M mutations. This was in line with National Institute for Health and Care Excellence (NICE) guidance TA416.

National Audit of Inpatient Falls

The table below summarises West Suffolk Hospital’s performance in the 2017 National Audit of Inpatient Falls. The audit reports on the extent to which key indicators were met and grades performance as red (less than 50% of patients received the assessment/intervention), amber (between 50% and 79% of patients received the assessment/intervention) and green (more than 80% of patients received the assessment/intervention).

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Met national aspirational standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the trust have a multidisciplinary working group for falls prevention where data on falls are discussed at most or all the meetings?</td>
<td>Yes</td>
<td>n/a</td>
<td>Met</td>
</tr>
<tr>
<td>Crude proportion of patients who had a vision assessment (if applicable) (Having a vision assessment is indicative of good practice in falls prevention)</td>
<td>3.5%</td>
<td>Red</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) (Having a lying and standing blood pressure assessment is indicative of good practice in falls prevention)</td>
<td>42.3%</td>
<td>Red</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude proportion of patients assessed for the presence or absence of delirium (if applicable) (Having an assessment for delirium is indicative of good practice in falls prevention)</td>
<td>33.3%</td>
<td>Red</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude proportion of patients with a call bell in reach (if applicable) (Having a call bell in reach is an important environmental factor that may impact on the risk of falls)</td>
<td>93.1%</td>
<td>Green</td>
<td>Did not meet</td>
</tr>
</tbody>
</table>

(Source: National Audit of Inpatient Falls)

The service did not meet four out of five standards in the national falls audit. This was corroborated by the number of serious incidents involving falls. Please refer to the ‘safe’ section of this report for more details.
We requested an action plan to improve the division’s performance in the falls audit and were provided with a rolling action log from the trust’s fall group. This included actions such as discussing the reporting of falls on the trust’s electronic records system and including bed rails risk assessments on the electronic records system. However, we could not see actions correlated to the areas not met.

### Chronic Obstructive Pulmonary Disease Audit

The table below summarises West Suffolk Hospital’s performance in the 2019 Chronic Obstructive Pulmonary Disease Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients seen by a member of the respiratory team within 24hrs of admission? (Specialist input improves processes and outcomes for COPD patients)</td>
<td>Not available</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Percentage of patients receiving oxygen in which this was prescribed to a stipulated target oxygen saturation (SpO2) range (of 88-92% or 94-98%) (Inappropriate administration of oxygen is associated with an increased risk of respiratory acidosis, the requirement for assisted ventilation, and death)</td>
<td>100.0%</td>
<td>Better than the national aggregate</td>
<td>Met</td>
</tr>
<tr>
<td>Percentage of patients receiving non-invasive ventilation (NIV) within the first 24 hours of arrival who do so within 3 hours of arrival (NIV is an evidence-based intervention that halves the mortality if applied early in the admission)</td>
<td>Not available</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Percentage of documented current smokers prescribed smoking-cessation pharmacotherapy (Smoking cessation is one of the few interventions that can alter the trajectory of COPD)</td>
<td>Not available</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Percentage of patients for whom a British Thoracic Society, or equivalent, discharge bundle was completed for the admission (Completion of a discharge bundle improves readmission rates and integration of care)</td>
<td>0.0%</td>
<td>Worse than the national aggregate</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Percentage of patients with spirometry confirming FEV1/FVC</td>
<td>0.0%</td>
<td>Worse than the national aggregate</td>
<td>Did not meet</td>
</tr>
</tbody>
</table>
Three of the indicators above state that the data was not available. This was due to the small numbers of cases submitted for the audit. For the last two indicators the trust submitted data for nine patients but indicated that none of these met the measure, which is why it states 0% performance.

National Audit of Dementia

The table below summarises West Suffolk Hospital’s performance in the 2017 National Audit of Dementia.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of carers rating overall care received by the person cared for in hospital as Excellent or Very Good (A key aim of the audit was to collect feedback from carers to ask them to rate the care that was received by the person they care for while in hospital)</td>
<td>86.4%</td>
<td>Better</td>
<td>No current standard</td>
</tr>
<tr>
<td>Percentage of staff responding “always” or “most of the time” to the question “Is your ward/service able to respond to the needs of people with dementia as they arise?” (This measure could reflect on staff perception of adequate staffing and/or training available to meet the needs of people with dementia in hospital)</td>
<td>81.2%</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
<tr>
<td>Mental state assessment carried out upon or during admission for recent changes or fluctuation in behaviour that may indicate the presence of delirium (Delirium is five times more likely to affect people with dementia, who should have an initial assessment for any possible signs, followed by a full clinical assessment if necessary)</td>
<td>44.0%</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
<tr>
<td>Multi-disciplinary team involvement in discussion of discharge (Timely coordination and adequate discharge planning is essential to)</td>
<td>87.2%</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
</tbody>
</table>
The department also conducted the National Diabetes Footcare Audit. The 2017 results showed that 50.4% of patients with ulcer episodes were seen by the footcare service within two days of initial presentation, compared to 14% nationally. Furthermore, 73% of patients with ulcer episodes were reported to be alive and ulcer-free at 24 weeks, compared to 57.9% nationally. However, areas for improvement included lower than average numbers of patients self-presenting directly to the footcare team (13.3% compared to 28.6% nationally). We requested an action plan to improve these survey outcomes and saw that a foot assessment template had been created and podiatrists had raised awareness with staff groups about feet care.

The department also took part in the National Diabetes Inpatient Audit. The 2017 results showed that the trust performed better than the national average in nine indicators. There was a higher than average number of diabetes specialist nursing hours per week per patient (1.34 compared to 0.85 nationally) and the average number of consultant hours spent providing inpatient care per week per patient was better than the average (0.91 compared to 0.29). However, the service performed either worse than the national average or worse than their previous performance in 10 indicators. These included a decline in the number of patients receiving a diabetic foot risk assessment (75% compared to 100% in 2016), the number of patients experiencing glucose management errors (23.7% compared to 14.6% in 2016), and the number of patients experiencing insulin errors (21.1% compared to 8.3% in 2016 and 18.6% nationally). We requested an action plan but the plan we were provided with only focused on improving the numbers of patients with hypoglycaemia (low blood sugar levels). It did not mention any of the negative indicators mentioned above.

Managers used information from the audits to improve care and treatment. Action plans were made following audit outcomes to improve areas for concern. However, as noted above, not all action plans appeared to respond to the areas for improvement identified in the audits.

There were engagement meetings and/or follow-up of audit outliers. Audit outliers (outcomes outside of the expected range) were discussed at clinical governance meetings so that they could be monitored.

Managers shared and made sure staff understood information from the audits. Relevant audit outcomes were shared at handover and on the ‘matron’s message’ poster which was displayed in staff areas on the wards.

Improvement was checked and monitored. Action plans were updated regularly as improvement was made or to highlight areas of ongoing concern.

The endoscopy service was accredited by the Joint Advisory Group (JAG) on GI Endoscopy. The endoscopy service had first achieved this status in 2011 and had continued to be re-awarded the status.

Competent staff
The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff had the right skills and completed additional competencies as needed for their roles. Examples of extra competencies included dementia study days and bitesize renal sessions.

Managers gave all new staff a full induction tailored to their role before they started work. All new staff had an induction to their new role and were supernumerary for a period of time whilst they got used to their role and surroundings.

**Appraisal rates**

Managers supported staff to develop through yearly, constructive appraisals of their work. However, not all staff groups met the target for appraisals.

Staff we spoke with said that they received yearly appraisals and that these were helpful for identifying areas to compete extra training in.

From April 2018 to March 2019, 85.9% of required staff in medical care at West Suffolk Hospital received an appraisal, which was below the trust target of 90%. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff who received an appraisal</td>
<td>Eligible staff</td>
</tr>
<tr>
<td>Additional professional, scientific and technical</td>
<td>4</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>52</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>72</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>218</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>192</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>58</td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>610</td>
</tr>
</tbody>
</table>

Additional professional, scientific and technical, and medical and dental staff in medical care at West Suffolk Hospital both met the 90% target. Qualified nursing staffing almost met the target, with 87.6% of staff receiving an appraisal.

Updated analysis for April to mid-June 2019 found that 17.3% of required staff in medical care at West Suffolk Hospital received an appraisal compared to the trust target of 90%. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April to mid-June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff who received an appraisal</td>
<td>Eligible staff</td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td>5</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>45</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>48</td>
</tr>
</tbody>
</table>
None of the staff groups in medical care at West Suffolk Hospital met the 90% target. However, this data only represents a partial year and so we would not expect a high appraisal completion rate.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Managers supported nursing and medical staff to develop through regular, constructive clinical supervision of their work. The latest General Medical Council’s doctors in training survey showed that the trust was ranked the number one acute trust in the East of England in terms of overall satisfaction for training.

There were enough clinical educators to support staff learning and development. Clinical educators were in place and organised training. Managers on G1 had obtained charitable funding to second four nurses into specialist roles so that they could qualify as clinical nurse specialists. Consultants completed clinical supervision with junior doctors and held weekly training sessions.

Managers did not hold team meetings. We were told on several wards that team meetings did not occur but that important messages were shared via handover or posters.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Training needs were identified through a variety of sources. These included any incidents staff had been involved in, appraisals and through staff requesting additional training. A training link nurse was in post, who helped to organise and manage additional training. We saw study sessions were organised on G1 oncology for resuscitation training and glucose monitoring training.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff we spoke with told us their line managers were supportive in developing their skills and that they felt confident in requesting additional training. Following from the death of a young oncology patient staff told their managers that would like training on dealing with emotional situations. As a result, the department organised external training on building emotional resilience.

Managers made sure staff received any specialist training for their role. Staff who required specialist training for their role, for example, specialist stroke or oncology competencies, received these in order to carry out their roles. We saw completed competency booklets to evidence this.

Managers identified poor staff performance promptly and supported staff to improve. Senior staff provided examples of identifying poor performance and the action they took to ensure patient safety.

Managers recruited, trained and supported volunteers to support patients in the service. Volunteers were recruited to assist nursing staff with duties including feeding patients and making beds. Volunteers were only allowed to undertake these roles once they had completed the appropriate competencies.

**Multidisciplinary working**

<table>
<thead>
<tr>
<th>Administrative and clerical</th>
<th>13</th>
<th>71</th>
<th>18.3%</th>
<th>90%</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and dental</td>
<td>9</td>
<td>56</td>
<td>16.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>3</td>
<td>81</td>
<td>3.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Additional professional, scientific and technical</td>
<td>0</td>
<td>4</td>
<td>0.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>123</td>
<td>710</td>
<td>17.3%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We saw regular multidisciplinary (MDT) ‘red to green’ meetings were held, with input from nursing staff, medical staff, allied health professionals, mental health colleagues and social care.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff we spoke with gave examples of cross sector working with district nurses, social care and the clinical commissioning groups (CCGs) in order to care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff we spoke with were aware of the mental health liaison teams and could provide examples of cases where they referred patients to them.

Patients had their care pathway reviewed by relevant consultants. Consultants conducted daily ward rounds. Details of the ward rounds are detailed below.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients are reviewed by consultants depending on the care pathway. Consultant services were available seven days a week. An acute medical unit (AMU) consultant was available 9am to 9pm. Out of hours an on-call consultant was available. Specialist consultants were available on-call for gastrointestinal bleeds, cardiology pacing, haematology and microbiology.

Consultant ward rounds on the general medicine wards occurred daily Monday to Friday. On Saturdays and Sundays consultants reviewed any new patients, any patients needing to be discharged and any unstable patients.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. The pharmacy was open Monday to Friday 8.30am to 6.30pm, and Saturdays and bank holidays 9am to 4.30pm. Out of hours an on-call pharmacist was available. Diagnostic tests, for example, MRI and x-rays were available 24 hours a day, seven days a week.

Health promotion

Staff did not always give patients practical support and advice to lead healthier lives.

The service did not have relevant information promoting healthy lifestyles and support on every ward/unit. During our inspection we visited 12 wards and did not see any evidence of information promoting healthy lifestyles. Information on patient conditions were observed but we did not see any promotion of smoking cessation, healthy weights or limiting alcohol consumption.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Patients were weighed and had a medical history taken on admission. This included information such as smoking and recreational drug use. One patient we spoke with told us their consultant had encouraged them to stop smoking for the health benefits.
Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were familiar with the test for identifying whether patients had the mental capacity to make decisions about their care. They were able to explain factors that would be involved in making the decision.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Patients we spoke with, and records we reviewed, showed that consent was gained prior to any treatments beginning.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff were familiar with best interest decision making and how to ensure that any best interest decisions were the least restrictive possible.

Staff made sure patients consented to treatment based on all the information available. Staff discussed the risks and benefits of the treatment plans to patients so that they could give informed consent.

Staff clearly recorded consent in the patients' records. Out of the seven records we reviewed, all had consent recorded where required.

Mental Capacity Act and Deprivation of Liberty training completion

Nursing and clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards. The trust reported that Mental Health Act (MHA), Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) are covered in the safeguarding adults training.

The trust set a target of 90% for the completion of safeguarding adults training.

A breakdown of compliance for safeguarding adults training as of June 2019 for qualified nurses and medical staff in medicine at West Suffolk Hospital is shown below:

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing and midwifery staff</td>
<td>290</td>
<td>304</td>
<td>95.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical staff</td>
<td>49</td>
<td>61</td>
<td>80.3%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine, the 90% target for safeguarding adults training was met by qualified nursing staff at West Suffolk Hospital. The target was not met by medical staff, with a completion rate of 80.3%.

(Source: Routine Provider Information Request – Training tab)

Details on actions being taken to improve the safeguarding training compliance are discussed above in the ‘safe’ section of the report.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff were familiar with the legislation.
regarding consent and the differences between the pieces of legislation. Staff told us they would contact the safeguarding lead if they had any concerns or needed specialist advice.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Ward managers kept a list of all patients who were under a deprivation of liberty safeguard (DOLS) and ensured that applications were completed on time.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff accessed the policy through the staff intranet and could demonstrate how this was accessed.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. We saw that DOLS applications were completed online through an electronic system. We saw three patients had appropriate DOLS on ward G5.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed positive interactions between staff members and patients and relatives. Staff knocked on doors before entering and spoke kindly to patients and their relatives.

Patients said staff treated them well and with kindness. All patients spoke very highly of the staff and told us that they were treated well. Staff on G1 provided an example of organising a snowball fight during the winter for a patient who loved the snow.

Staff followed policy to keep patient care and treatment confidential. Staff understood the importance of keeping patient care and treatment confidential. They discussed private information in side rooms or appropriate environments where confidentiality could be maintained.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. All staff we spoke with spoke respectfully about their patients. They showed empathy and understanding when discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff understood and appreciated the varying social and religious needs of their patients. They provided examples of accessing the chaplaincy service for patients who wanted spiritual assistance.

Friends and Family test performance

A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey. The lowest recommendation rate between June 2018 and May 2019 was 78% in May 2019 on ward F9.

The feedback from the family and friends test was largely positive for all wards. The table below breaks down the data per ward.
The Friends and Family Test response rate for medicine at West Suffolk Hospital was 22.2% which was worse than the England average of 24% from June 2018 to May 2019. We requested an action plan to improve the score but were not provided with one by the trust. The trust’s response focused on the emergency department, not the medical care division.

A breakdown of FFT performance by ward for medical wards at this hospital over the same period is shown below. The percentage of respondents that said they would recommend the ward to family or friends was 88% or higher for all medical wards for these 12 months, overall. However, caution is advised in interpreting these results given the low response rates for all wards.

(Source: NHS England Friends and Family Test)

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff provided patients and relatives with emotional support when they needed it. Staff explained how they would help patients come to terms with their condition and how they would signpost them to organisations which could help them cope with it. Chaplaincy staff were available to provide religious assistance if needed and staff knew how to contact them if needed.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff were aware of the importance of maintaining patients’ dignity and privacy, especially if they were distressed. Staff gave examples of patients living with dementia and becoming upset and removing their clothes, and how this was managed. Staff provided examples in endoscopy of how they ensured patients’ dignity was maintained during intimate procedures.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff undertook extra training in having difficult conversations and breaking bad news. Clinical nurse specialists on G1 completed an advanced communication course and junior staff shadowed more experienced staff so they gained experience in how to broach these types of conversations.
Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Staff gave examples of patients with a learning disability who liked a particular musical band. Staff on the ward downloaded the music to their phones so that they could play it for the patient when they were feeling emotional. Staff on G1 also provided an example of having a Disney themed party for a patient who had young children, so that they could make memories together on the ward.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with confirmed that they understood their care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We saw staff used language that patients understood and gave them time to ask questions if they were unsure about anything.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients and their relatives provided feedback via the FFT and through the complaints and compliments procedure. We also saw thank you cards displayed on some wards.

Staff supported patients to make advanced decisions about their care. Staff spoke to patients about the importance of making advanced decisions so that could have control over what happened to them. We saw advanced decisions were made about topics such as resuscitation status.

Staff supported patients to make informed decisions about their care. Staff spoke openly with patients about the risks and benefits of procedures and treatment plans, so that they could make informed decisions about their care.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. Prior to our inspection, managers had opened a new acute assessment unit (AAU) to meet the changing needs of the local population. Plans were also in place to adapt the medical treatment unit (MTU) to remove beds to free up space for more chairs. This would allow more patients to have treatment on the MTU and avoid admission to an inpatient ward.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. From 1 June 2018 to 31 May 2019 there were four mixed sex breaches involving 30 patients. The reasons for the breaches included patients needing to be near the nurses’ station for mobility reasons and winter escalation areas being opened and patients being transferred to them without consideration for bathroom constraints. Staff were familiar with the
importance of same sex accommodation. The only inpatients who were nursed in a mixed sex bay at the time our inspection were level 2 cardiology patients, which was in line with accepted practice.

Facilities and premises were appropriate for the services being delivered. The facilities and premises provided adequate accommodation for the services being provided. Some areas of the hospital were aged, and some wards lacked storage space for equipment. Newer areas of the hospital, including the AAU, were designed well to meet the needs of patients and staff.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. A mental health team worked on site and operated an on-call system. They visited the ward for reviews of patients when required. Staff who received specialist dementia training operated as dementia champions on the ward.

The service had systems to help care for patients in need of additional support or specialist intervention. The department’s electronic records system had an alert for patients living with a learning disability. There was a box under the alert for staff to put in personalised information about the learning disability the patient lived with. A list of these patients were sent automatically to the safeguarding lead. We observed this practice in action during our inspection, where the safeguarding lead attended the ward to assist with a patient’s admission process. Health passports were also used to ensure relevant information was available to staff to help them care appropriately for the patient.

Managers monitored and took action to minimise missed appointments. Staff on the MTU called patients the day before their appointment to remind them of it, and to reduce the number of missed appointments.

Managers ensured that patients who did not attend appointments were contacted. All patients who missed appointments on the MTU were contacted by staff to find out why they did not attend and if they needed to reschedule their appointment. All missed appointments were monitored by the management team.

**Meeting people’s individual needs**

**The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The electronic records system was able to flag patients living with dementia. Any patients living with dementia were highlighted during the daily safety huddle so that the appropriate teams could be involved. A lead nurse for dementia was in post. A daily report of current inpatients living with dementia was also produced.

An electronic flag alert was also available for patients with a learning disability. The learning disability nurse senior nursing staff received daily lists of patients with learning disabilities. A learning disability liaison nurse worked Monday to Friday 9am to 5pm.

Activity boxes containing puzzles, books and ‘twiddle muffins’ (a hand muff designed to provide sensory stimulation) were put together for patients living with dementia to assist with agitation. Staff had also purchased reminiscence therapy interactive computers which provided patients living with dementia entertainment.
Wards were designed to meet the needs of patients living with dementia. The environment had been adapted on ward G4 to have dementia friendly signage to help orientate patients living with dementia. For example, there was a picture of a toilet on the toilet door. However, there was also a high proportion of patients on G5 who were living with dementia. G5 did not have any dementia friendly signage on the ward. This meant that we were concerned patients living with dementia were not always nursed in the most appropriate environments. The corridor connecting G4 and G5 was a dementia memory walk. It featured photographs and film posters from previous decades to help orientate patients living with dementia who could be distressed by the new surroundings of the hospital.

Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. Patient passports were used to help staff know more about the patients’ conditions and how best to care for them.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff knew how to meet the communication needs of patients with a disability and were to go for more assistance if necessary. Staff told us they would speak to the safeguarding lead if they were unsure how to communicate with patients.

The service did not have information leaflets available in languages spoken by the patients and local community. All leaflets we saw in the hospital were in English. We were told that the patient advice and liaison service (PALS) could print them in other languages if required but they were not readily displayed or available.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. A translation service was in place to help staff and patients communicate without language barriers.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Menus were provided to patients each day so that they could choose food choices that met their cultural and religious preferences.

Staff had access to communication aids to help patients become partners in their care and treatment. Communication aids were in place to help communicate with patients who were non-verbal. These were booklets with pictures and words, to help patients share their views and preferences, even if they were unable to talk.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. A new acute assessment unit (AAU) was opened in December 2018. The unit reviewed patients who needed observation, diagnosis and treatment but did not require major emergency care. This included patients presenting with chest pain. We reviewed performance data from June to September 2019 and saw that 41% of patients had an initial national early warning score (NEWS) within 15 minutes and 26% of patients had a length of stay longer than 12 hours. We requested data on whether the introduction of the AAU had impacted positively on ED waiting times, but we were not provided
with this information. Therefore, we were unsure whether they monitored the impact of the new unit.

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

From July 2018 to June 2019 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was consistently better than the England average.

In the most recent month, June 2019, 95.3% of patients at the trust were treated within 18 weeks compared to the England average of 87.5%.

![Graph showing referral to treatment percentage within 18 weeks from July 2018 to June 2019.](Source: NHS England)

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

From July 2018 to June 2019, seven specialties were above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>100.0%</td>
<td>96.7%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>100.0%</td>
<td>94.8%</td>
</tr>
<tr>
<td>General medicine</td>
<td>99.9%</td>
<td>96.6%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>98.2%</td>
<td>94.2%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>95.7%</td>
<td>80.9%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>93.5%</td>
<td>80.8%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>92.5%</td>
<td>92.5%</td>
</tr>
</tbody>
</table>

One specialty was below the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurology</td>
<td>64.3%</td>
<td>88.8%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

We requested the service’s action plan to improve their neurology RTT, but the trust provided a different data set to that from NHS England. The trust’s data showed that they had consistently exceeded the target of 92% from April to August 2019.

**Average length of stay**

Managers and staff worked to make sure patients did not stay longer than they needed to. The medical treatment unit (MTU) received referrals from all specialities, for patients who required treatments or investigations but did not require an overnight stay. Procedures undertaken included liver biopsies (where cells are taken for testing), vascular angioplasty (a procedure where a stent
is placed in an artery to open blocked blood vessels) and insertion of PICC lines (a tube inserted into a patient’s arm which goes into a vein above their heart). This meant these patients did not have to stay overnight unnecessarily.

From March 2018 to February 2019 the average length of stay for medical elective patients at West Suffolk Hospital was 5.1 days, which was lower than England average of 5.9 days.

Average length of stay for elective specialties:

- Average lengths of stay for elective patients in cardiology and gastroenterology were higher than the England averages.
- Average length of stay for elective patients in dermatology was lower than the England average.

**Elective Average Length of Stay - West Suffolk Hospital**

From March 2018 to February 2019 the average length of stay for medical non-elective patients at West Suffolk Hospital was 6.5 days, which was slightly higher than England average of 6.1 days.

Average length of stay for non-elective specialties:

- Average lengths of stay for non-elective patients in general medicine and respiratory medicine were slightly higher than the England averages.
- Average length of stay for non-elective patients in geriatric medicine was lower than the England average.

**Non-Elective Average Length of Stay - West Suffolk Hospital**

Note: Top three specialties for specific site based on count of activity.
(Source: Hospital Episode Statistics)

**Patient moving wards per admission**
Patient moves between wards/services were monitored. However, not all moves were due to clear medical reason or in the patients best interest.

From June 2018 to May 2019, among patients who moved medical wards during their admission at West Suffolk Hospital, 77.6% of individuals moved for clinical reasons, and 22.4% moved once or more for non-clinical reasons. This analysis included non-clinical moves from the acute assessment unit (AAU), cardiac care unit and medical treatment unit (MTU) as well as medical wards.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

We were told that ‘golden patients’ were identified during board rounds. These were patients that were due to be discharged before 10pm the next day. These patients, due to their positive clinical picture were more likely to be moved. Patients who were receiving palliative (end of life) care had blue ribbons attached to their beds. This indicated that they were not to be moved.

Patient moving wards at night

Staff moved patients between wards at night. From June 2018 to May 2019, there were 4,299 patient moving wards at night within medicine at West Suffolk Hospital, with 1,969 ward moves at night (45.8%) occurring in ward F7.

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

We requested the trust’s action plan to reduce bed moves at night but were informed that the trust did not have one as they did not consider the numbers of bed moves at night to be significant. It was noted that ward F7 was a short stay unit, which would account for the bigger proportion of bed moves at night.

Managers monitored that patient moves between wards/services were kept to a minimum. Managers were aware of patient moves. We were told that patients who were very unwell or nearing the end of their life would not be moved unless absolutely necessary.

Managers and staff worked to make sure that they started discharge planning as early as possible. We saw that discharge planning started on admission, with plans put in place to contact external agencies where appropriate for patients needs upon discharge. An early intervention team was in place which helped to plan discharges, especially on weekends. Care coordinators were also based on wards to assist patient discharge.

Staff planned patients’ discharge carefully, particularly for those with complex mental health and social care needs. Staff ensured that patients were being discharged to a safe location and care packages were in place if required. We saw patients on the ward who were waiting for care packages to be finalised so that they could be safely discharged. Stranded patient reviews happened twice a week where staff discussed patients who had been admitted for longer than seven days. They involved the local clinical commissioning group (CCG) and social services, where needed, to ensure these patients had a supportive discharge. A transport liaison service was in place from the discharge lounge to arrange transport for patients. Care coordinators based on the wards alerted the discharge lounge if patients were elderly and lived alone. They then ensured that help was in place, for example, referring patients to charitable welcome home services.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. From 1 April 2018 to 31 March 2019 there were 72,250
discharges. Of these 3,518 were delayed, which was just under 5%. The main recorded reason for delayed discharges was waiting for medications for patients to take home (TTOs). We were told pharmacy were coming onto the wards to help get TTOs ready to try and reduce the number.

Staff supported patients when they were referred or transferred between services. Staff explained why patients were being moved between services and accompanied them to their new ward if needed. Within the stroke speciality the service had developed a repatriation document to record all communications with other NHS providers.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. Staff told us that consultants reviewed each medical patient on non-medical wards; known as outliers, on a daily basis. However, one patient contacted the CQC during the inspection period and told us they had been an outlier on a non-medical ward for several days without seeing a speciality doctor.

Managers worked to minimise the number of medical patients on non-medical wards. Staff tried to minimise the number of medical outliers. Data provided demonstrated that 64 patients had been cared for on non-medical wards from July 2019 to September 2019.

**Learning from complaints and concerns**

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. However, complaints were not investigated and closed within the deadline set in the trust’s internal policy.

**Summary of complaints**

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with confirmed that they knew who to contact if they had a complaint or wanted to raise any concerns.

The service clearly displayed information about how to raise a concern in patient areas. Information was displayed on the wards on how to make a complaint.

Staff understood the policy on complaints and knew how to handle them. Staff were familiar with the policy and knew how to access it. Staff were confident in dealing with complaints and escalating them as necessary.

Managers investigated complaints and identified themes. From June 2018 to May 2019 the trust received 26 complaints about medicine (15.0% of the total complaints received by the trust). All of the complaints related to care received at West Suffolk Hospital.

For the 17 complaints that had been closed at the time of data submission, the trust took an average of 38.6 days to investigate and close these complaints. This was not in line with their complaints policy, which states complaints should be dealt with within 25 working days.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

We requested an action plan to improve complaints response times but were not provided with one. The trust responded by saying that they were recruiting to the patient experience team and that poor complaints response times was an issue for the whole organisation, not just the medical division.
The nine complaints that had not yet been closed had been open for an average of 79.0 working days at the time of data submission.

The subjects of the complaints are shown below. However, please note that the trust attributed multiple subjects to some complaints and these are indicated in the table below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
<th>Percentage of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient care</td>
<td>7</td>
<td>26.9%</td>
</tr>
<tr>
<td>Communications</td>
<td>5</td>
<td>19.2%</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>4</td>
<td>15.4%</td>
</tr>
<tr>
<td>Prescribing</td>
<td>2</td>
<td>7.7%</td>
</tr>
<tr>
<td>Clinical treatment, communications</td>
<td>1</td>
<td>3.8%</td>
</tr>
<tr>
<td>Clinical treatment, communications, end of life care</td>
<td>1</td>
<td>3.8%</td>
</tr>
<tr>
<td>Clinical treatment, admissions, discharge &amp; transfers, facilities services</td>
<td>1</td>
<td>3.8%</td>
</tr>
<tr>
<td>Clinical treatment, end of life care</td>
<td>1</td>
<td>3.8%</td>
</tr>
<tr>
<td>Privacy, dignity &amp; well being</td>
<td>1</td>
<td>3.8%</td>
</tr>
<tr>
<td>Clinical treatment, patient care, admissions &amp; discharge</td>
<td>1</td>
<td>3.8%</td>
</tr>
<tr>
<td>Clinical treatment</td>
<td>1</td>
<td>3.8%</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>1</td>
<td>3.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>26</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

The table below shows a breakdown of complaints by ward/team:

<table>
<thead>
<tr>
<th>Ward/team</th>
<th>Number of complaints</th>
<th>Percentage of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward F7</td>
<td>5</td>
<td>19.2%</td>
</tr>
<tr>
<td>Ward F9</td>
<td>5</td>
<td>19.2%</td>
</tr>
<tr>
<td>Respiratory Ward</td>
<td>3</td>
<td>11.5%</td>
</tr>
<tr>
<td>Ward G5</td>
<td>2</td>
<td>7.7%</td>
</tr>
<tr>
<td>Ward G4</td>
<td>2</td>
<td>7.7%</td>
</tr>
<tr>
<td>Winter escalation ward</td>
<td>2</td>
<td>7.7%</td>
</tr>
<tr>
<td>Oncology</td>
<td>1</td>
<td>3.8%</td>
</tr>
<tr>
<td>Ward G1</td>
<td>1</td>
<td>3.8%</td>
</tr>
<tr>
<td>Ward G3 (endocrine)</td>
<td>1</td>
<td>3.8%</td>
</tr>
<tr>
<td>Acute assessment unit</td>
<td>1</td>
<td>3.8%</td>
</tr>
<tr>
<td>Ward F12</td>
<td>1</td>
<td>3.8%</td>
</tr>
<tr>
<td>Cardiac Ward</td>
<td>1</td>
<td>3.8%</td>
</tr>
<tr>
<td>Ward G8</td>
<td>1</td>
<td>3.8%</td>
</tr>
</tbody>
</table>
Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff verbally acknowledged receipt of complaints initially, and once it had been escalated patients received a letter. Patients received feedback via letter after their complaint had been investigated.

Managers shared feedback from complaints with staff and learning was used to improve the service. Changes were made to the service as a result of feedback and complaints. Following complaints regarding patients’ dentures being lost on G8, staff introduced ‘gnashers at nine’ where patients’ dentures were checked, cleaned and stored securely to improve mouth care and reduce lost dentures.

**Number of compliments made to the trust**

From June 2018 to May 2019 the trust received 172 compliments for medicine (22.6% of all compliments received trust-wide). All of the compliments related to care received at West Suffolk Hospital.

A breakdown of compliments by department is shown below:

<table>
<thead>
<tr>
<th>Department</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward F7</td>
<td>33</td>
<td>19.2%</td>
</tr>
<tr>
<td>Ward F12</td>
<td>30</td>
<td>17.4%</td>
</tr>
<tr>
<td>Ward G4</td>
<td>23</td>
<td>13.4%</td>
</tr>
<tr>
<td>Haematology</td>
<td>20</td>
<td>11.6%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>10</td>
<td>5.8%</td>
</tr>
<tr>
<td>Endoscopy</td>
<td>10</td>
<td>5.8%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>6</td>
<td>3.5%</td>
</tr>
<tr>
<td>Ward G3</td>
<td>6</td>
<td>3.5%</td>
</tr>
<tr>
<td>Coronary care unit</td>
<td>6</td>
<td>3.5%</td>
</tr>
<tr>
<td>Ward G1 (Macmillan unit)</td>
<td>5</td>
<td>2.9%</td>
</tr>
<tr>
<td>Ward F8</td>
<td>4</td>
<td>2.3%</td>
</tr>
<tr>
<td>Diabetic care</td>
<td>3</td>
<td>1.7%</td>
</tr>
<tr>
<td>Ward G8</td>
<td>3</td>
<td>1.7%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>2</td>
<td>1.2%</td>
</tr>
<tr>
<td>Medical treatment unit</td>
<td>2</td>
<td>1.2%</td>
</tr>
<tr>
<td>Ward G9 (Winter escalation ward)</td>
<td>2</td>
<td>1.2%</td>
</tr>
<tr>
<td>Ward G5</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Respiratory</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Nephrology</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Anticoagulation</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Acute Assessment Unit (AAU)</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Dietetics</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Ward F9</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>172</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)
The trust noted that the majority of compliments received trust-wide related to overall care along the whole pathway; and patients and relatives thanking staff for their kindness and compassion during difficult and stressful times. 

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

### Is the service well-led?

#### Leadership

A number of leaders had been recently recruited into post, however they were being given support to develop in their new role. Leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The medical division was led by a head of nursing and two clinical directors; one for specialist medicine and one for acute medicine. At local level matrons oversaw multiple wards and assisted ward managers. At the time of our inspection several ward managers were new in post and told us they had been well supported in their new roles. Staff spoke positively about having the new ward managers in post and that since they had been appointed, the leadership of the wards had gotten stronger. Development programmes were in place to help the new leaders learn the skills necessary to manage their wards.

All staff we spoke with spoke very highly of the chief executive, saying that they were visible, approachable and new staff members’ names.

There was a lead for mental health, who some staff were aware of. Staff were aware of the whistleblowing policy and knew how to access it.

Leadership arrangements were in place for the cancer services to ensure that the cancer service was in line with national cancer strategy goals. Four consultant oncologists were employed to run the service.

#### Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The hospital had a trust wide vision ‘to deliver the best quality and safest care for our community’. This fed into three priorities; deliver for today, invest in quality, staff and clinical leadership and build a joined-up future. The medical division also had its own vision ‘to increase the health and happiness of patients receiving services’.

The hospital’s values were focused on patients, integrated, respectful, staff focused and two-way communication. These were developed in conjunction with staff and patients.

A business strategy was in place within the medical division. The senior leadership team had asked each speciality to complete a ‘SWOT’ analysis (strengths, weaknesses, opportunity and threats) which then fed into the business plan. This was aligned to local plans in the wider health economy. Services were planned to meet the needs of the local population. Examples of this included the adapting of the medical treatment unit to include more chairs and less beds, so that
more patients could be treated. Progress against the strategy was monitored and reviewed through regular strategy meetings.

Staff we spoke with were familiar with the vision and values of the division and were able to explain how they used these in their work.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. However, not all staff were aware of the freedom to speak up guardian.

All staff we spoke with told us that there was a positive culture within the division. Staff felt supported and cared for and strong relationships were formed between colleagues.

The culture was centred on the needs and experiences of patients who were using the service. All staff we spoke with told us that patient experience was extremely important and that teams worked together to ensure patients had positive outcomes.

Staff told us they felt able to speak up if they felt something was wrong, however, very few staff we spoke with knew who the freedom to speak up guardian was, and some staff had not heard of the title. None of the staff we spoke with knew about the anonymous telephone line that had been set up.

Staff felt positive and proud to work for the organisation. Many staff we spoke with had worked for the hospital for a long time and told us this was testament to the culture of the service.

Mechanisms were in place for providing staff with development, including appraisal and career development conversations. All staff we spoke with had an appraisal and many staff had worked their way up the organisation.

There was a strong emphasis on the safety and well-being of staff. Staff told us that managers and colleagues took an interest in each other’s lives and supported each other during difficult times.

Equality and diversity were promoted within the organisation. Staff we spoke with, including those with particular protected characteristics under the Equality Act, told us that they felt they were treated equitably.

Governance

Governance processes were in place, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities. However, team meetings were not held regularly to discuss and learn from the performance of the service.

There was a structured governance system in place. Monthly departmental governance meetings fed into the integrated medical board performance review meetings. This was then fed into the board meetings and allowed ward to board assurance. We requested minutes of these meetings and saw that risk registers, incidents and complaints were discussed.

Each ward or clinical area held monthly clinical governance meetings which were well attended by medical staff and senior nursing and allied health staff. We reviewed minutes of these and saw
that staffing issues, staff competencies and clinical incidents were discussed. However, we saw that junior nursing staff were not invited to these and we were unsure how feedback from these meetings were shared with them.

There were processes and systems of accountability. Staff were clear about their roles and what they were accountable for. However, we were concerned that not all poor audit outcomes had relevant actions plans in place to ensure ongoing improvement and accountability. Furthermore, team meetings were not held regularly throughout the division. This meant that not all staff had the chance to discuss and learn from the performance of the service.

Complaints were not investigated and closed in a timely fashion. The trust took an average of 38.6 days to investigate and close complaints from the medical division. This was not in line with their complaints policy, which states complaints should be dealt with within 25 working days. We requested an action plan to improve complaints response times but were not provided with one. The trust responded by saying that they were recruiting to the patient experience team and that poor complaints response times was an issue for the whole organisation, not just the medical division.

Management of risk, issues and performance

Leaders and teams had systems to manage performance. However, leaders did not always identify and escalate relevant risks and issues or identify actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The risk register was managed electronically, in the same system used for incident management. The divisional risk register used a colour coded scoring mechanism, from red to green, depending on risk level. The only red risk on the medical care risk register included moving the prescription of Methotrexate to primary care due to the risk of possible duplication of prescription. From information provided post inspection we saw that this risk had been added to the register in October 2018 and was due for review on 12 September 2020. Work was ongoing with the clinical commissioning group (CCG) and a local GP practice to move to shared care, hopefully by the end of February 2020 to mitigate this risk.

Other amber risks included a lack of timely psychiatric assessment service provision on G5, and short staffing on G1 and G3. The risk register we were provided with did not detail the date the risks had been added or the date for their review and/or removal.

Information provided following the inspection detailed the risk approver, the date the risks had been added and date of next review. The oldest entry, ID782, was opened on 30 September 2008 and related to staffing issues within oncology. It was next dated for review on 31 January 2020. Specific risk assessments were not provided which meant we could not review actions taken to mitigate the risks which meant we were unable to determine if these were effectively managed on a timely basis.

Risks were discussed at the daily safety huddle, so any urgent patient safety risks could be dealt with promptly.

When we spoke with senior leaders they told us their main concerns were recruitment and retention. Due to this they had recruited nursing assistants and physician’s assistants to try to fill gaps in their staffing quotas and mitigate the risks. The actions taken were not recorded on the medical division risk register.
We found some areas of risk on inspection which the department were not aware of prior to us raising concerns. These included sharps being available on F12, concerns around controlled drugs and medicine security on G4, G5 and G1, hazardous cleaning chemicals being stored inappropriately on G4 and a lack of formalised local induction for agency staff across the department. Risk assessments for these concerns had not been completed and they had not been identified as risks until we highlighted them. Furthermore, when we returned on our unannounced inspection we saw that no mitigating actions had been taken at that point in relation to securing hazardous cleaning chemicals. Once this was raised again the trust took action to reduce this risk.

We were concerned that there was no documented formalised local ward inductions for bank and agency staff. When we raised this as a concern we were told it was completed informally, but there were no records of this. This meant we were concerned that there was no oversight at a managerial level of this and there was no evidence that local inductions occurred.

Not all areas that required improvement, for example, the chronic obstructive pulmonary disease audit, had had action plans in place to improve performance. Therefore, we were not assured that robust arrangements for identifying, recording and managing risks, issues and mitigating actions were fully in place or embedded.

Performance within the division was generally positive, with high scoring results in stroke care and having a JAG accredited endoscopy suite.

**Information management**

The service did not always collect data and analyse it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff did not always have access to up-to-date, accurate, and comprehensive information on patients’ care and treatment. The safety thermometer was not fully utilised to give staff and patients a reliable picture of harm free care. Not all audits had action plans available and some action plans did not reflect all areas requiring improvement. Following inspection, we received information that demonstrated service leaders monitored new areas, such as the acute assessment unit and cardiology centre. However, data provided did not include the overall impact these new areas had in reducing pressure in other areas. For example, if the introduction of the acute assessment unit had reduced the waiting times in Accident and Emergency.

There were clear service performance measures, which were reported and monitored. However, as mentioned above, these did not always have appropriate follow up actions.

There was a holistic understanding of performance, which included patient feedback, quality outcomes and financial data. However, this information was not always used to improve performance.

Staff were aware of how to use and store confidential information. The service used a combination of paper and electronic records.

The electronic system had inbuilt systems to identify patients living with a learning disability.

There were arrangements in place which ensured data was submitted to external providers as required for example, serious incidents and never events.
Information technology systems were used effectively to improve the quality of care. A new ‘medic bleep’ system had been introduced which allowed all medical and operational staff to easily message each other. Clinical groups had made their own chat groups within the system. As the system was encrypted they were able to discuss confidential patient details and get advice, even if their colleagues were off site at the time. This reduced delays in patient reviews and multidisciplinary meetings as they could be held virtually.

**Engagement**

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Patients and relatives were given the opportunity to provide feedback using the NHS Friends and Family Test (FFT). Outcomes from this were discussed above under the ‘caring’ section of this report.

The hospital’s communication team also shared ‘thank you Thursdays’ where they shared positive feedback from patients online.

The division did not hold formalised meetings for junior staff. We were told management engaged with staff through the ‘matron’s message’ poster and information shared at handover. Staff told us that they were happy with this arrangement as it meant more time could be spent on the wards. However, we were not assured that all information was adequately shared with junior staff as not all staff we spoke with were aware of serious incidents, including never events that had happened across the hospital site.

Senior leadership had an ‘open door’ policy, which staff on the wards confirmed. Staff told us they felt engaged with the service and that their views were listened to in the planning and delivery of services. Staff provided examples of changes to services that had been implemented from their ideas.

We saw that a staff listening event was held on G8 which was experiencing high vacancies and low staff morale. This resulted in a new ward manager being recruited and ongoing recruitment to improve the situation on the ward.

**Learning, continuous improvement and innovation**

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

Staff were working to improve the service they offered patients. Examples included new pathways to repatriate cardiology and stroke patients from other NHS trusts, so they could be cared for in their locality. The stroke unit had a wall diagram of a patient named Clarence who had a variety of equipment attached to him. All the equipment was explained so that visitors and new staff on the ward could learn about the types of equipment they may see. Clarence also outlined the types of assessments that needed to be carried out for patients, including mental capacity and fluid balance charts.

Two sisters on ward G5 had won a ‘Shining Lights’ award though the Bury Free Press Patient Choice Award, following a patient nomination.
We spoke with a renal consultant who had conducted research into acute kidney injury, which had then been presented at the Royal College of Physicians.
The trust provided the following information about their surgical services:

The surgical division has 131 beds, including 32 ring fenced elective beds on ward F4 to support the orthopaedic joint replacement service. All core inpatient services are provided at the West Suffolk Hospital main site. Core specialities delivered by the division include: breast, urology, plastics, vascular, ear, nose and throat (ENT), trauma & orthopaedics, general surgery including colorectal surgery, ophthalmic, audiology, and support of cancer services.

The division provides support for the entire pre-, peri- and post-operative patient pathway with a dedicated pre-assessment unit for elective surgery management. The division also hosts the newly integrated tissue viability service.

Primarily, the emergency pathway is supported by wards F3 and F6, and the elective pathway is supported by wards F4 and F5. The emergency pathway is also supported by the surgical assessment unit on ward F6 which offers a direct point of access for GP surgical referrals and fast track assessment of surgical emergency department (ED) admissions. This unit is undergoing a planned change to form part of the trust wide emergency assessment model and is operating in a limited capacity while this change is implemented.

Each core service is also supported by clinical nurse specialists supporting the surgical pathway alongside consultant colleagues.

(Source: Acute Routine Provider Information Request (RPIR) – Acute context)

The trust had 23,641 surgical admissions from March 2018 to February 2019. Emergency admissions accounted for 6,512 (27.5%), 14,425 (61.0%) were day case, and the remaining 2,704 (11.4%) were elective.

(Source: Hospital Episode Statistics (HES))

During the inspection, we spoke with 35 staff of various grades including nurses, doctors, senior managers, allied health professionals, clinical support workers, administrative staff and volunteers. We spoke with eight patients and relatives. We observed interactions between patients and staff, considered the environment and looked at ten care records, including patients’ medical notes and nursing notes. We also reviewed other documentation from stakeholders and nationally published performance data for the trust.

The service was last inspected in August 2016. At that inspection, outpatients was rated good overall.

The inspection team consisted of a lead inspector and two specialist advisors.
Is the service safe?

Mandatory Training

The service provided mandatory training in key skills to all staff however not all staff completed it. Training for medical staff did not meet any of the trust’s targets in any of the mandatory courses.

Mandatory training completion rates

The trust set a target of 90% for the completion of all mandatory training, with the exception of information governance training which had a target of 95%.

A breakdown of compliance for mandatory training courses as of June 2019 for qualified nursing staff in surgery at West Suffolk Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
</tr>
<tr>
<td>Infection control - classroom</td>
<td>187</td>
<td>192</td>
<td>97.4%</td>
<td>90%</td>
</tr>
<tr>
<td>Medicine management (refresher)</td>
<td>182</td>
<td>189</td>
<td>96.3%</td>
<td>90%</td>
</tr>
<tr>
<td>MAJAX (Major accident)</td>
<td>182</td>
<td>192</td>
<td>94.8%</td>
<td>90%</td>
</tr>
<tr>
<td>Blood borne viruses/inoculation incidents</td>
<td>180</td>
<td>190</td>
<td>94.7%</td>
<td>90%</td>
</tr>
<tr>
<td>Slips trips falls</td>
<td>181</td>
<td>192</td>
<td>94.3%</td>
<td>90%</td>
</tr>
<tr>
<td>Health &amp; safety / risk management</td>
<td>179</td>
<td>192</td>
<td>93.2%</td>
<td>90%</td>
</tr>
<tr>
<td>Conflict resolution – e-learning</td>
<td>55</td>
<td>59</td>
<td>93.2%</td>
<td>90%</td>
</tr>
<tr>
<td>Security awareness</td>
<td>178</td>
<td>192</td>
<td>92.7%</td>
<td>90%</td>
</tr>
<tr>
<td>Fire safety training - classroom</td>
<td>172</td>
<td>192</td>
<td>89.6%</td>
<td>90%</td>
</tr>
<tr>
<td>Basic life support (adult)</td>
<td>160</td>
<td>188</td>
<td>85.1%</td>
<td>90%</td>
</tr>
<tr>
<td>Information governance</td>
<td>162</td>
<td>192</td>
<td>84.4%</td>
<td>95%</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>161</td>
<td>192</td>
<td>83.9%</td>
<td>90%</td>
</tr>
<tr>
<td>Fire safety training - e-learning</td>
<td>159</td>
<td>192</td>
<td>82.8%</td>
<td>90%</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>99</td>
<td>123</td>
<td>80.5%</td>
<td>90%</td>
</tr>
<tr>
<td>Moving and handling - clinical</td>
<td>154</td>
<td>192</td>
<td>80.2%</td>
<td>90%</td>
</tr>
<tr>
<td>Blood products &amp; transfusion processes (refresher)</td>
<td>121</td>
<td>154</td>
<td>78.6%</td>
<td>90%</td>
</tr>
</tbody>
</table>

Nursing staff received mandatory training. In surgery, the targets were met for eight of the 16 mandatory training modules for which qualified nursing staff were eligible, and almost met for a further training module.

We requested up to date training rates as staff told us that they had completed mandatory training. This demonstrated that of the courses above not meeting target in June 2019 only Information governance now met the trusts target in September 2019. The following had improved: Equality and Diversity 89%, Fire safety 89%, Moving and handling 83% and Blood products and transfusion 81%.

A breakdown of compliance for mandatory training courses as of June 2019 for medical staff in surgery at West Suffolk Hospital is shown below:
Not all medical staff received or keep up-to-date with their mandatory training.

In surgery, the targets were met for two of the 16 mandatory training modules for which medical staff were eligible.

We requested up to date training rates as staff told us that they had completed mandatory training. This demonstrated that none of the training rates met the trusts target in September 2019.

Staff told us that at times they experienced difficulty in attending training due to the needs of the service. Where training was cancelled they were rebooked on the next available course. Staff also had access to eLearning which they completed when required or capacity allowed.

The mandatory training was comprehensive and met the needs of patients and staff. Staff we spoke with told us training was comprehensive, encouraged professional development and was monitored during supervision and appraisal. The staff in recovery had paediatric intermediate life support training, advanced life support training and eight staff had the European paediatric advanced life support training. This ensured that should an emergency arise with children or adults the team in recovery would be able to initiate life support prior to help arriving from the theatre team or the resuscitation team.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities and, autism and dementia. Staff were able to articulate how they would accommodate patients who had mental health needs. There was a good awareness of caring for a patient with dementia and their specific needs.

Managers monitored mandatory training and alerted staff when they needed to update their training. All staff we asked confirmed that they were notified by their manager and by email when they were required to attend training and were allocated time to complete mandatory training. Staff were able to access their own training on the trust’s intranet, which showed when training was due and what training was available.
Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Nursing staff had training on how to recognise and report abuse, and they knew how to apply it. However, training compliance under trust target.

Safeguarding training completion rates

The trust set a target of 90% for the completion of safeguarding training.

The tables below include prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

Nursing staff received training specific for their role on how to recognise and report abuse.

A breakdown of compliance for safeguarding training courses as of June 2019 for qualified nursing staff in surgery at West Suffolk Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>187</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>185</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>184</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2</td>
<td>182</td>
</tr>
<tr>
<td>(basic prevent awareness)</td>
<td></td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5</td>
<td>158</td>
</tr>
<tr>
<td>(prevent awareness)</td>
<td></td>
</tr>
</tbody>
</table>

In surgery, the 90% target was met for four of the five safeguarding training modules for which qualified nursing staff were eligible. Data from September 2019 demonstrated that preventing radicalisation level 3-5 compliance had increased to 87%.

Medical staff received training specific for their role on how to recognise and report abuse. However, not all medical staff had attended this training and the trust only met one of their training targets. We requested up to date data in September 2019 and this demonstrated that the medical staff still did not meet the trusts target for safeguarding training.

A breakdown of compliance for safeguarding training courses as of June 2019 for medical staff in surgery at West Suffolk Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>128</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>127</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2</td>
<td>122</td>
</tr>
<tr>
<td>(basic prevent awareness)</td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>119</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5</td>
<td>110</td>
</tr>
<tr>
<td>(prevent awareness)</td>
<td></td>
</tr>
</tbody>
</table>

In surgery, the 90% target was met for one of the five safeguarding training modules for which
medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Patients were assessed at the pre-assessment clinic in regard of any safeguarding concerns. This was reviewed on admission. Staff were able to provide an example which demonstrated that they were aware of how to protect patients and the actions they took to ensure that patients felt safe within the hospital.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke to were able to tell us about the different types of abuse and what they would do if they identified a concern.

A trust wide policy was in place for safeguarding adults and a further policy for children. Staff we spoke with could easily access it. The policy was in date and included information about different types of abuse, female genital mutilation (FGM) as well as domestic violence and other key areas of safeguarding.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. All staff we spoke with were clear about how to make a safeguarding referral or how to escalate concerns within the organisation.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff completed an electronic referral on the trusts IT system or physically called the safeguarding teams for advice. The service had a number of champions throughout who had received extra training and provided support to staff on issues such as domestic abuse and dementia.

Staff followed safe procedures for children visiting the ward. Staff were aware of how to protect children visiting the wards. They contacted a named safeguarding lead if they were concerned. Within the theatre department there was a children's champion who provided the paediatric team and other staff with support in the care of vulnerable children.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and tidy and were clean and well-maintained. Cubicles had disposable curtains. All that we checked were clean and in date for renewal and disposal. Patients with known infectious diseases were nursed in side rooms.

Cleaning records in all areas we visited were up-to-date and showed that all areas were cleaned regularly. Staff used records to identify how well the service prevented infections, for example audits of cleaning records.

Staff followed infection control principles including the use of personal protective equipment (PPE). PPE, such as gloves and aprons, were available in the clinical areas we visited to prevent the spread of infection when providing care. We saw staff using PPE appropriately. Theatre staff were aware of the additional needs of the department and were appropriately dressed within the theatre department.
All areas we visited hand gel dispensers at the entrance with signs asking visitors to clean their hands. All were full and in working order. We observed staff washing their hand before and after administering care to patients.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw that equipment was cleaned using the appropriate method after use. In theatre tables and the environment were cleaned between patients.

Staff worked effectively to prevent, identify and treat surgical site infections. The service collected surgical site infection surveillance (SSIS) for certain orthopaedic procedures as per mandate from Public Health England. In general surgery the hospital had undergone a Getting It Right First Time (GIRFT) assessment in 2017 and were currently re-auditing at the time of inspection. Following the pervious assessment, the service had undertaken some work to automate the collection of surgical site infection within general surgery. This work was due for completion in October 2019. The trust had also worked to further improve the data collection of post discharge infections in patients using the Surgical Wound Care Assessment and Review (SCAR). They had introduced a virtual clinic and a patient information leaflet. The patient information leaflet contains a patient directed self-diagnostic checklist encouraging the patient to look out for this signs and symptoms of wound infection and report it back to the trust through the SCAR virtual clinic.

Environment and equipment

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**

Patients could reach call bells and staff responded quickly when called. Patients reported that whilst at times staff were busy their needs were attended too quickly.

The design of the environment followed national guidance. Cleaning materials that were covered by control of substances hazardous to health (COSHH) were locked and secured in line with legislation in all areas we visited.

The service had enough suitable equipment to help them to safely care for patients. Staff carried out daily safety checks of specialist equipment. We reviewed over 15 pieces of equipment, on the wards, including blood pressure machines, defibrillators, pumps and air mattresses and found all of them to be up to date with servicing and electrical testing. Within the theatre department we checked 10 items and found that these had been tested to ensure patient safety. Equipment that needed servicing was tracked and either returned to the manufacturer for servicing or serviced on site.

Some areas were visibly cluttered. Staff in main theatres told us that the there was a lack of suitable storage space for the increased amount of specialist equipment. This lack of space was on the service risk register but finding a solution was a challenge due to the lack of physical space.

Resuscitation equipment was available on the wards and in theatre areas. This equipment should be checked daily by staff. We found that in general this check was undertaken. Resuscitation equipment was secured using a tagging system. Staff noted the tag number when checking the resuscitation trolley. Within the theatre department there was a difficult airway trolley which was also checked daily by staff.

Staff disposed of clinical waste safely. Clinical waste was separated appropriately into clinical waste bins. We observed these being regularly collected and removed. General waste bins were
available for non-clinical waste. Sharps bins were used for all contaminated sharps such as needles. These were dated, labelled and closed appropriately.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. National Early Warning Scores (NEWS2) were used to identify and escalate deteriorating patients. NEWS 2 is a national tool which scores a patient’s vital signs to assess their physiological stability and their risk of deterioration. The trust had an up to date and comprehensive procedure for the management of deteriorating patients. All staff we spoke with knew how to escalate deteriorating patients and understood the importance of doing this in a timely manner. The trust had introduced a NEWS 2 escalation mobile application. This meant that once a patient’s observations had been recorded the system would notify the ward manager and outreach team when identified parameters were met. This meant that patients who may have been at risk of deteriorating were identified in a timely manner. Staff reported that the outreach team were very responsive and attended to review any patient that triggered on NEWS and required escalation. Staff told us they felt particularly well supported by the critical care outreach team who would review patients, offer advice and escalate to consultants.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 10 sets of patient records and found all were completed, legible and risks were monitored routinely.

The trust had implemented the World Health Organisation (WHO) and five steps to safer surgery checklist. The trust audited the process at all five stages. We noted from audits that the team debrief in main theatres was consistently not meeting the trust’s target of 95% compliance apart from once in quarter 4 2018/19. All other aspects of the checklist met the trust’s target. We observed a pre-procedure theatre checklist being completed. Previous procedures and medical history were checked. Within the theatre department patient identification was confirmed by the surgeon in the anaesthetic room. We did not see a second check prior to the procedure being undertaken in the time out process. We also noted that although the allergy check was completed it was carried out after the scrub nurse had cleaned the site of surgery meaning that the patient’s if the patient was allergic to the cleaning solutions this was not checked prior to the substance being applied to the patient’s skin. We noted that all staff were engaged with three of the five steps to safer surgery but not everyone was engaged in the sign out stage or the team debrief. The trust had a rolling action plan to undertake actions to address shortfalls. However, despite only one quarter where the team debrief met the trust’s target this did not show an improving trajectory.

Surgical pre- assessment used standard criteria to determine the relative risk of patients undergoing surgery. There was a clear process for identifying patients who may be at greater risk. The service triaged patients and coded them according to the level of risk. Patients were then allocated to the appropriate pre-assessment clinic with those with the most complex needs being allocated to be reviewed by the anaesthetist.

The service had 24-hour access to mental health liaison and specialist mental health support. A mental health team were onsite Monday to Friday, 9am to 5pm. Outside of these hours an on-call system was in place. Staff knew how to access this service.
Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff described how they would access the mental health team should they have any concerns.

Staff shared key information to keep patients safe when handing over their care to others. We saw that safety huddles occurred in all areas. Safety huddles included discussion around staffing, skill mix and identified any cancelled patients. Appropriate actions were taken following the safety huddle and concerns escalated to senior staff.

Shift changes and handovers included all necessary key information to keep patients safe. Nursing staff on wards held a handover when staffing changed. This included all relevant information on patients’ needs.

### Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The table below shows a summary of the nursing staffing metrics in surgery at West Suffolk Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
<th>June 2018 to May 2019</th>
<th>May 2018 to April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annual average establishment</td>
<td>Annual vacancy rate</td>
<td>Annual turnover rate</td>
</tr>
<tr>
<td>Target</td>
<td>6%</td>
<td>10%</td>
<td>3.5%</td>
</tr>
<tr>
<td>All staff</td>
<td>609</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>258</td>
<td>5%</td>
<td>4%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Nurse staffing rates within surgery were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness and agency use.

The service had low turnover rates.

The service had sickness rates which were above the trust’s target.

The service had enough nursing and support staff to keep patients safe.
The ward manager could adjust staffing levels daily according to the needs of patients. Staffing levels were reviewed daily and staff relocated to cover shortfalls to ensure patient safety. However, staff on the elective surgery ward raised concerns with us about the frequency that they were moved and the fact that they did not feel confident to work on some of the medical wards they were reallocated to as they felt that they did not have the specific skills required to look after the acuity of the patients. Following the inspection, we requested information relating to the risk assessment completed when staff were relocated. The trust informed us that “On occasions, staff are asked to move wards or departments to support other teams who require support to manage these pressures and keep patients safe and well cared for, there is every attempt made to place a registered nurse or nursing assistant to an area best suited to complement their skills and competence.” They also told us that the nurse of nursing assistant would receive an induction to the ward if necessary.

The number of nurses and healthcare assistants matched the planned numbers. The planned and actual numbers of staff were displayed on each ward. Most highlighted that at the time of our inspection actual numbers of staff met the planned numbers of staff required. Within the theatre department an anaesthetic assistant and three staff were within each theatre.

**Vacancy rates**

The service had reducing vacancy rates.

![Vacancy rate - qualified nurses, health visitors and midwives](chart)

Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives in surgery showed an upward trend from May 2018 to September 2018.

*Source: Routine Provider Information Request (RPIR) – Vacancy tab*

Managers limited their use of bank and agency staff and requested staff familiar with the service. All temporary staff received an induction to their working area by staff experience in that area.

The service had reducing rates of bank and agency nurses.

**Bank staff usage**
Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives showed a shift from November 2018 to April 2019.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

Please note that the bank and locum figures in the table below include data for medical staff working across surgery and critical care.

The table below shows a summary of the medical staffing metrics in surgery at West Suffolk Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
<th>June 2018 to May 2019</th>
<th>May 2018 to April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annual average establishment</td>
<td>Annual vacancy rate</td>
<td>Annual turnover rate</td>
</tr>
<tr>
<td>Target</td>
<td>6%</td>
<td>10%</td>
<td>3.5%</td>
</tr>
<tr>
<td>All staff</td>
<td>609</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Medical staff</td>
<td>168</td>
<td>-1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)
Medical staffing rates within surgery were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover in surgery and locum usage across surgery and critical care.

Please note that the negative vacancy rate for medical staff in the table above indicate that the service was over-established.

The service had enough medical staff to keep patients safe, with low turnover rates and low vacancy rates for medical staff.

### Vacancy rates

![Vacancy rate - medical staff](chart)

Monthly vacancy rates over the last 12 months for medical staff in surgery showed a shift from October 2018 to March 2019.

*(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

### Sickness rates

![Sickness rate - medical staff](chart)

Monthly sickness rates over the last 12 months for medical staff in surgery showed an upward trend from January to May 2019.

*(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

The service had reducing rate of bank and locum staff.
Bank staff usage

Monthly bank hours over the last 12 months for medical staff working across surgery and critical care showed a shift from November 2018 to April 2019.

(Source: Routine Provider Information Request (RPIR) – Medical locum tab)

Staffing skill mix

In April 2019, the proportions of consultant and junior (foundation year 1-2) staff reported to be working at the trust were higher than the England averages.

Staffing skill mix for the whole time equivalent staff working at West Suffolk NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>56%</td>
<td>50%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>7%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>21%</td>
<td>28%</td>
</tr>
<tr>
<td>Junior*</td>
<td>17%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)
The service had a good skill mix of medical staff on each shift and reviewed this regularly. The trust had a higher number of consultants in post than the England average. Due to the lack of middle and registrar grade doctors, consultants sometimes had to “act down” to cover these roles. The service always had a consultant on call during evenings and weekends. Junior doctors reported feeling supported by consultants who were always available to them.

Records

**Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.**

Patient notes were comprehensive, and all staff could access them easily. There was an electronic patient record system in place on which patient records were kept. We reviewed 10 sets of records and found that these were completed appropriately. Records contained adequate information on which staff could make decisions regarding care.

When patients transferred to a new team, there were no delays in staff accessing their records. Due to the electronic nature of the care records when patients transferred between teams their records were immediately available to the new care team. In recovery we saw that appropriate handovers as to care were given to the receiving nurse.

Records were stored securely in all the areas we visited. Computers with patient sensitive information were locked when not in use. Some patient records that were in constant use were maintained at the patient’s bedside.

Medicines

**The service had effective systems and processes to safely prescribe, administer and record medicines. However, medicines were not always stored securely.**

The service had effective systems and processes to safely prescribe, administer and record medicines. We observed nursing staff administering medicines and saw that patients were supported to take their medicines and that this was in line with safe administration practices. Medicine allergies were clearly recorded on all of the 10 electronic and paper medicines charts we reviewed. Omissions were clearly recorded, and records were accurate and reflected the needs of the patients.

Staff did not always follow systems and processes when safely storing medicines. There were inconsistent processes in place for medicines management across different areas of the service, and no clear risk assessment in place to explain why there was variation. On the ward areas we saw that all medicines cupboards and trolley were locked and secured. Controlled medicines were checked in line with trust policy, however this was not always the case in the theatre environments.

Within the main theatre department, we found during our inspection that medicine cupboards in all anaesthetic rooms in main theatre were unlocked. We were told by staff that they were never locked even at night. Not all of the drug cupboard doors had locks on, and there were no keys in the department for the cupboards that could be locked. However, medicines that were controlled under legislation were kept secure and administered in line with national guidance. These medicines were checked in line with trust policy. The drugs fridge on main theatre corridor was unlocked and staff confirmed that this was not locked at night.
We were also informed by the senior operating department practitioner that there were a high number of trolleys utilised in the department that stored drugs which were not secured. When we raised this as a concern we were informed that this had been risk assessed and deemed appropriate as the theatre environment had controlled secure access and was staffed 24 hours a day. However, we found differing practice within the main theatre department itself that contradicted this reasoning as the cupboards in recovery were locked and secured when operating had finished. We were concerned that this was not in line with best practice, and there was an additional increased risk that medication held on numerous trolleys would be missed in stock rotation and audit resulting in out of date drugs being available.

In the day surgery unit medicines were not locked away. Cupboards containing medicines in the theatre were not locked. A store room with trolleys containing drugs was not locked. Staff confirmed that these were not locked at night again stating that the department was locked out of hours.

Fridge temperatures were monitored but there was no escalation process to follow if fridge was out of range. Staff we asked could not clearly explain the actions they would take if the fridge was out of range. The maximum temperature for the fridge was 8 degrees. When reviewing records, we saw that the fridge temperature was frequently recorded as exceeding the maximum temperature. When we asked staff what action they would take they explained that the would reset the fridge temperature to cool it but there was no consideration given to the efficacy of the medication in the fridge if it had been stored at a higher temperature.

Within the theatre department medicines taken from the fridge for use in theatre were kept on the side in the anaesthetic room throughout the day. The temperature that these medications were stored at during the day was not controlled and this could potentially affect the efficacy of this medication.

Within the anaesthetic room we observed “emergency drugs” for the patient in theatre drawn up but not taken into theatre with the patient but left unattended in the anaesthetic room for the duration of the procedure.

There was a trust audit programme in place that looked at safe and secure handling of medicines, use of antimicrobials and controlled drugs. The audit was overseen by pharmacy only at ward level, with the oversight of medicines in areas such as theatres undertaken at a divisional level both for risk assessment of storage and the reporting of omitted doses.

Staff stored and managed prescribing documents in line with the provider’s policy. Prescription pads (FP10) were stored securely in a locked cupboard on the wards. Staff told us that they were rarely used but there was a check out process in place to monitor the use of prescriptions and record the patient the prescription was for. We reviewed 10 prescription charts and found that the pharmacy team reviewed these.

Staff followed current national practice to check patients had the correct medicines. There was a process to monitor and record medication administration on the ward. The patient wrist band was scanned when medication was given which updated the patient record on the electronic records system.

Staff reviewed patients’ medicines regularly and provided specific advice to patients and carers about their medicines. Patients’ medications were reviewed daily during the ward rounds.

Pharmacy staff visited the wards daily to review new patients, complete medication reconciliation and to arrange TTOs (medication to take home). Patients were provided with advice and information about their medications.
The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Safety alerts were shared at clinical governance meetings, with the information shared through the hospital’s new ‘medic bleep’ system.

Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines. Staff ensured that patients’ behaviour was not being controlled by inappropriate use of medicines. All medications administered were recorded, including those that could be taken PRN ‘as needed’, to ensure no patients were taking excessive amounts. Patients were advised to see their GP if they required further medication.

Incidents
The service had established processes in place to manage patient safety incidents. Not all staff reported incidents appropriately or in a timely manner. Whilst managers investigated incidents wider analysis to identify learnings was not always undertaken. However, where lessons were identified these were shared with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Never Events
Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From August 2018 to July 2019, the trust reported one incident that was classified as a never event for surgery. The incident occurred in December 2018 and related to wrong site surgery. (Source: Strategic Executive Information System (STEIS))

Managers shared learning about never events with their staff and across the trust. There was evidence that changes had been made as a result of feedback. We asked staff about learning from the never event. All staff were able to tell us about the never event which had occurred. They could demonstrate changes to practice which had occurred following the never event. They reported that there had been an open culture following the never event and that staff now felt able to challenge each other in a positive way to ensure that patients received safe care.

Serious incidents, incidents and near misses were not always reported in line with trust policy. The trust used an electronic reporting system and staff were aware of how to use it. The trust also had a mechanism for reporting examples of good patient care so that positive events could also be shared. Staff we spoke with knew what incidents to report, how to report them and could demonstrate when they had reported incidents. However, we were also provided with examples when reporting was not undertaken appropriately or in a timely manner. For example, there had been a serious incident in main theatres that involved a member of staff self-administering medication whilst on duty. This had been witnessed by a number of staff but was not formally reported until five months after the incident took place. This meant that there was a potential ongoing risk to both patient and staff safety and a delay in the provision of support for the individual involved. The incident investigation, when undertaken, had also failed to identify wider actions and learnings to mitigate ongoing risk to patients. For example, drug cupboards within
theatres remained unlocked and we found that the risk assessment had not been reviewed following the serious incident.

During the inspection ward staff told us that they were frequently asked to work in other areas. When they had raised concerns around a gap in clinical competency to do so, their concerns were not listened to or addressed by service leaders, and that they had been actively discouraged from reporting staff ward moves as an incident. Therefore, we could not assess the scale of this issue.

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 10 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from August 2018 to July 2019.

A breakdown of the incident types reported is in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>5</td>
<td>50.0%</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>2</td>
<td>20.0%</td>
</tr>
<tr>
<td>Abuse/alleged abuse of adult patient by third party</td>
<td>1</td>
<td>10.0%</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>1</td>
<td>10.0%</td>
</tr>
<tr>
<td>Medication incident meeting SI criteria</td>
<td>1</td>
<td>10.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff could give examples of when they had been open with patients even if the incident did not meet the serious incident criteria. Duty of candour had been applied following the never event.

Managers investigated incidents and staff received feedback from investigations, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. Learning from incidents were discussed at monthly staff meetings and during safety huddles. Staff told us that they received feedback from incidents that they had reported. Learning from incidents was also shared via email and staff bulletins for example ward F3 had “F3 Times” where learning from incidents was shared on the ward. Staff were able to give examples of changes that had been made as a result of incidents that occurred within the trust. For example, staff told us about changes in practice regarding the administration and monitoring of warfarin following a serious incident in the trust. This included warfarin chart colour changed to yellow and reminders generated on the electronic records system.

**Safety thermometer**

Safety thermometer data was displayed on wards for staff and patients to see. We saw the safety thermometer on display is each area that we visited.

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 the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported nine new pressure ulcers, four falls with harm and three new catheter urinary tract infections from May 2018 to May 2019 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at West Suffolk NHS Foundation Trust

1. Total Pressure ulcers (9)
2. Total Falls (4)
3. Total CUTIs (3)

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients’ subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We reviewed eight policies and found that these were up to date and referenced national guidelines. Therapy staff told us that the trust had implemented individualised patient pathways for patients having hip and knee replacements. Pathways commenced in the
pre-operative assessment clinic where equipment was ordered to be supplied to patients prior to their surgery. Pathways reflected best practice.

The service was compliant with National Institute for the Health and Care Excellence (NICE) guidance CG50 ‘Acute Illness, Recognising and Responding to the deteriorating patient in all clinical areas.” For example; we saw the wards were using the National Early Warning Scoring 2 (NEWS 2) system and no issues or concerns were found during the inspection.

Medical staff followed professional guidance and recorded medical device implants using the National Joint Registry (NJR). The NJR collects information on joint replacement surgery and monitors the performance of joint implants which ensured traceability at national level, if concerns were raised about the quality of joints, or any adverse effects.

The pre-operotive assessment clinics assessed patients in accordance with NICE NG45 ‘Routine pre-operative tests for elective surgery’ (2016). For example, MRSA screening and blood tests were undertaken following this guidance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. As outlined below staff demonstrated a knowledge of the Mental Health Act and were able to articulate examples where they had taken action to address their individual needs.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Daily safety huddles included reference to patients psychological and emotional wellbeing.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff undertook risk assessments to ascertain if patients were at risk of malnourishment. Specialist diets could be offered for patients with religious, cultural and other needs. Volunteers received training in order to support patients who needed assistance when eating and drinking. Meal times were protected so that intervention during this time was kept to a minimum.

Staff fully and accurately completed patients’ fluid and nutrition charts where needed. We reviewed six fluid and food charts which were completed appropriately. Staff identified patients who needed assistance or encouragement to drink and eat during the safety huddle.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The trust used the malnutrition universal screening tool (MUST) to assess and monitor patients at risk of malnutrition. We found that in the 10 records we reviewed that these were completed appropriately.

Specialist support from staff such as dieticians and speech and language therapists was available for patients who needed it. Dieticians and speech and language therapists visited the medical wards on a daily basis. Staff made referrals to the teams if they needed an assessment in order to maintain hydration and nutrition.

Patients waiting to have surgery were not left nil by mouth for long periods. Staff were knowledgeable about the restrictions used when patients were going to theatre. If the theatre list
changed or delays happened staff contacted the anaesthetist to enquire if the patient could have a drink.

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used a pain scale based on numerical scoring of 1-10. This scoring system was well known by staff and explained to patients. Staff stated that they always responded to the patients perception of their pain. In recovery the ward manager told us that for patients who could not communicate verbally the service used the Australian pain tool. This pain tool takes into account any verbal signs of pain, facial expressions or changes in physical appearances or behaviour. A score is calculated, and pain relief given to match the score.

Patients received pain relief soon after requesting it. Patients told us that the staff provided pain relief when requested. They checked with patients if they were still in pain following administration of the medication.

Staff prescribed, administered and recorded pain relief accurately. The consultant anaesthetist undertook a ward round with pain clinical specialist nurse on Monday and Friday. At all other times, specialist advice from pain specialists was available until 5pm week days. Out of hours and bank holidays the service was covered by on call obstetric anaesthetist.

**Patient outcomes**

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Local and national audits were undertaken to improve patient outcomes. Local audits included the perfect ward, IV cannula audits, catheter audits and WHO safety audits. Following the audit an action plan was developed and this was monitored through governance meetings. The service performed well in national clinical outcome audits and managers used the results to improve services further.

The trust participated in the Commissioning for Quality and Innovation (CQUIN) national goals. The aim of the CQUIN framework is to improve the quality of services and provide better outcomes for patients. For example; reducing the impact of serious infections (including sepsis) and staff health and wellbeing. Sepsis is a life-threatening condition that arises when the body’s response to infection causes injury to its own tissues and organs.

Managers carried out a comprehensive audit programme. Staff completed a monthly nursing quality dashboard which covered a range of areas including; bed occupancy, staffing, patient safety and patient experience. The trust performed as expected or better than expected in most national audits.
Managers used information from the audits to improve care and treatment. The trust had introduced the “Getting it Right First Time” (GIRFT) programme. We saw the GIRFT orthopaedics action plan following the assessment in 2017 included the recommendations, actions taken, the completion date and who was responsible for the action. We noted that some of the actions were ongoing at the time of our inspection. These included the patient information leaflet which was being developed in order that patients outside of hospital recognise a potential surgical site infection.

Managers shared and made sure staff understood information from the audits. Staff informed us that they were given feedback at daily huddles should a concern or issue be identified on the nursing quality dashboard. Staff also said that managers fed back lessons learnt from meetings they attended.

Improvement is checked and monitored. Results from audits were monitored in a variety of forums including the safer surgery meeting, the performance meeting and the mortality and morbidity meeting. A Trauma Audit Research Network (TARN) audit group meets quarterly chaired by the head of patient safety with a membership of all stakeholders clinical and non-clinical. The group review the trust performance and audit reports and identifies themes of learning and cases for review. The group has an on-going rolling action plan to improve performance. The group reports 6 monthly to the board level assurance Clinical Safety and Effectiveness Committee (CSEC) as part of the Trauma report. Six-day trauma lists are now in place in response to the Trauma Peer review. The CSEC report includes the action plan for the Trauma Care Group.

Relative risk of readmission

Elective Admissions – West Suffolk Hospital

From February 2018 to January 2019, patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average of 100.

- General surgery, trauma and orthopaedic and ear, nose and throat patients at the trust had lower than expected risks of readmission for elective admissions when compared to the England average of 100.

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 represents the opposite. Top three specialties for specific trust based on count of activity

Non-Elective Admissions – West Suffolk Hospital

From February 2018 to January 2019, patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery, trauma and orthopaedic and urology patients at the trust had lower than expected risks of readmission for non-elective admissions when compared to the England average.
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 represents the opposite. Top three specialties for specific trust based on count of activity.

(Source: Hospital Episode Statistics - HES - Readmissions (01/02/2018 - 31/01/2019))

### National Hip Fracture Database

The table below summarises West Suffolk Hospital’s performance in the 2018 National Hip Fracture Database. For five measures, the audit reports performance in quartiles. In this context, ‘similar’ means that the trust’s performance fell within the middle 50% of results nationally.

<table>
<thead>
<tr>
<th>Metrics (Audit indicators)</th>
<th>Hospital performance</th>
<th>Comparison to other trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case ascertainment</strong> (Proportion of eligible cases included in the audit)</td>
<td>118.7%</td>
<td>Better</td>
<td>Met</td>
</tr>
<tr>
<td><strong>Crude proportion of patients having surgery on the day or day after admission</strong></td>
<td>94.5%</td>
<td>Better</td>
<td>Met</td>
</tr>
<tr>
<td>(It is important to avoid any unnecessary delays for people who are assessed as fit for surgery as delays in surgery are associated with negative outcomes for mortality and return to mobility)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Crude peri-operative medical assessment rate</strong> (NICE guidance specifically recommends the involvement and assessment by a Care of the Elderly doctor around the time of the operation to ensure the best outcome)</td>
<td>99.7%</td>
<td>Better</td>
<td>Met</td>
</tr>
<tr>
<td><strong>Crude proportion of patients documented as not developing a pressure ulcer</strong></td>
<td>99.0%</td>
<td>Better</td>
<td>Did not meet</td>
</tr>
<tr>
<td>(Careful assessment, documentation and preventative measures should be taken to reduce the risk of hospital-acquired pressure damage (grade 2 or above) during a patient’s admission); this measures an organisation’s ability to report ‘documented as no pressure ulcer’ for a patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Crude overall hospital length of stay</strong> (A longer overall length of stay may indicate that patients are not discharged or transferred sufficiently quickly; a too short length of stay may be indicative of a premature discharge and a risk of readmission)</td>
<td>15.7 days</td>
<td>Better</td>
<td>No current standard</td>
</tr>
</tbody>
</table>
**Risk-adjusted 30-day mortality rate**  
(Adjusted scores take into account the differences in the case-mix of patients treated)  
<table>
<thead>
<tr>
<th></th>
<th>Trust performance</th>
<th>Comparison to other trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case ascertainment</td>
<td>87.2%</td>
<td>Good</td>
<td>Good is over 80%</td>
</tr>
</tbody>
</table>
| Risk-adjusted post-operative length of stay >5 days after major resection  
(A prolonged length of stay can pose risks to patients) | 61.6% | Better than national aggregate | No current standard |
| Risk-adjusted 90-day post-operative mortality rate  
(Proportion of patients who died within 90 days of surgery; post-operative mortality for bowel cancer surgery varies according to whether surgery occurs as an emergency or as an elective procedure) | 3.1% | Within expected range | No current standard |
| Risk-adjusted 2-year post-operative mortality rate  
(Variation in two-year mortality may reflect, at least in part, differences in surgical care, patient characteristics and provision of chemotherapy and radiotherapy) | 30.8% | Worse than expected | No current standard |
| Risk-adjusted 30-day unplanned readmission rate  
(A potential risk for early/inappropriate discharge is the need for unplanned readmission) | 17.4% | Worse than expected | No current standard |
| Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection  
(After the diseased section of the bowel/rectum has been removed, the bowel/rectum may be reconnected. In some cases it will not, and a temporary stoma would be created. For some procedures this can be reversed at a later date) | 40.4% | Within expected range | No current standard |

(Source: National Bowel Cancer Audit)
National Vascular Registry
The trust did not participate in the 2018 National Vascular Registry audit, based on data for January 2015 to December 2018.
(Source: National Vascular Registry)

National Oesophago-gastric Cancer Audit
(Audit of the overall quality of care provided for patients with cancer of the oesophagus [the food pipe] and stomach).

East of England Cancer Alliance

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust-level metrics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case ascertainment</td>
<td>&gt;90%</td>
<td>Better</td>
<td>No current standard</td>
</tr>
<tr>
<td>Age and sex adjusted proportion of patients diagnosed after an emergency admission</td>
<td>15.1%</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk adjusted 90-day post-operative mortality rate</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td>No current standard</td>
</tr>
<tr>
<td>Cancer Alliance level metrics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude proportion of patients treated with curative intent in the Cancer Alliance</td>
<td>37.7%</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Oesophago-Gastric Cancer Audit)

National Emergency Laparotomy Audit
The table below summarises West Suffolk Hospital’s performance in the 2018 National Emergency Laparotomy Audit, based on data for December 2016 to November 2017. The audit reports on the extent to which key performance measures were met and grades performance as red (less than 50% of patients achieving the standard), amber (between 50% and 80% of patients achieving the standard) and green (more than 80% of patients achieved the standard).

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>88%</td>
<td>Green</td>
<td>Met</td>
</tr>
<tr>
<td>Crude proportion of cases with pre-operative documentation of risk of death (Proportion of patients having their risk of death assessed and recorded in their notes before undergoing an operation)</td>
<td>95%</td>
<td>Green</td>
<td>Met</td>
</tr>
<tr>
<td>Crude proportion of cases with access to theatres within clinically appropriate time frames (Proportion of patients who were operated on within recommended times)</td>
<td>86%</td>
<td>Green</td>
<td>Met</td>
</tr>
<tr>
<td>Crude proportion of high-risk cases (greater than or equal to 5% predicted mortality) with consultant surgeon and anaesthetist present in theatre (Proportion of patients with a high risk of death (5% or more) who have a Consultant Surgeon and Anaesthetist present at the time of their operation)</td>
<td>93%</td>
<td>Green</td>
<td>Met</td>
</tr>
<tr>
<td>Crude proportion of highest-risk cases (greater than 10% predicted mortality) admitted to critical care post-operatively (Proportion of patients with a high risk of death (10% or more) who are admitted to a Critical/Intensive Care ward after their operation)</td>
<td>88%</td>
<td>Green</td>
<td>Met</td>
</tr>
<tr>
<td>Risk-adjusted 30-day mortality rate (Proportion of patients who die within 30 days of admission, adjusted for the case-mix of patients seen by the provider)</td>
<td>10%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Emergency Laparotomy Audit)

National Ophthalmology Database Audit

(Audit of patients undergoing cataract surgery).

The trust did not participate in the 2018 National Ophthalmology Database Audit, based on data for September 2016 to August 2017.

(Source: National Ophthalmology Database Audit)
National Joint Registry

The trust participated in the 2018 National Joint Registry audit, based on data for April 2017 to March 2018. 100% of eligible records were submitted.

(Source: National Joint Registry)

National Prostate Cancer Audit

In the 2018 National Prostate Cancer Audit, the trust scored 96.8% for ‘men with complete information to determine disease status’ (this is a classification that describes how advanced the cancer is and includes the size of the tumour, the involvement of lymph nodes and whether the cancer has spread to different part of the body) and did not meet the national standard of 100%.

There was no data available for the remaining three metrics.

(Source: National Prostate Cancer Audit)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left. These changes are measured in a number of different ways, descriptions of some of the indicators presented are below.

The visual analogue scale (EQ VAS) asks patients to mark their health status on the day of the interview on a vertical scale. The bottom rate (0) corresponds to “the worst health you can imagine”, and the highest rate (100) corresponds to “the best health you can imagine”.

The EQ-5D-5L questionnaire has two parts. Five domain questions ask about specific issues; namely mobility, self-care, usual activities, pain or discomfort, anxiety or depression. The EQ-5D-5L uses five levels of responsiveness to measure problems. The range is; no problem - disabling/extreme.

The Oxford Hip Score (OHS) is a patient self-completion report on outcomes of hip operations containing 12 questions about activities of daily living. A simple scoring and summing system provides an overall scale for assessing the outcome of hip interventions.
In 2016/17 performance on groin hernias was about the same as the England average for the EQ-VAS and better for the EQ-5D index.

For hip and knee replacements, performance was about the same as the England average for all measures.

For varicose veins, performance was better than the England average in the Aberdeen Varicose Vein questionnaire. However, the trust’s performance was worse than the England average for the EQ VAS and EQ-5D index metrics.

(Source: NHS Digital)

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff had the right skills and completed additional competencies as needed for their roles. Examples of extra competencies included dementia study days and paediatric competencies for nursing staff in recovery.

Managers gave all new staff a full induction tailored to their role before they started work. All new staff had an induction to their new role and were supernumerary for a period of time whilst they got used to their role and surroundings. The service had recruited a number of overseas staff who were mentored and supervised prior to leading a team.

Managers supported staff to develop through yearly, constructive appraisals of their work. The clinical educators supported the learning and development needs of staff. Whilst appraisal rate compliance was below the trust target staff we spoke to found that appraisals were meaningful. One member of staff informed us of how through their appraisal they had been encouraged to develop a pathway for patients with memory loss.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The theatre staff told us that they had been supported to undertake the advanced theatre practitioner course. Ward staff were enabled to develop in areas of interest and the outputs of this was used to improve care for patients. Staff attended the 5 o’clock club which enabled them to hear from specialists in a variety of subjects in order that they used this information in their practice.

(See graph)
Managers identified poor staff performance promptly and supported staff to improve. Managers could identify where they had identified poor performance and the steps that they had taken to address this. This included re-training and mentorship.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff attended monthly staff meetings where information was shared with them in order to develop knowledge and understanding. We saw minutes of these meetings which were available for staff who had not been present.

Managers recruited, trained and supported volunteers to support patients in the service. The hospital has a large number of volunteers who received extra training in order to support them in delivering non-clinical care to patients. This included being able to assist patients to eat and drink.

**Appraisal rates**

From April 2018 to March 2019, 82.1% of required staff in surgery at West Suffolk Hospital received an appraisal, which was below the trust target of 90%. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>3</td>
</tr>
<tr>
<td>Estates and ancillary</td>
<td>6</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>90</td>
</tr>
<tr>
<td>Additional professional, scientific and technical</td>
<td>75</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>139</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>45</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>69</td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>428</td>
</tr>
</tbody>
</table>

Allied health professionals, estates and ancillary staff and medical and dental staff in surgery at West Suffolk Hospital met the 90% target. However, only 78.5% of registered nursing staff had received an appraisal.

Updated analysis for April 2019 to mid-June 2019 found that 15.7% of required staff in surgery at West Suffolk Hospital received an appraisal compared to the trust target of 90%. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2019 to mid-June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>23</td>
</tr>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>20</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>1</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>23</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>10</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>5</td>
</tr>
<tr>
<td>----------------------------</td>
<td>----</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>0</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>82</td>
</tr>
</tbody>
</table>

None of the staff groups in surgery met the 90% target. However, this data only represents a partial year and so we would not expect a high appraisal completion rate.

(Source: Routine Provider Information Request (RPIR) – Appraisals tab)

**Multidisciplinary working**

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Multidisciplinary ward rounds occurred daily. Therapists, other allied health professionals and mental health colleagues attended these ward rounds.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff we spoke with gave examples of cross sector working with district nurses and social care) in order to care for patients. Staff were able to give us examples of when working across health and social care sectors had had positive outcomes for patients. These included the care of a homeless person and a patient with learning disabilities.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. Staff were aware of the mental health team and could access them if they had any concerns about a patient’s mental well-being.

**Seven-day services**

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients are reviewed by consultants depending on the care pathway. A consultant was on call out of hours. Junior doctors reported that they could easily access consultants for support at any time. We saw from patient records that consultants reviewed patients on a daily basis.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. The pharmacy was open Monday to Friday 8.30am to 6.30pm, and Saturdays and bank holidays 9am to 4.30pm. Out of hours an on-call pharmacist was available. Diagnostic tests, for example, MRI and x-rays were available 24 hours a day, seven days a week.

**Health promotion**

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards. The pre-assessment clinic had access to information in order to promote healthy lifestyles. We saw patient information leaflets on wards to assist patients in caring for themselves post surgery.
Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. The pre-assessment clinic advised patients on stopping smoking prior to surgery. They also discussed alcohol intake and weight management where appropriate.

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

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients’ liberty.

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that Mental Health Act (MHA), Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) are covered in the safeguarding adults training.

The trust set a target of 90% for the completion of safeguarding adults training.

A breakdown of compliance for safeguarding adults training by staff group as of June 2019 in surgery at West Suffolk Hospital is shown below:

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>187</td>
<td>192</td>
<td>97.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>119</td>
<td>142</td>
<td>83.8%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery, the 90% target for safeguarding adults training was met by qualified nursing staff, while 83.8% of medical staff had completed the training.

*(Source: Routine Provider Information Request – Training tab)*

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff were familiar with the process for identifying whether patients had the mental capacity to make decisions about their care. They were able to explain factors that would be involved in making the decision.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. The trust had an up to date consent policy that was available to staff on the trust intranet. In the day surgery unit a member of staff confirmed that there was a two-stage consent process for elective care patients. They told us that that the patient would initially be consented in clinic and then would have consent taken again on the day of their surgery.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients’ records. We checked five sets of patient records and saw that consent was clearly documented. Staff ensured that the risks and benefits of planned treatment had been explained to patients. They were able to describe an example where they were not sure that one patient had understood what the planned care was and the actions they took to ensure that this person understood.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions. Staff understood how and
when to assess whether a patient had the capacity to make decisions about their care. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with confirmed they had received training in consent and the Mental Capacity Act 2005. Staff demonstrated an understanding of mental capacity and described what they would do if a person lacked capacity to consent.

**Is the service caring?**

**Compassionate care**

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed throughout our inspection that staff took time to interact with patients and those close to them, Staff were respectful, considerate and treated them with kindness. Staff in the theatre and recovery area ensured that patients were treated with respect and consideration.

Patients said staff treated them well and with kindness. Feedback from people who use the service, those close to them and stakeholders was consistently positive. We saw feedback on ward notice boards from patients, saying how positive their experience had been. One patient told us that staff were friendly and caring. Another patient told us that they were always treated with kindness.

Staff followed policy to keep patient care and treatment confidential. Staff respected patient dignity and ensured that patient care and treatment was confidential. Staff closed doors and used curtains when delivering care. Within the theatre department we saw that patients had their dignity maintained. Staff ensured that patients were covered with blankets and sheets as soon as the surgical drapes were removed.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff could identify when they had treated patients with mental health issues and highlighted how they had sought to care for them in a non-judgemental way. We saw staff caring with compassion and kindness for a patient living with dementia. Staff sought to provide reassurance. We heard about a patient living with dementia who was upset about being in hospital. Staff described how they had sat with this patient and reassured them. The staff member had sung to them and used distraction techniques until the patient was calm and more compliant with treatment.

**Friends and Family test performance**

The Friends and Family Test response rate for surgery at the trust was 29.1% which was better than the England average of 27% from June 2018 to May 2019.

A breakdown of FFT performance by ward for surgical wards at this hospital over the same period is shown below. The percentage of respondents that said they would recommend the ward to family or friends was 98% or higher for all surgical wards for these 12 months, overall. However, caution is advised in interpreting these results given the low response rates for some wards.
1. The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above), as well as wards where there were less than 100 responses in total over the 12 month period.

2. Sorted by total response.

3. The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff offered emotional support to patients in their care. They took time to talk to patients and answer any questions or concerns they may have had about their care and treatment.

One patient told us that she was very anxious coming to their appointment in pre-assessment, but the nurse had been very supportive, and this had really helped put them at ease.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. All staff we spoke with were patient focused and were aware of the patient experience and did what they could to make their visit to the departments good as possible.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff were able to describe instances when they had had to alter care programmes in order to support patients. One member of staff described an incident with a patient with learning difficulties whose care and treatment had to be adapted to meet their needs. To reduce the stress of coming into hospital the staff met the patient prior to admission and at the front door on the day of admission. Another member of staff was able to describe the care of a homeless person who was seen at pre-assessment clinic prior to surgery. The staff worked with the social care department in order that the person had somewhere to stay post operatively. Staff also took into account the concerns of this person whilst in hospital and adapted care to ensure that they had an early discharge.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff explained care clearly and checked that patients understood and gave them the opportunity to ask any questions.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey.

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with confirmed that they understood their care and treatment. One relative stated that the staff could not have been more supportive. This person had a partner who was afraid of leaving the home and therefore had missed appointments. The staff had provided the carer with a number of a professional who would provide home support in order that the person did not have to leave the house.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We saw staff used language that patients understood and gave them time to ask questions if they were unsure about anything. Staff stated that they always had time to listen to patients and their families as they believed that this was important part of care and assisted in recovery of the patient.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients and their relatives provided feedback via the friends and Family Test and through the complaints and compliments procedure. We also saw thank you cards displayed on some wards.

**Is the service responsive?**

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

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. The trust understood the different requirements of the local people it served by ensuring that it actioned the needs of local people through planning, design and delivery of service. Services were planned in a way which ensured flexibility and choice. For example, the expansion of a virtual clinic for patients with fractures five days a week, the introduction of diabetic hypo simulation education sessions, the introduction of a second weekend emergency trauma list and the move of bladder Botox procedures from main theatres to an outpatient setting.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The service reported no mixed sex breaches in the reporting period. Bathrooms and toilets were designated as single sex and were mostly sited within single sex bays. The service was compliant with Department of Health guidance on single sex accommodation.

Facilities and premises were appropriate for the services being delivered. All surgical wards and operating theatres we visited had appropriate facilities to meet the needs of patients. Surgical wards that had been refurbished included LED lights which detected daylight and illuminated
accordingly. These were sensor operated which ensured that there was limited bright lights during the night time to assist patients sleeping. Wards were divided into single sex bays and there were a small number of side rooms that were mainly used for patients with infections.

The service had systems to help care for patients in need of additional support or specialist intervention. The trust had a number of clinical specialist nurses to provide support for patients. This included a learning disabilities nurse specialist who would support patients both in the hospital and prior to their admission for surgery. The trust had also undertaken significant improvements to the care of patients living with dementia. There was a memory walk within the hospital and specialist communication and remembrance aids available to reduce the patient’s anxiety of attending for surgery.

Managers monitored and acted to minimise missed appointments. The breast service had initiated a follow up service for patients who were less likely to attend appointments such as transgender patients.

The service relieved pressure on other departments when they could treat patients in a day. The surgical team reviewed current good practice in order that they could provide more day surgery to patients. An example of this is the move from main theatres to the day surgery unit for patients undergoing bladder Botox treatment. This meant that patients received a timelier service. Virtual clinics such as the fracture clinic were being trialled in other areas such as urology which meant that patients were able to be assessed without coming into hospital.

**Meeting people’s individual needs**

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. There were dementia and learning difficulty link nurses in all areas that we visited. Staff were able to cite instances where patients with learning disabilities had been supported to attend for surgery. The trust had a learning disability lead available to offer support to patient’s with learning difficulties or dementia. Staff knew how to contact them and told us that they were very responsive. We observed that the learning disability lead visiting a patient on the ward.

Staff supported patients living with dementia and learning disabilities. The service used the forget me not scheme to ensure that patients living with dementia were easily identified by staff and their care was planned accordingly. We observed that single patient use “twiddle muffs” made by relatives of a member of staff were given to patients living with dementia. Staff on a surgical ward told us about a support that was provided to patients living with dementia provided by an external organisation that attend the ward and entertain the patients by singing to them. Staff accessed this support for a patient who was very distressed in the ward environment. They told us that the patient found the singing very calming and was much less distressed following their visit.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Recent initiatives included introduction of digital reminiscence aids for patients living with dementia, as well as appropriate signage and facilities for the disabled, such as wet rooms. The learning disability nurse attends: Suffolk Disability forum to gather feedback from service users and their advocates. As part of the roll-out of health passport
and health action plan they had undertaken visits to West Suffolk College and Riverwalk special needs school to meet and speak to people with learning disabilities families and therapists to improve the service. The trust has signed up to ‘Green Light champion’ network which enables access to resources and best practice initiatives for the care of patients with a learning disability.

The service had information leaflets available in languages spoken by the patients and local community. Staff we asked told us that information leaflets could be accessed in different languages on request.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The trust had a provision for translation and braille services. The trust told us that the bookings for face to face translation services were fulfilled 97% of the total bookings. For patients requiring the services of a British Sign Language interpreters the trust was able to fulfil this need 100% of the time. The trust has an accessible information standard working group. This group had a rolling action plan for monitoring and improving compliance with the standard and an associated risk which is updated accordingly. Posters are displayed across the acute hospital alerting patients that they can request information in alternative formats. When a need is identified, this can be recorded on the electronic patient record system which then appears as an alert on their record. This alert ensures that all departments are aware of the individual’s needs.

Staff had access to communication aids to help patients become partners in their care and treatment. As described above staff were able to access a number of communication aids for patients requiring support. The trust worked with Suffolk Family Carers to develop young adult carer identification cards, launched in June. This enabled enabling young adult carer’s to identify themselves to staff to be included and involved in decision making and discharge planning. Any complaints making reference to particular protected characteristics are escalated to the trust’s Equality, Diversity and Inclusion Steering Group, chaired by the Executive Director of Workforce and Communications for the identification of any action. This process helps us to identify where health inequalities exist for patients, service users, carers or relatives.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were variable dependant on specialties. Performance was in line or better than national standards for three specialities.

Managers and staff worked to make sure patients did not stay longer than they needed to. The service worked with external services to ensure that patient were able to return to their homes as soon as possible. The therapists ensure that post-operative equipment was delivered to patients undergoing joint replacement surgery prior to their surgery date.

Average length of stay

West Suffolk Hospital - elective patients

From March 2018 to February 2019 the average length of stay for patients having elective surgery at West Suffolk Hospital was 3.0 days. The average for England was 3.8 days.

• The average length of stay for patients having elective trauma and orthopaedics surgery at West Suffolk Hospital was 3.5 days. The average for England was 3.7 days.
The average length of stay for patients having elective general surgery at West Suffolk Hospital was 4.2 days. The average for England was 3.9 days.

The average length of stay for patients having elective urology surgery at West Suffolk Hospital was 1.8 days. The average for England was 2.5 days.

**Elective Average Length of Stay - West Suffolk Hospital**

![Bar chart showing elective average length of stay for West Suffolk Hospital compared to England average.](chart)

Note: Top three specialties for specific site based on count of activity.

**West Suffolk Hospital - non-elective patients**

The average length of stay for patients having non-elective surgery at West Suffolk Hospital was 4.6 days. The average for England was 4.7 days.

- The average length of stay for patients having non-elective general surgery at West Suffolk Hospital was 3.5 days. The average for England was 3.6 days.
- The average length of stay for patients having non-elective trauma and orthopaedics surgery at West Suffolk Hospital was 8.1 days. The average for England was 8.4 days.
- The average length of stay for patients having non-elective urology surgery at West Suffolk Hospital was 3.0 days. The average for England was 2.7 days.

**Non-Elective Average Length of Stay - West Suffolk Hospital**

![Bar chart showing non-elective average length of stay for West Suffolk Hospital compared to England average.](chart)

Note: Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

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

From July to December 2018, the trust’s referral to treatment time (RTT) for admitted pathways for surgery was similar to the England average. However, in the most recent six months, January
to June 2019, performance was slightly worse than the England average.

In the most recent month, June 2019, the rate at the trust was 56.4% compared to the England average of 64.0%.

(Source: NHS England)

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

From July 2018 to June 2019, three specialities were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plastic surgery</td>
<td>92.2%</td>
<td>79.0%</td>
</tr>
<tr>
<td>General surgery</td>
<td>76.0%</td>
<td>72.1%</td>
</tr>
<tr>
<td>Ear, nose &amp; throat (ENT)</td>
<td>70.1%</td>
<td>60.0%</td>
</tr>
</tbody>
</table>

Three specialities were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>66.5%</td>
<td>75.1%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>44.3%</td>
<td>58.6%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>37.9%</td>
<td>62.8%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Managers monitored waiting times to monitor patients could access services when needed and received treatment within agreed timeframes and national targets. Long waits were managed daily by divisional teams to minimise the number of breaches. The trust implemented a trust wide procedure for assessing harm because of long waits and aimed to minimise harm and reduce waiting times where possible.

The service had a referral to treatment time (RTT) action plan in place to address delays in RTT.

Cancelled operations
A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation, then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

The percentage of cancelled operations where people were not treated within 28 days fluctuated between 6% and 17% from April 2017 to March 2019 and has been above the England average since July 2018.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - West Suffolk NHS Foundation Trust**

![Graph showing percentage of patients whose operation was cancelled and were not treated within 28 days](image)

Over the two years from April 2017 to March 2019, the percentage of cancelled operations as a percentage of elective admissions at the trust fluctuated. In the most recent quarter (January to March 2019), performance was slightly lower than the England average, when there were 71 cancelled surgeries.

Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

**Cancelled Operations as a percentage of elective admissions - West Suffolk NHS Foundation Trust**

![Graph showing cancelled operations as a percentage of elective admissions](image)

(Source: NHS England)

Managers worked to keep the number of cancelled operations to a minimum.

When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. The trust reported and
monitored operations cancelled for non-medical reasons. There was a cancelled operations standard operating procedure. Cancelled operations were reported as an incident. The policy stated that the patient was to be rebooked within 28 days. The trust provided information following the inspection which showed that cancelled operations were monitored and managed through the divisional and trust governance and business meetings. Cancelled operations were discussed at the divisional patient tracking list meeting and monitored at the weekly trust access meeting. Data provided by the trust showed that there was a slight reduction in the number of operations cancelled for non-clinical reasons between April and August 2019. The percentage of operations re-booked within 28 days was 100% in June 2019, July 2019 this figure was 90% and in August 2019, 95% of operations were rebooked within 28 days.

The senior surgical team had explored both outsourcing and insourcing alternatives for some specialities to assist with access to surgery. However, we were informed that the opportunities were limited. Any insourcing of activity was considered carefully due to the potential impact on planned elective surgery as the trust did not have additional bed base capacity. For this reason, additional sessions tended to be undertaken in the day surgery setting, however there was also some difficulty in sourcing staff for these sessions. There had been opportunities considered for outsourcing for certain specialties, such as ophthalmology, however quality concerns had seen these discounted.

Patient moving wards per admission

From June 2018 to May 2019, among patients who moved surgical wards during their admission at the trust, 51.9% of individuals did not move wards for non-clinical reasons, and 48.1% moved once or more for non-clinical reasons. This included non-clinical moves from the surgical assessment unit as well as the surgical wards.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

The service attempted to move patients only when there was a clear medical reason, or it was in their best interest. Data provided by the trust showed that 19 patients experienced more than one bed move during their admission within the surgical wards, not including those areas where patients were admitted and then transferred for a longer stay. This was a slight increase in the numbers form the previous year but amounted to less than 1% of the total number of patients.

Patient moving wards at night

From June 2018 to May 2019, there were 857 patient moving wards at night within surgery, with 277 (32.3%) occurring in ward F5 (general surgery ward).

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

Managers and staff worked to make sure that they started discharge planning as early as possible. Staff in pre-assessment told us that discharge planning was part of the preadmission process in an attempt to avoid any delays.

The trust operated a red to green system to avoid delayed discharges. We observed that each patient on the ward had a daily plan for discharge or medically fit.

Staff planned patients’ discharge carefully, particularly for those with social care needs. Staff gave us examples of two complicated cases for recent patients for discharge from a surgery ward. One patient was homeless. Staff told us that they liaised closely with social workers and specialist
teams to support their discharge to an appropriate safe place. Another example related to a patient who was a prisoner at the local prison and told us how they liaised with prison services to ensure that the patient had the appropriate equipment available when they were discharged.

**Learning from complaints and concerns**

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

**Summary of complaints**

From June 2018 to May 2019 the trust received 34 complaints about medicine (19.7% of the total complaints received by the trust). All of the complaints related to care received at West Suffolk Hospital.

For the 25 complaints that had been closed at the time of data submission, the trust took an average of 35.1 days to investigate and close these complaints. This was not in line with their complaints policy, which states complaints should be dealt with within 25 working days.

The nine complaints, that had not yet been closed, had been open for an average of 32.7 working days at the time of data submission.

The subjects of the complaints are shown below. However, please note that the trust attributed multiple subjects to some complaints and these are indicated in the table below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
<th>Percentage of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient care</td>
<td>8</td>
<td>23.5%</td>
</tr>
<tr>
<td>Clinical treatment</td>
<td>6</td>
<td>17.6%</td>
</tr>
<tr>
<td>Clinical treatment, communications</td>
<td>4</td>
<td>11.8%</td>
</tr>
<tr>
<td>Prescribing</td>
<td>3</td>
<td>8.8%</td>
</tr>
<tr>
<td>Communications</td>
<td>2</td>
<td>5.9%</td>
</tr>
<tr>
<td>Consent</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Clinical treatment, admissions &amp; discharge, patient care, communications</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Clinical treatment, appointments</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Clinical treatment, admissions, discharge &amp; transfers, values &amp; behaviours, end of life care</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Clinical treatment, patient care</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Clinical treatment, admissions &amp; discharge, patient care</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Clinical treatment, awaiting patient consent</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Clinical treatment, communications, patient care</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Clinical treatment, communications, values &amp; behaviour</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Clinical treatment, waiting times, admissions, discharge &amp; transfers</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>34</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>
The table below shows a breakdown of complaints by ward/team:

<table>
<thead>
<tr>
<th>Ward/team</th>
<th>Number of complaints</th>
<th>Percentage of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward F3</td>
<td>7</td>
<td>20.6%</td>
</tr>
<tr>
<td>Ward F5</td>
<td>6</td>
<td>17.6%</td>
</tr>
<tr>
<td>Ward F6</td>
<td>5</td>
<td>14.7%</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>4</td>
<td>11.8%</td>
</tr>
<tr>
<td>General surgery</td>
<td>4</td>
<td>11.8%</td>
</tr>
<tr>
<td>Ward F4</td>
<td>2</td>
<td>5.9%</td>
</tr>
<tr>
<td>Breast care</td>
<td>2</td>
<td>5.9%</td>
</tr>
<tr>
<td>Main theatres</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Urology</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Colorectal surgery</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>34</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Patients, relatives and carers knew how to complain or raise concerns. Patients we asked told us that they were aware of how to make a complaint.

The service clearly displayed information about how to raise a concern in patient areas. We saw complaints leaflets and posters were clearly visible throughout the wards we visited. We reviewed two complaints in relation to the surgical teams and noted these had been dealt with in line with trust policy.

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint had been completed. A ward manager told us that they attempted to deal with a complaint at the time as this provided better care for the patient and often prevented a complaint escalating through a formal process.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us they received feedback from complaints through email or team briefings. A member of staff gave an example of where a change had been made as a result of a patient complaint.

**Number of compliments made to the trust**

From June 2018 to May 2019 the trust received 196 compliments for surgery (25.8% of all compliments received trust-wide). All of the compliments related to care received at West Suffolk Hospital.

A breakdown of compliments by department is shown below:

<table>
<thead>
<tr>
<th>Department</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward F5</td>
<td>53</td>
<td>27.0%</td>
</tr>
<tr>
<td>Day surgery unit</td>
<td>34</td>
<td>17.3%</td>
</tr>
<tr>
<td>Urology</td>
<td>33</td>
<td>16.8%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>20</td>
<td>10.2%</td>
</tr>
<tr>
<td>Colorectal surgery</td>
<td>10</td>
<td>5.1%</td>
</tr>
</tbody>
</table>
The trust noted that the majority of compliments received trust-wide related to overall care along the whole pathway; and patients and relatives thanking staff for their kindness and compassion during difficult and stressful times.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

<table>
<thead>
<tr>
<th>Service</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>8</td>
<td>4.1%</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>7</td>
<td>3.6%</td>
</tr>
<tr>
<td>Breast care</td>
<td>7</td>
<td>3.6%</td>
</tr>
<tr>
<td>Ward F3</td>
<td>6</td>
<td>3.1%</td>
</tr>
<tr>
<td>Ward F4</td>
<td>6</td>
<td>3.1%</td>
</tr>
<tr>
<td>Ward F6</td>
<td>4</td>
<td>2.0%</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>3</td>
<td>1.5%</td>
</tr>
<tr>
<td>Ear, nose and throat</td>
<td>3</td>
<td>1.5%</td>
</tr>
<tr>
<td>Audiology</td>
<td>1</td>
<td>0.5%</td>
</tr>
<tr>
<td>Plastics</td>
<td>1</td>
<td>0.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>196</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Surgery services were managed within the surgical division. The surgical division was led by a triumvirate including a senior nurse, operations manager and two clinical directors. We saw the team was committed and determined to drive forward improvements to the service and tackle issues. Matrons were available to support ward managers. Staff told us that the matron comes to ward daily. Most of the staff we spoke with were very positive about the divisional leadership team and felt they were credible, grounded and willing to face the challenges.

We observed the presence of the matron on the surgical wards throughout the day. The ward managers confirmed the matrons had a detailed knowledge of the pressure on the wards and took prompt action to address any problems.

We spoke with ward managers, who were approachable and enthusiastic. Some of the ward managers were looking at initiatives to improve the quality of care. All staff we spoke with were very positive about the leadership of the ward managers.

Several members of the multi-disciplinary team praised the ward managers and how they had improved morale on the wards and the positive changes that had been made to improve patient care. Therapists on the pre-assessment service told us that they felt included within the unit’s team.

The trust had invested in leadership programmes for staff at all levels. The surgical division had participated in the Leadership Summit in June 2019. This focussed on creating a more compassionate and inclusive culture and overcoming the challenge of bullying and harassment.
Vision and strategy
The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The hospital had a trust wide vision ‘to deliver the best quality and safest care for our community’. This fed into three priorities; deliver for today, invest in quality, staff and clinical leadership and build a joined-up future. The medical division also had its own vision ‘to increase the health and happiness of patients receiving services’.

The hospital’s values were focused on patients, integrated, respectful, staff focused and two-way communication. These were developed in conjunction with staff and patients.

A business strategy was in place within the surgical division. The senior leadership team had asked themselves two questions: how can we learn from others do and how do we integrate with community providers to break down traditional barriers to provide care? The division was committed to collaborative working and maintained and developed positive relationships across and within aligned organisations including primary care and commissioning partnerships to enhance the patient experience. The division also reviewed opportunities for peer and self-assessment of services as well as developing action plans to increase performance in national audits. The service had six objectives.

<table>
<thead>
<tr>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliver for today</td>
</tr>
<tr>
<td>1. Working across system ensure plans are delivered to maintain safe and effective services during winter 2018-19</td>
</tr>
<tr>
<td>2. Deliver sustainable operational performance against the national standards</td>
</tr>
<tr>
<td>Invest in quality, staff and clinical leadership</td>
</tr>
<tr>
<td>3. Deliver systematic quality improvement and assurance of services</td>
</tr>
<tr>
<td>4. Support staff and teams to think strategically, empowering change</td>
</tr>
<tr>
<td>Build a joined-up future</td>
</tr>
<tr>
<td>5. Develop an integrated model of service delivery for the west of Suffolk</td>
</tr>
<tr>
<td>6. Ensure effective controls are in place to achieve sustainable financial performance and deliver agreed Cost Improvement Plans</td>
</tr>
</tbody>
</table>

Staff we spoke with were familiar with the vision and values of the division and were able to explain how they used these in their work.

Culture
Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided
opportunities for career development. Not all the service felt that they had an open culture where staff could raise concerns without fear.

Most staff we spoke with told us that there was a positive culture within the division. Staff felt supported and cared for and strong relationships were formed between colleagues. Staff in the theatre department told us they felt able to speak up if they felt something was wrong and were able to challenge poor practice when they saw this. They stated that the never event had improved this culture as it was investigated in a no blame manner. However, staff on one ward told us that there was still a bullying culture and that they did not feel able to speak up. As reported previously staff had been discouraged from reporting concerns they had raised around competencies when asked to work in other areas. Not all staff we spoke with knew who the freedom to speak up guardian was.

At the leadership summit in June 2019 the surgical divisional leaders were part of a group of senior leaders who developed an action plan to ensure staff were able to report concerns and access the right support if they need it. A “lessons learned” process following grievance investigations has been trialled however we were not informed of any review or results from this. In addition, following the never event, a consultant in human factors attended the theatre department to provide support and well-being training.

**Governance**

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a structured governance system in place. Individual ward and department meetings, fed into business unit meetings. The business unit meetings, and separate safer surgery meeting then fed into the surgical and anaesthetic divisional board meeting, that reported into the surgical and anaesthetic division performance meeting, up to the trust executive group and then board. This governance structure allowed ward to board assurance.

We reviewed the surgery report provided to the executive performance review meetings based on data for July, August and September 2019. Information provided to the executive team through the performance meetings highlighted updates from the previous month, achievements in the month, key issues and a summary using the CREWS nonmonic to report data. This used the CQC domains of caring, responsive, effective, well led and safe to display data for the executive team. Key performance targets were monitored as well as the patient experience data held by the trust. Exception reporting and areas for escalation were also highlighted.

We saw that key issues in all three reports reviewed (July- September) included sustaining and improving referral to treatment (RTT) performance and preventing 52 week breaches, sustaining and improving cancer performance, continued consultant absence driving locum costs in various different specialties with anaesthetics, plastic surgery, trauma and orthopaedics and general surgery all featuring. The loss of locum cover in plastic services compounding service capacity issues was noted in July and August. The “potential lost to follow up issue in vascular surgery” was noted in all three months reports. However, actions taken against these ongoing key issues were not clearly recorded for all. Whilst we saw summary and highlight narrative were included under the performance data slides for RTT and 52 week breaches, there was limited progress notes for these key issues in any of the updates from previous months summary slides.
For example, in September 2019 it was noted that discussion around RTT money and propriety agreements were to be undertaken and ongoing discussion following the scrutiny committee. There was no narrative or update in relation to consultant staffing or the lost to follow up issue.

The trust attended a number of local meetings in order to work with partner organisations to enhance care. Examples of this included working with social care organisations and community interest groups.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. Whilst arrangements for identifying, recording and managing risks, issues and mitigating actions were in place these were not always robust. There were plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Risks were managed and escalated through the divisional performance report to the executives on a monthly basis. Risks were also discussed at the daily safety huddle, so any urgent patient safety risks could be dealt with promptly. The divisional risk register was managed electronically through the operating system which included the reporting of incidents. The trust used a colour coded scoring mechanism, from red to green, depending on risk level.

We found that the arrangements for risk management were not fully robust. Not all incidents were reported in a timely manner or considered wider actions and learnings to mitigate ongoing risk to patients. Recorded risks were not fully aligned to what staff stated was on their worry list. In September 2019 a new red risk was added to the risk register. This was in relation to the medical cover within the critical care unit.

Amber risks included a number of issues regarding the environment and refurbishment, extended patients waits and concerns around the message centre process. The risk register we were provided with did not detail the date the risks had been added or the date for their review and/or removal.

We requested any underpinning documents that may have contained that detail, but we were not provided with any extra information. As such there was no evidence of how long the risks had been present or what actions were being taken to mitigate the risks.

When we spoke with senior leaders they told us their main concerns were around having sufficient staff available at times of peak activity and increased patient acuity. However, this was not recorded on the risk register. The divisional triumvirate told us that they were assured that this risk was managed through robust actions plans. However, having reviewed the risk register and associated risk assessment for the security of drug storage in main theatres, we found the assessment lacking in detail, reviews had not been timely, and actions remained outstanding. The current risk level on the divisional risk register was amber, risk rating 10. Current consequence was recorded as catastrophic with likelihood recorded as “expected to occur once every five years”. The trust had only reviewed the risk assessment following our raising (latest review dated 29 October 2019). The original risk assessment date had been 1 December 2015. The description of the issue included a recognition that there were a significant amount of drugs and intravenous fluids stored in the main theatre that were not locked away, but only included a potential risk that patient relatives could access these items. There was no consideration that there was a risk that these could be accessed by unauthorised staff.
It was noted in the risk assessment that there were two points of potential unauthorised access, between theatres and recovery and theatres and central delivery suite. We noted that magnetic locks were fitted in May 2019 at one of these two identified points (into the central delivery suite). An action remained in place to fit magnetic security locks to doors (exact location of which doors was not stated) with medium priority and due date of 1 January 2020. A second action, with high priority, was that a quote be obtained for fitting security to the cylinder room had the same due date of 1 January 2020.

There were different processes in place across the surgery service for storage and security of medications. It was unclear in the risk assessment provided as to why different practices varied. Despite a serious incident having occurred there was no timely review of the risk assessment or consideration of additional security measures required to mitigate unauthorised staff access to medications. Additional actions were still ongoing. The entry on the risk register was specifically for medication security in main theatres and did not address or review potential risk for day surgery. Audit process of these specialised areas also differed with divisional responsibility, with no involvement of pharmacy. We found inconsistencies with monitoring fridge temperatures and subsequent actions taken to ensure efficacy of medications were maintained. Therefore, we were not assured that the security, storage and medicine management processes across the service were robust.

Cost improvement plans were agreed at a local level and filtered through the divisional team to the executives. These were monitored at the performance meeting. Patient experience and outcomes within the division was good however the division recognised and had plans in place to address patients access to timely treatment.

**Information management**

The service collected data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff had access to up-to-date, accurate, and comprehensive information on patients’ care and treatment. Staff were aware of how to use and store confidential information. The service used a combination of paper and electronic records.

At the time of inspection there was a manual process being undertaken for review of theatre utilisation. The previous theatre system had become obsolete and had been replaced by a theatre module within the e-Care system however there had been a period of time between the two. The e-Care module had been introduced in March 2019, and a new theatre dashboard had been built and was in the process of being tested. Senior staff informed us that theatre productivity was discussed regularly at the weekly access meetings, performance review meeting and monthly theatre utilisation group.

We were informed that the e-Care dashboard was a bespoke development with the aim to enable more effective and efficient utilisation through accurate data capture and trend analysis. For example, the dashboard would include details such as the operating list start and finish times, over-runs and under runs of sessions, overall utilisation by specialty / consultant, timeliness of booking, cancelling and making available theatre sessions. However, this was yet to be fully implemented, with senior staff stating that the system would not begin to properly report for
another couple of months and that the information technology team had advised that it may take 12 months to be fully accurate.

The electronic system had inbuilt systems to identify patients living with a learning disability and those needing extra support.

There were arrangements in place which ensured data was submitted to external providers as required for example, serious incidents and never events. Data was used by the division in order to make decisions and to plan improvements to the patient experience. This included managing the referral to treatment times and improvements following the getting it right first time (GIRFT) audit undertaken in 2017.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Patients and relatives were given the opportunity to provide feedback using the NHS Friends and Family Test (FFT). Outcomes from this were discussed above under the ‘caring’ section of this report. The trust also engaged in a number of community meetings in order to gain feedback from patients, carers and relatives. The surgical division had positively interacted with the transgender community to ensure that patients engaged with the breast service.

The hospital’s communication team also shared ‘thank you Thursdays’ where they shared positive feedback from patients online. Staff on the surgical wards appreciated this method of sharing feedback.

Most staff felt that they could approach all levels of management and challenge in relation to poor care. Most staff felt encouraged to pursue initiatives that would improve care.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The surgical division could highlight a number initiatives which had improved care for patients. These included:

- Development of a human factors group to support staff and improve the safety of patients.
- Setting up of virtual clinics to improve patient access.
- Patient engagement sessions and tea party to gain feedback
- Dementia initiatives including reminiscence technology, visiting volunteers providing activities for patients.
- Engagement with Suffolk Artlink to support dementia care
- Introduction and roll out of diabetes hypo simulation education sessions
- Quality improvement initiative to promote recycling of plastics and waste
- Use of identified ‘Golden Patient’ to ensure positive utilisation of emergency theatre capacity.
Leaders encouraged staff to develop new initiatives to improve patient care. For example, the development of pathways for patients living with dementia. Managers also encouraged the staff to participate in research projects and attend the five o’clock club to learn and implement new initiatives.
Maternity

Facts and data about this service

The trust provided the following information about their maternity services:

The maternity service at West Suffolk Hospital delivers approximately 2,500 babies per year and offers a choice of three birth settings: around 2.5% of women delivered each year choose to birth at home; around 20% of women birth in the co-located low risk midwifery led birthing unit (MLBU); with the remainder of women delivering on the consultant led labour suite.

The service is provided by a team of consultant obstetricians, training grade doctors and midwives who work across the inpatient maternity areas. Community maternity services are provided by four teams of midwives who also provide care in the midwifery-led birthing unit.

Additionally, the maternity service has a number of specialist midwives. A perinatal mental health midwife works in partnership with the perinatal team at another trust.

Birth reflections is offered to all women following birth. The service has a midwife who leads on bereavement and offers ongoing support to women and partners who have suffered a pregnancy loss. This is supported by a specialist bereavement counselling service.

Midwives working in the community are addressing the public health issues that affect pregnant women. A specialist clinic is run with a local health and wellbeing coordinator for women who book with a raised body mass index (BMI). Additionally, target support is offered to all women who are smoking at the beginning of pregnancy.

(Source: Routine Provider Information Request (RPIR) – Acute context)

From January to December 2018 there were 2,309 deliveries at the trust.

A comparison from the number of deliveries at the trust and the national totals during this period is shown below.

Number of deliveries at West Suffolk NHS Foundation Trust – Comparison with other trusts in England
A profile of all deliveries and gestation periods at the trust from January to December 2018 can be seen in the tables below. The trust had a similar profile of deliveries in terms of single/multiple births, mother’s age and gestation period, when compared to the England averages.

**Profile of all deliveries (January to December 2018)**

<table>
<thead>
<tr>
<th></th>
<th>West Suffolk NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td><strong>Single or multiple births</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>2,272</td>
<td>98.8%</td>
</tr>
<tr>
<td>Multiple</td>
<td>28</td>
<td>1.2%</td>
</tr>
<tr>
<td><strong>Mother’s age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>72</td>
<td>3.1%</td>
</tr>
<tr>
<td>20-34</td>
<td>1,775</td>
<td>77.2%</td>
</tr>
<tr>
<td>35-39</td>
<td>379</td>
<td>16.5%</td>
</tr>
<tr>
<td>40+</td>
<td>74</td>
<td>3.2%</td>
</tr>
<tr>
<td><strong>Total number of deliveries</strong></td>
<td>2,300</td>
<td></td>
</tr>
</tbody>
</table>

Note: A single birth includes any delivery where there is no indication of a multiple birth. This table does not include deliveries where delivery method is ‘other’ or ‘unrecorded’.
### Gestation periods (January to December 2018)

<table>
<thead>
<tr>
<th>Gestation period</th>
<th>West Suffolk NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Under 24 weeks</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Pre term 24-36 weeks</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Term 37-42 weeks</td>
<td>2,141</td>
<td>93.2%</td>
</tr>
<tr>
<td>Post Term &gt;42 weeks</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td><strong>Total number of deliveries with a valid gestation period recorded</strong></td>
<td><strong>Total</strong></td>
<td><strong>2,298</strong></td>
</tr>
</tbody>
</table>

Notes: This table does not include deliveries where the delivery method is 'other' or 'unrecorded'. Gestation periods were unrecorded for 0.7% of deliveries at this trust compared to 18.7% nationally.

To protect patient confidentiality, figures between one and five have been suppressed and replaced with "*" (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, additional numbers (generally the next smallest) have also been suppressed.

(Source: Hospital Episodes Statistics (HES))

### Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

### Mandatory training

The service provided mandatory training in key skills to all staff. The service’s midwifery staff overall compliance rate of 91.2% was above the trust’s target of 90%. However, the service had low levels of compliance in maternity specific mandatory training such as Practical Obstetric Multi-Professional Training (PROMPT) and Gestation Related Optimal Weight (GROW) training.

### Mandatory training completion rates

The trust set a target of 90% for the completion of all mandatory training, with the exception of information governance training which had a target of 95%.

Please note that the trust’s medical staff work across both maternity and gynaecology. They only provided training data for maternity services based at West Suffolk Hospital.

West Suffolk Hospital
A breakdown of compliance for mandatory training courses as of June 2019 for qualified midwifery staff in maternity at West Suffolk Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Fire safety training - classroom</td>
<td>114</td>
</tr>
<tr>
<td>Medicine management (refresher)</td>
<td>113</td>
</tr>
<tr>
<td>Infection control - classroom</td>
<td>112</td>
</tr>
<tr>
<td>Fire safety training - e-learning</td>
<td>108</td>
</tr>
<tr>
<td>Blood products &amp; transfusion processes (refresher)</td>
<td>98</td>
</tr>
<tr>
<td>Basic life support (adult)</td>
<td>102</td>
</tr>
<tr>
<td>Moving and handling - clinical</td>
<td>104</td>
</tr>
<tr>
<td>Security awareness</td>
<td>103</td>
</tr>
<tr>
<td>Health &amp; safety / risk management</td>
<td>103</td>
</tr>
<tr>
<td>Slips trips falls</td>
<td>102</td>
</tr>
<tr>
<td>Blood borne viruses/inoculation incidents</td>
<td>97</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>100</td>
</tr>
<tr>
<td>MAJAX (Major accident)</td>
<td>99</td>
</tr>
<tr>
<td>Information governance</td>
<td>94</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>86</td>
</tr>
</tbody>
</table>

In maternity, the targets were met for seven of the 15 mandatory training modules for which qualified midwifery staff were eligible, and almost met for a further four modules. However, the services overall compliance rate for all modules was 90.2%.

A breakdown of compliance for mandatory training courses as of June 2019 for medical staff in maternity and gynaecology at West Suffolk Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>23</td>
</tr>
<tr>
<td>Security awareness</td>
<td>23</td>
</tr>
<tr>
<td>Health &amp; safety / risk management</td>
<td>23</td>
</tr>
<tr>
<td>Information governance</td>
<td>22</td>
</tr>
<tr>
<td>Slips trips falls</td>
<td>22</td>
</tr>
<tr>
<td>Infection control – e-learning</td>
<td>22</td>
</tr>
<tr>
<td>Blood borne viruses/inoculation incidents</td>
<td>21</td>
</tr>
<tr>
<td>Moving &amp; handling – e-learning</td>
<td>21</td>
</tr>
<tr>
<td>MAJAX (Major accident)</td>
<td>21</td>
</tr>
<tr>
<td>Medicine management (refresher)</td>
<td>21</td>
</tr>
<tr>
<td>Fire safety training - e-learning</td>
<td>21</td>
</tr>
<tr>
<td>Conflict resolution – e-learning</td>
<td>17</td>
</tr>
<tr>
<td>Fire safety training - classroom</td>
<td>20</td>
</tr>
</tbody>
</table>
In maternity and gynaecology, the targets were met for 11 of the 16 mandatory training modules for which medical staff were eligible, and almost met for a further training module. The overall compliance rate for medical staff was 82.8% which did not meet the service’s 90% target.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Midwifery staff received and kept up-to-date with their mandatory training with an overall compliance rate of 91.2%

The mandatory training was comprehensive and met the needs of women and staff. The service’s training was provided as online learning and face to face sessions. The service’s mandatory training was split into trust mandatory training and maternity specific mandatory training which included training on screening, smoking cessation, tissue viability, breastfeeding and diabetes.

The service used Practical Obstetric Multi-Professional Training (PROMPT) to deliver some of the maternity mandatory training. The topics covered by the PROMPT training included: fetal monitoring, inverted uterus, human factors, sepsis, Modified Early Obstetrics Warning Score, obstetric haemorrhage, shoulder dystocia, breech, eclampsia, twin birth and cord prolapse. The training was delivered by a multidisciplinary team and involved a mixture of skills and live drills sessions and presentations.

However, only 75% of midwives completed PROMPT training. Whilst this was in line with the trust’s target it meant that 25% of midwives did not have up to date training in emergency situations and cardiotocography training. This was also did not align to the PROMPT principles that say that 100% of the maternity team should be trained.

PROMPT training incorporated the service’s cardiotocography training, which meant that only 75% of staff were up to date with this training.

The service had poor training completion rates for the ‘Gestation Related Optimal Weight’ (GROW) e-learning, a recommendation from Saving Babies’ Lives 2019, 61% of midwives and 73% of doctors had completed the training.

Clinical staff completed training on recognising and responding to women with mental health needs and learning disabilities. The service’s maternity specific mandatory training included perinatal mental health training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training attendance was monitored electronically, and staff received reminders to complete training. Clinicians had to ensure their mandatory training was complete as a requirement to pass their appraisal.

Safeguarding

Staff were not following the service’s policy on domestic abuse and had not conducted any abduction drills. However, staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
Staff were not consistently asking women if they were at risk of domestic abuse when they were alone, in line with national guidance and the service’s policy. The National Institute for Health and Care Excellence clinical guideline CG11, September 2010 states that in order to facilitate discussion of sensitive issues, provide each woman with a one-to-one consultation without her partner, a family member or a legal guardian present, on at least one occasion. We reviewed twenty records to see whether women were asked whether they were at risk of domestic violence. We saw that women were asked in all 20 records but in seven records they were not asked when they were alone. This posed a risk that women would not disclose important information about their safety as they may not feel comfortable doing so. It also heightens the risk to women if asked in the presence of a perpetrator. Women who do not disclose their risk would not be able to access support services and appropriate safeguarding referrals would not be made.

**Safeguarding training completion rates**

The trust set a target of 90% for the completion of safeguarding training.

The tables below include Prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

Please note that the trust’s medical staff work across both maternity and gynaecology. They only provided training data for maternity services based at West Suffolk Hospital.

A breakdown of compliance for safeguarding training courses as of June 2019 for qualified midwifery staff in maternity at West Suffolk Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>114</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>114</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>112</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>112</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2 (basic prevent awareness)</td>
<td>110</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5 (prevent awareness)</td>
<td>83</td>
</tr>
</tbody>
</table>

In maternity, the 90% target was met for five out of the six safeguarding training modules for which qualified midwifery staff were eligible.

A breakdown of compliance for safeguarding training courses as of June 2019 for medical staff in maternity and gynaecology at West Suffolk Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>22</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>21</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5 (prevent awareness)</td>
<td>21</td>
</tr>
<tr>
<td>Prevalent radicalisation - levels 1 &amp; 2 (basic prevent awareness)</td>
<td>21</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>21</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>18</td>
</tr>
</tbody>
</table>

In maternity and gynaecology, the 90% target was met for all six safeguarding training modules for which medical staff were eligible.

*(Source: Routine Provider Information Request (RPIR) – Training tab)*

Midwifery and medical staff received training specific for their role on how to recognise and report abuse. We saw that medical staff have achieved the trust’s compliance rate of 90% in all topics. The service’s midwifery staff achieved the compliance rate in all topics except preventing radicalisation levels 3 to 5. The safeguarding training staff received included child sexual exploitation (CSE) and female genital mutilation (FGM).

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff performed risk assessments which identified women potentially at risk. Women at risk were referred to the appropriate members of the multidisciplinary team, all staff who were involved in the woman’s care pathway were notified and community midwives gave women a telephone number to contact the service if they felt endangered.

The service had purple pages for any peri-natal mental health referrals and placed purple dots on the woman’s records to highlight to staff that a safeguarding referral had been made.

The service had a baby abduction policy which all staff we spoke with were aware of. However, the service had not completed any baby abduction drills to practice the policy and ensure all staff were aware of their roles in a baby abduction incident. The manager of the antenatal and postnatal ward, F11, told us that they intended to have drills going forward. We were concerned that the service had not conducted drills as staff told us about two incidents in the service where abduction attempts had taken place but were unsuccessful.

The labour suite, birthing unit and maternity ward all had locked doors that were accessed using swipe cards by staff and an intercom system for women and their relatives to gain entry and leave the areas.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with were familiar with the process of escalation and referral to the safeguarding specialist for extra support and understood the reporting system for women presenting with FGM. Staff told us they were always able to get support from the lead safeguarding midwife if they needed advice.

Staff followed safe procedures for children visiting the ward. Visiting times were restricted for children, only siblings were able to visit the ward with the woman’s family members and had to be supervised at all times.
Cleanliness, infection control and hygiene

The service generally controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were generally clean and had suitable furnishings which were clean and well-maintained. However, we found that the services emergency trolley had a thick layer of dust in areas. We raised this as a concern with the midwife in charge and the trolley was cleaned.

The service generally performed well for cleanliness. Women were screened for Methicillin-resistant Staphylococcus aureus (MRSA) at booking. Where inpatient women had a known or suspected infection, they were cared for in single side rooms.

There had been no cases of C difficile or MRSA bloodstream infections in maternity from October 2018 to September 2019.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We saw that the services cleaning schedule was displayed on F11 ward. The service performed monthly Infection Prevention and Control (IPC) inspections and performed well. In September 2018, the service scored 97% for F11 ward.

The service audited hand hygiene and displayed the results at the entrance to F11 ward. We saw that for August 2019 the service scored 100%.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff using PPE which was readily available, such as disposable gloves and aprons. We observed that all staff were bare below the elbow and performed hand washing before and after episodes of direct care. Hand sanitising units and handwashing facilities were available throughout the unit and handwashing prompts were visible for staff, women and the public. However, we saw that suction packets and oxygen mask packets were open on the resuscitation trolley which posed an infection risk.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw that there was a system in use throughout the service to identify clean equipment by using ‘I am clean stickers’.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Women could reach call bells and staff responded quickly when called. Women we spoke with told us that staff responded to them quickly.

The design of the environment followed national guidance. The labour suite had been designed in accordance with the department of health’s building note 09-02: Maternity care facilities. The labour suite had been recently refurbished and the environment was comfortable and felt non-clinical.

The labour suite had been designed to enable women’s privacy. Each room had a light up sign above the door stating do not enter when the room was in use to ensure that the privacy and dignity of women was maintained.
The service had easy access to a theatre located at the end of the labour suite and access to a second theatre in the event of an emergency. The neonatal unit was close by if a baby’s condition deteriorated and they required an urgent transfer.

Staff did not always carry out daily safety checks of specialist equipment. We saw that staff completed daily checks of resus trolleys and emergency equipment on the, midwifery led birthing unit and F11 ward, however, on the labour suite we saw that checks were missing for four days in both August and September 2019.

The service had suitable facilities to meet the needs of women's families. The service’s labour suite had eight en-suite birthing rooms and the midwifery led birthing unit had a further four en-suite birthing rooms. There was a separate bereavement suite located on the labour suite with an en-suite and small living area for women’s families. One of the labour suite rooms had high dependency equipment and one room was used for women recovering from caesarean sections (CS).

The service had enough suitable equipment to help them to safely care for women and babies. We checked ten items of equipment and saw that they had up to date safety testing including resuscitaires, weighting scales and Dopplers, which are used to monitor output of fetal heartbeat.

Community midwives told us that they had good access to equipment and that they all carried carbon monoxide monitors, scales and dopplers with them. The community midwives had equipment checklists to ensure their equipment was up to date with servicing requirements.

Staff disposed of clinical waste safely. Clinical waste was placed in appropriate bags and removed from locked dirty utility room by hospital porters.

**Assessing and responding to risk to women and babies**

**Staff did not always complete and update risk assessments for each woman. Staff were not using a nationally recognised tool to identify if new born babies on the ward and women in the triage and maternity day assessment unit were at risk of deterioration. Staff did not record and monitor women’s carbon monoxide levels in line with policy.**

Staff used a nationally recognised tool to identify women at risk of deterioration however, staff were not consistently taking all observations required and scoring correctly on the Modified Early Obstetric Warning Score (MEOWS) charts. We reviewed 19 MEOWS charts in women’s records on the labour suite and F11 ward. We found in seven of the charts there were observations or scores missing. For example, one chart did not have respirations recorded on nine out of 30 occasions and another chart that did not have any respirations recorded on seven out of 11 occasions and eight out of 11 occasions observations had not been scored. This meant that women at risk of deterioration may not be identified.

Staff were not using a nationally recognised tool to identify new born babies at risk of deterioration. The service used a form that took basic observations but did not use a recognised national tool to score the observations, to easily detect babies at risk of deterioration. Staff told us that they would rely on clinical knowledge to detect deterioration in new born babies, observations were taken by band three maternity support workers who were not competency assessed to do so.

Staff did not always complete risk assessments for each woman on admission using a recognised tool, in all areas of the service. The recognised vital observations MEOWS tool was only used on the labour suite and the maternity ward. Women with concerns who accessed the triage area and
the maternity day assessment unit (MDAU) were not assessed using the nationally recognised tool.

The MDAU used a form to document women’s vital observations which included: pulse, blood pressure, temperature and urinalysis, but did not use a recognised national tool to take a full range of observations to include respirations and oxygen saturations, to score and detect any deterioration in women presenting with pregnancy complications. Women calling with concerns and attending the triage area and the MDAU were more likely to be high-risk.

Staff did not use a recognised tool to take vital observations for babies, staff told us that they would rely on clinical knowledge to detect deterioration in new-born babies. Observations were often taken by maternity support workers without evidence that training and clinical competencies were in place to enable them to detect deterioration.

We raised our concerns about the service not using nationally recognised tools to detect deterioration in all areas with the trust leadership team on our inspection. When we returned on our unannounced inspection on 11 October 2019 the service had not put in any measure to address our concerns. Following our unannounced inspection, the service leaders created an action plan which included the implementation of the Modified Early Obstetric Warning Score in the MDAU and triage areas.

Staff did not always deal with specific risk issues. For example, we found that carbon monoxide screening which is part of the ‘saving babies lives 2016’ initiative was not always performed in line with trust guidance. We reviewed 24 records for carbon monoxide monitoring and found that eight women’s records showed that they were not monitored in line with the trust’s policy.

Staff completed risk assessments for each woman at their initial booking visit and throughout their pregnancy. This included a history of previous pregnancies, family history, social, medical and mental health assessments. Staff knew about and dealt with certain specific risk issues, for example, assessments of venous thromboembolism (VTE) were completed in line with the service guidelines. VTE is a life-threatening condition where a blood clot forms in a vein.

The service was compliant with the World Health Organisations (WHO) surgical safety checklist that supported safer care and reduction in patient safety incidents. We observed part of a caesarean section list in theatre and saw that the checklist was completed appropriately. However, we requested the service’s swab count audits and action plans for the last 12 months and received just one audit that detailed out of ten records reviewed, two did not have completed swab counts. The service did not provide any action plans on re-audit to show improvement.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff within the service told us about the different options they had to access specialist mental health support. Staff within the service could refer to the local mental health trust’s peri-natal mental health team if they were concerned about a woman’s mental health. If staff were unsure of what input may be required, they could refer the woman to the service’s peri-natal mental health midwife who ran weekly peri-natal mental health clinics. Out of hours staff would refer women to the local crisis team.

Staff shared key information to keep women safe when handing over their care to others. Staff completed situation, background, assessment, recommendation (SBAR) templates on the electronic system prior to transferring women to another ward. SBAR is a tool used to facilitate prompt and appropriate communication between wards/services. We attended a staff handover between shifts and observed this format being used to discuss women on the labour suite.
The service had arrangements in place to ensure women using the service could access appropriate advice at any time. The service had a community led phone-line in place during working hours and women were provided the labour suite telephone number to contact should they have any concerns out of hours.

The service held ‘take five’ meetings Monday to Friday on the labour suite, birthing centre, theatres and maternity ward. The meetings communicated three main points and were repeated each day for a week to ensure that large numbers of staff got the message. The main points comprised of incident learning, safety alerts, concerns of managers or risks identified.

**Midwifery and nurse staffing**

The service did not always have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not always have enough nursing and midwifery staff to keep women and babies safe. The labour suite coordinator was not supernumerary which meant that in the event that a high number of women attended the labour suite then they would be providing one to one care for a woman and not facilitating the communication between professionals and overseeing the risk and appropriate use of resources. This was not in line with the Safer Childbirth recommendations, October 2007, which states that each labour ward must have a rota of experience senior midwives as labour ward shift coordinators, supernumerary to the staffing numbers required for one-to-one care.

Acuity is the measurement used to decide the level of care needed by a woman when in labour and giving birth. The labour suite did not use a recognised acuity tool to identify if the service had the correct number of midwives employed to match the acuity of women accessing the service. Staff we spoke with told us they were regularly very busy, and that community staff were often called in to assist the labour suite and birthing unit. However, the service had conducted a birth-rate plus staffing review in 2019 and found that the staffing levels were compliant, but they lacked a smoking cessation midwife which they were in the process of advertising for.

The ward manager could adjust staffing levels daily according to the needs of women. The service had an escalation policy which all staff we spoke with were aware of. The policy included calling in community midwives in the event of high levels of activity or staff shortages. Staffing was reviewed by senior leaders within the service four times a day.

The number of midwives and healthcare assistants on all shifts on each ward matched the planned numbers. We saw that midwife and midwifery care assistant numbers were displayed on the maternity ward and the labour suite on the days of our inspection and staffing numbers matched the expected levels.

**West Suffolk Hospital**

The table below shows a summary of the midwifery staffing metrics in maternity at West Suffolk Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Maternity (and gynaecology) annual staffing metrics</th>
</tr>
</thead>
</table>
Midwife staffing rates within maternity at West Suffolk Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and bank use. There was no agency use from May 2018 to April 2019.

Please note that the trust also reported nursing bank usage of 2,127 hours (3%) in community settings with 1,256 hours (2%) remaining unfilled by nursing bank and agency staff.

Vacancy rates

The service had low and reducing vacancy rates.

Monthly vacancy rates over the last 12 months for midwives in maternity showed a downward shift from October 2018 to March 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)
Sickness rates

Monthly sickness rates over the last 12 months for qualified midwives in maternity showed an upward trend from August 2018 to January 2019, although this did not continue.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank staff usage

Monthly bank hours over the last 12 months for qualified midwives were not stable and may be subject to ongoing change.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

The service had reducing rates of using bank staff.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The service did not use any agency staff and relied on bank staff. Staff who were members of the bank told us that it was easy to book onto shifts and that they could do this electronically through an “allocate me” app.

Managers made sure all bank staff had a full induction and understood the service. Staff we spoke with said that they used regular bank midwives who were familiar with the service or already...
worked for the service. The practice development midwife told us that bank staff received a full induction prior to starting their role.

**Midwife to birth ratio**

From January to December 2018, the trust had a ratio of one midwife to every 23.6 births. This was similar to the England average of one midwife to every 24.6 births.

*(Source: Electronic Staff Records – EST Data Warehouse)*

**Medical staffing**

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep women and babies safe. Medical staffing was planned and reviewed to enable women to receive care and treatment by the correct grade of medical staff. Staffing was available from a medical team consisting of a consultant, a middle doctor and a junior doctor 24hrs seven days a week. An anaesthetist was available 24 hours a day, seven days a week for the labour ward to administer an epidural or spinal anaesthesia.

Please note that the trust’s medical staff worked across obstetrics and gynaecology so the figures for all staff below include medical staff working across both maternity and gynaecology. The trust only provided medical staffing data for maternity services based at West Suffolk Hospital.

The table below shows a summary of the medical staffing metrics in maternity and gynaecology at West Suffolk Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Maternity and gynaecology annual staffing metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>April 2018 to March 2019</strong></td>
</tr>
<tr>
<td><strong>June 2018 to May 2019</strong></td>
</tr>
<tr>
<td><strong>Staff group</strong></td>
</tr>
<tr>
<td>Annual average establishment</td>
</tr>
<tr>
<td>Target</td>
</tr>
<tr>
<td>All staff</td>
</tr>
<tr>
<td>Medical staff</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)*

Medical staffing rates within maternity and gynaecology were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness and locum usage.
Vacancy rates

The service had low and reducing vacancy rates for medical staff.

Monthly vacancy rates over the last 12 months for medical staff in maternity and gynaecology showed a downward shift from October 2018 to March 2019.

Please note that the negative vacancy rate from August 2018 onwards indicates that the service was over-established.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Bank staff usage

The service had low rates of bank and locum staff.

Monthly bank hours over the last 12 months for medical staff in maternity and gynaecology at West Suffolk Hospital were not stable and may be subject to ongoing change.

(Source: Routine Provider Information Request (RPIR) – Medical locum agency tab)

Managers could access locums when they needed additional medical staff.

Managers made sure locums and junior doctors had a full induction to the service before they started work. Junior doctors received a trust induction and a full day local induction to the maternity service.
Staffing skill mix

In April 2019, 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 similar.

Staffing skill mix for the 22.1 whole time equivalent staff working in maternity at West Suffolk NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>54%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>0%</td>
<td>9%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>39%</td>
<td>44%</td>
</tr>
<tr>
<td>Junior*</td>
<td>7%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

The service had a good skill mix of medical staff on each shift. The service’s arrangements for handover ensured that people were safe. The service held handovers from the junior night staff at 8am, there was a 5pm board round and an 8pm handover and ward round for the night staff. Board rounds are a summary discussion of the women’s journey and what is required that day for it to progress.

The service always had a consultant on call during evenings and weekends. The service had a consultant anaesthetist on site from 8am to 6pm on weekdays. Consultant and anaesthetic cover were available 24 hours a day, seven days a week.

Records

Records were clear, up-to-date, stored securely and easily available to all staff providing care. However, records of women’s care and treatment were not always detailed.

Staff could access women’s records easily. The service had plans in place to have electronic records but at the time of our inspection were using paper records.

Women’s notes were not always comprehensive. Staff did not always complete the Modified Early Obstetric Warning Score. We have provided further detail in the assessing and responding to risk to women and babies section.
Records were stored securely. We saw that records were kept behind the nurse’s station in a closed cabinet. Previous records were stored securely in a locked room and sent to the site team for archiving.

When women transferred to a new team, there were no delays in staff accessing their records. All admissions had an electronic discharge letter sent to their GP. The service’s doctors prepared discharge letters if women went home with medication postnatally.

**Medicines**

**The service did not always safely store and prescribe medicines.**

Staff did not always follow systems and processes when administering, recording and storing medicines. Staff did not consistently record women’s weights when prescribing medicines. We reviewed 21 prescription charts and saw that 11 did not have women’s weights recorded.

We saw that staff kept records of medicines fridge temperatures on the labour suite, birthing unit and F11 ward. However, the service did not record the ambient air temperature of their medicine rooms. Medicines often have storage instructions that include not exceeding certain temperatures, therefore the service would not be able to determine if the medicines were still safe to use.

We saw that community midwives followed the service’s processes and policy for transporting medicines and ensured that they were within their expiry date by changing the medicines bi-monthly. We checked medicines in two community midwives’ cars and saw that they were all in date.

Staff reviewed women’s medicines regularly and provided specific advice to in relation to options of pain relief during and following the birth of their baby. The service had access to pharmacy staff to support the maternity areas.

Staff stored and managed medicines in line with the provider’s policy. Controlled medicines were stored in a double locked cabinet in line with The Misuse of Drugs (Safe Custody) Regulations (1973). We viewed the controlled drugs register on the birthing unit and saw that entries were correct, dated and signed.

Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines. All twenty prescription charts we reviewed had the correct medication prescribed for pregnant women, during and after the birth of their baby. Women received medicines on time and the charts were signed and dated correctly.

**Incidents**

**The service did not always manage safety incidents well.** Staff recognised incidents and near misses but did not always report them appropriately. However, managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women honest information and suitable support.

Staff did not always know what incidents to report. Staff told us about concerns they had with lack of access to equipment such as dopplers, delays with induction of labour for women and instances where women could not deliver in the birthing unit because of staffing pressures but told us that they did not report these occurrences as incidents.
The service did not always meet their own pathway deadlines for closing down incidents which stated all incidents investigations should be completed within 60 working days. At the time of our inspection there was 110 open incidents with the oldest incident dating back to April 2019.

Never events
The service had no never events on any wards. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From August 2018 to July 2019, the trust did not report any incidents that were classified as a never event in maternity.

(Source: Strategic Executive Information System (STEIS))

Managers shared learning with their staff about never events that happened elsewhere. Serious incident reports were shared through the local learning set. Learning was shared at the services women’s health governance meeting and the trust’s learning from deaths group.

Breakdown of serious incidents reported to STEIS
In accordance with the Serious Incident Framework 2015, the trust reported six serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from August 2018 to July 2019.

A breakdown of the incident types reported is in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity/obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)</td>
<td>5</td>
<td>83.3%</td>
</tr>
<tr>
<td>Maternity/obstetric incident meeting SI criteria: mother only</td>
<td>1</td>
<td>16.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

The five serious incidents relating to the baby only occurred within the labour suite at West Suffolk Hospital. However, the remaining incident related to a maternal death at another hospital following complications from an emergency caesarean section at the trust.

(Source: Strategic Executive Information System (STEIS))

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong. We saw evidence that the duty of candour had been completed for the five serious incident reports we reviewed. Most staff we spoke with could explain the process.

Staff received feedback from investigation of incidents, both internal and external to the service. We saw that arrangements for sharing learning and feedback from serious incidents always included staff who were involved in the investigation. Wider learning was shared through the service’s monthly incident newsletter “risky business” and daily “take five” meetings.
Staff met to discuss the feedback and look at improvements to women's care. The service’s medical team met weekly for clinical reviews that discussed any cases where there had been incidents where learning had been identified by the medical team. These were attended by the obstetric team, anaesthetists and neonatal medical teams.

There was evidence that changes had been made as a result of feedback. Staff could provide examples of changes that had been made following incidents. For example, following a number of incidents where babies deteriorated because they were cold, staff provided a leaflet to new mums about the ideal temperature for babies and clothing used to keep them warm.

Managers investigated incidents thoroughly. Women and their families were involved in these investigations. We saw in the five serious incident investigation reports that we reviewed that women and their families had been invited to contribute and in one serious incident a woman and her partner provided a series of questions they wished to have answered from the investigation. Women were invited to meet with the clinicians involved with their care as part of the serious incident process.

Managers debriefed and supported staff after any serious incident. Service leads had put in place processes to support staff following traumatic events, which included debrief sessions held by the trust’s clinical psychologist.

Safety thermometer

The service did not use monitoring results well to improve safety. Safety information was not shared with staff, women and visitors. The service did not participate in the maternity safety thermometer.

The service participated in the trust safety thermometer which was not maternity specific and displayed the results at the entrance to F11 ward. The trust safety thermometer looked at falls and pressure ulcer incidents, however it did not cover the areas of the maternity safety thermometer which were; perineal and abdominal trauma, post-partum haemorrhage, infection and separation from baby. This meant the maternity specific information on safety was not shared with women and staff or used to improve safety.

We asked leaders within the service why they do not contribute to the maternity safety thermometer and we were told that the service had tried to implement it before but the staff compliance to use the maternity safety thermometer was difficult to embed, so managers agreed not to use it.

Is the service effective?

Evidence-based care and treatment

A significant number of the service’s clinical guidelines were out of date which meant that treatment provided may not be based on national guidance and best practice. Staff protected the rights of women subject to the Mental Health Act 1983.

The service had a number of out of date guidelines. We requested the number of out of date guidelines the service had and any mitigating actions for this. The service’s data request showed that there were 23 out of date guidelines at the time of our inspection. The service’s Women
“Attending A&E or Admitted Under Other Specialist Teams” guideline had a review date of December 2014 which meant that at the time of our inspection it was nearly five years out of date.

Six of the guidelines were in the process of being updated. Seven were delayed due to updates in national guidance or process changes there was no timeframe given as to when they would be renewed. The service leaders did not provide any reasoning or mitigation for the other ten out of date guidelines.

There was a process in place to review guidelines. They were reviewed by senior staff and shared with staff for a consultation prior to being signed off at the women’s health governance meetings. Guidelines were available on the intranet and staff knew where to find them.

We were not assured that staff were always following national guidance due to the high number of guidelines that were out of date. However, we observed staff used the sepsis six bundle to treat women suspected to have sepsis, all staff we spoke with were aware of the bundle and the actions to be taken if sepsis was suspected.

The service was in the process of implementing the recommendations from NHS England’s saving babies lives version two. Including the continuity of carer for women, the service decided to focus this initiative firstly for women undergoing an elective caesarean section. The service had a team of two midwives based in the hospital who attended women’s antenatal clinic appointments, went into theatre with them and provided their post-natal care. Evidence shows that the continuity models improve safety and outcomes.

The service had an evidence-based guideline in place for accessing the service’s perinatal mental health support. However, whilst the bereavement midwife was providing women with compassionate support and care, there was no formal bereavement care plan or pathway in place.

Staff protected the rights of women subject to the Mental Health Act and followed the Code of Practice. Staff we spoke with could describe processes to make a referral if a woman needed support from the specialist mental health midwife and mental health team. The service had created a guideline and Red-Amber-Green rated referral criteria cards for women with mental health concerns in order to be able to direct midwives to the most appropriate referral for the woman’s symptoms.

**Nutrition and hydration**

**Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women’s religious, cultural and other needs.**

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. We observed staff regularly offering women drinks. Outside of meal times staff had access to snack boxes for women and could make them toast. If a woman needed a referral for dietary support staff were able to access the trust’s dietician.

Specialist support from staff such as breastfeeding specialist midwives was available on the maternity ward. The service was accredited with full Baby Friendly status (Level 3) by the Baby Friendly Initiative.

There was a small fridge on F11 ward used to store expressed milk. We saw that this fridge was kept locked, the temperature monitored and that the milk inside was labelled and dated.
Pain relief

Staff did not always assess and monitored women regularly to see if they were in pain. However, women told us staff gave pain relief in a timely way.

Staff assessed women’s pain using a recognised tool and gave pain relief in line with individual needs and best practice. However, we saw that women’s pain was not consistently recorded using the MEOWS pain scoring tool. We reviewed five charts and saw that only one had pain scoring completed. Following our inspection the service conducted an audit into MEOWS charts and found that the service did not consistently record women’s pain scores.

Women received pain relief soon after requesting it. Women we spoke with told us that their pain had been well managed by the service.

Staff prescribed, administered and recorded pain relief accurately in the 21 prescription charts we reviewed.

Maternity outcomes

We were not assured that staff monitored the effectiveness of care and treatment or used the findings to make improvements and achieve good outcomes for women.

There was no evidence that the service participated in relevant national clinical audits. We requested the service provided us with all of their action plans from both national and local audits. We were provided with an overarching maternity action, which did not include actions from specific national audits such as the Neonatal Audit Programme, National Maternity and Perinatal Audit Programme or MBRRACE-UK Perinatal Mortality Surveillance Report. Therefore, we were not assured they were monitoring their outcomes effectively.

The service did provide us with an action plan for the avoiding term baby admissions to the neonatal unit and an action plan for implementing NHS England’s Saving Babies Lives 2.

The service had a comprehensive audit programme to follow, which was monitored at the maternity service governance meetings. However, the service did not send us any of the audit outcomes or action plans we requested, therefore we could not determine whether learning from audits was shared or used to improve outcomes for women.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The service had a rolling local audit plan in place which assigned audits and actions to members of staff. Local audits included ultrasound scanning, induction of labour, water oil study and intrapartum care for women with existing medical conditions or obstetric complications and their babies.

National Neonatal Audit Programme

The table below summarises West Suffolk Hospital's performance in the 2018 National Neonatal Audit Programme against measures related to maternity care.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Meets national standard?</th>
</tr>
</thead>
</table>

20190416 900885 Post-inspection Evidence appendix template v4
Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?
(Antenatal steroids reliably reduce the chance of babies developing respiratory distress syndrome and other complications of prematurity)

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>92.2%</td>
<td>Within expected range</td>
<td>Met</td>
</tr>
</tbody>
</table>

Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?
(Administering intravenous magnesium to women who are at risk of delivering a preterm baby reduces the chance that the baby will later develop cerebral palsy)
(Source: National Neonatal Audit Programme)

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>58.3%</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

### National Maternity and Perinatal Audit Programme

The table below summarises West Suffolk Hospital’s performance in the 2017 National Maternity and Perinatal Audit Programme against measures related to maternity care.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust-level case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>101.7%</td>
<td>n/a</td>
<td>Met</td>
</tr>
<tr>
<td>Antenatal measures (before birth, during or relating to pregnancy)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case-mix adjusted proportion of small-for-gestational-age babies (birthweight below 10th centile) who are not delivered before their due date (Babies who are small for their age at birth are at increased risk of problems before, during and after birth)</td>
<td>54.7%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Intra-partum measures (during labour and birth)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case-mix adjusted proportion of elective deliveries (caesarean or induction) between 37 and 39 weeks with no documented clinical indication for early delivery (For babies with a planned (or elective) birth, being born before 39 weeks is associated with an increased risk of breathing problems. This can lead to admission to the neonatal unit. There is also an association with long term health and behaviour problems)</td>
<td>17.3%</td>
<td>Lower than expected</td>
<td>No current standard</td>
</tr>
</tbody>
</table>
### Case-mix adjusted overall caesarean section rate for single, term babies

(The overall caesarean section rate is adjusted to take into account differences which may be related to the profile of women delivering at the hospital)

<table>
<thead>
<tr>
<th>Rate</th>
<th>Status</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>20.3%</td>
<td>Lower than expected</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

### Case-mix adjusted proportion of single, term infants with a 5-minute Apgar score of less than 7

(The Apgar score is used to summarise the condition of a new-born baby; it is not always a direct consequence of care given to the mother during pregnancy and birth, however a 5-minute Apgar score of less than 7 has been associated with an increased risk of problems for the baby)

<table>
<thead>
<tr>
<th>Rate</th>
<th>Status</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>n/a</td>
<td>n/a</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

### Case-mix adjusted proportion of vaginal births with a 3rd or 4th degree perineal tear

(Third or fourth degree tears are a major complication of vaginal birth. Only tears that are recognised are counted therefore a low rate may represent under-recognition as well as possible good practice)

<table>
<thead>
<tr>
<th>Rate</th>
<th>Status</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.2%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

### Case-mix adjusted proportion of women with severe post-partum haemorrhage of greater than or equal to 1500 ml

(Haemorrhage after birth is a major source of ill health after childbirth. Blood loss may be estimated by visual recognition or by weighing lost blood. High rates may be due to more accurate estimation and low rates due to under-recognition)

<table>
<thead>
<tr>
<th>Rate</th>
<th>Status</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.4%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

### Post-partum measures (following birth)

Proportion of live born babies who received breast milk for the first feed and at discharge from the maternity unit

(Breastfeeding is associated with significant benefits for mothers and babies. Higher values represent better performance)

<table>
<thead>
<tr>
<th>Rate</th>
<th>Status</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>76.9%</td>
<td>Middle 50%</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Maternity and Perinatal Audit Programme)

### Standardised caesarean section rates and modes of delivery

From January to December 2018, the total number of caesarean sections was lower than expected. The standardised caesarean section rates for elective and emergency sections were similar to expected.
## Standardised caesarean section rate (January to December 2018)

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>West Suffolk NHS Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caesarean rate</td>
<td>Caesareans (n)</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>12.8%</td>
<td>230</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>16.5%</td>
<td>297</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>29.3%</td>
<td>527</td>
</tr>
</tbody>
</table>

Notes: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries. Delivery methods are derived from the primary procedure code within a delivery episode. This table includes all deliveries, including where the delivery method is 'other' or 'unrecorded'.

In relation to other modes of delivery from January to December 2018 the table below shows the proportions of deliveries recorded by method in comparison to the England average. The non-interventional delivery rate at the trust was higher than the England average.

## Proportions of deliveries by recorded delivery method (January to December 2018)

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>West Suffolk NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections&lt;sup&gt;1&lt;/sup&gt;</td>
<td>527</td>
<td>22.9%</td>
</tr>
<tr>
<td>Instrumental deliveries&lt;sup&gt;2&lt;/sup&gt;</td>
<td>290</td>
<td>12.6%</td>
</tr>
<tr>
<td>Non-interventional deliveries&lt;sup&gt;3&lt;/sup&gt;</td>
<td>1,483</td>
<td>64.5%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>2,300</td>
<td>100%</td>
</tr>
</tbody>
</table>

Notes: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

<sup>1</sup>Includes elective and emergency caesareans
<sup>2</sup>Includes forceps and ventouse (vacuum) deliveries
<sup>3</sup>Includes breech and vaginal (non-assisted) deliveries

(Source: Hospital Episode Statistics (HES))

### Maternity active outlier alerts

As of 2 August 2019, the trust had no active maternity outliers.

(Source: Hospital Episode Statistics (HES))

### MBRRACE-UK Perinatal Mortality Surveillance Report

Stabilised and risk-adjusted perinatal mortality rate
(The death of a baby in the time period before, during or shortly after birth is a devastating outcome for families. There is evidence that the UK’s death rate varies across regions, even after taking into account differences in poverty, ethnicity and the age of the mother.)

|        | 4.83 | Up to 10% higher than the average for the comparator group | No current standard |

(Source: MBRRACE-UK)

We asked service leaders why the mortality rate was higher for this service than the average for the comparator group, but staff could not provide us with a clear answer. Senior leaders told us it was possibly because some women birth out of local area. We were concerned that there did not seem to be an action plan in place to improve the outcomes.

### Competent staff

We were not assured that the service made sure staff were competent for their roles. The service did not meet targets for midwifery appraisal rates and leaders within the service did not hold supervision meetings with midwives to provide support and development.

We were not assured that managers supported staff to develop through regular, constructive clinical supervision. The service had not put in any processes to replace the supervisor of midwives role. NHS England developed an employer-led model of midwifery clinical supervision to replace the former statutory model, but this had not been implemented by the trust. We were concerned that leaders within the service were unable to tell us how they are ensuring midwives received clinical supervision and were unfamiliar with NHS England’s new model.

Managers did not support midwifery staff to develop through regular, constructive clinical supervision of their work. All midwives we spoke to on our inspection told us that they found their recent appraisal meaningful and that they had good access to training and development. However, we saw in the staff survey that only 17.5% of staff found that their appraisal helped improve how they did their job and 44% of staff felt supported by their manager to receive training, learning or development.

### Appraisal rates

The service did not meet the trust target for appraisals between March 2018 and April 2019. When we spoke with senior leaders on our inspection they told us that the current rolling appraisal rate was around 83% for midwives, which was still below the 90% target. However, the service’s current appraisal rate for medical staff was complaint at 92.9%.

Please note that the trust’s medical staff work across both maternity and gynaecology. They only provided appraisal data for maternity services based at West Suffolk Hospital.

From April 2018 to March 2019, 83.7% of required staff in maternity (and gynaecology for medical staff) at West Suffolk Hospital received an appraisal, which was below the trust target of 90%. The breakdown by staff group can be seen in the table below:
### Staff group breakdown for appraisals April 2018 to March 2019

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff who received an appraisal</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>21</td>
<td>23</td>
<td>91.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Midwifery registered</td>
<td>78</td>
<td>97</td>
<td>80.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>12</td>
<td>15</td>
<td>80.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>123</strong></td>
<td><strong>147</strong></td>
<td><strong>83.7%</strong></td>
<td><strong>90%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

All medical working across maternity and gynaecology at West Suffolk Hospital had received an appraisal. However, only 80.4% of registered midwifery staff in maternity had received an appraisal.

Updated analysis for April 2019 to mid-June 2019 found that 18.4% of required staff in maternity (and gynaecology for medical staff) at West Suffolk Hospital received an appraisal compared to the trust target of 90%. The breakdown by staff group can be seen in the table below:

### Staff group breakdown for appraisals April 2019 to mid-June 2019

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff who received an appraisal</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative and clerical</td>
<td>6</td>
<td>15</td>
<td>40.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>18</td>
<td>97</td>
<td>18.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>2</td>
<td>23</td>
<td>8.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>1</td>
<td>12</td>
<td>8.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>27</strong></td>
<td><strong>147</strong></td>
<td><strong>18.4%</strong></td>
<td><strong>90%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

None of the staff groups in maternity (and gynaecology for medical staff) met the 90% target. However, this data only represents a partial year and so we would not expect a high appraisal completion rate.

(Source: Routine Provider Information Request (RPIR) – Appraisals tab)

All midwives’ appraisals were completed by the service’s band seven coordinators (senior midwives). Staff reported it was challenging completing appraisals due to staffing shortages. Reminders that appraisals were due were sent by the service’s inpatient manager.

Managers gave all new staff a full induction tailored to their role before they started work. The induction included two weeks in the community setting and two weeks in the hospital setting, as well as pairing new staff with a buddy and ensuring they completed competency assessments.

The clinical educators supported the learning and development needs of staff. The service had one practice development midwife (PDM) who worked 30 hours per week. The PDM’s role included organising mandatory training, inductions for new staff and band five midwives’ (junior midwives) preceptorship training. A preceptorship is a period to guide and support all newly qualified practitioners to make the transition from student to develop their practice further.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us about specialist training they had received for their role. The services specialist midwives had received external training specific to their roles. For
example, one specialist midwife had accessed training from the institute of health visiting and infant mental health training.

Managers made sure staff received any specialist training for their role. The service operated skills and drills sessions and recent drills had included emergency pool evacuation. The service’s mandatory training included training from the peri-natal mental health midwife on mental health and the service’s bereavement midwife provided training on supporting women to manage a bereavement.

Managers identified poor staff performance promptly and supported staff to improve. The service had a formal performance management programme in place and the service’s practice development midwife helped supervise and create action plans for staff who were not performing well.

**Multidisciplinary working**

Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss women and improve their care. We observed respectful relationships during our inspection. Staff spoke highly of their colleagues. Multidisciplinary teams worked together in the antenatal clinic to provide holistic care for women. For example, in the diabetes clinic women could receive a joint consultation with the consultant endocrinologist, diabetes nurse, consultant obstetrician and midwife with a specialist interest in diabetes.

Staff worked across health care disciplines and with other agencies when required to care for women. Staff worked as a team which ensured women received holistic woman centred care. We observed a multidisciplinary handover on the labour suite with midwives and obstetricians present. This included sharing information, risk assessments, and the woman’s emotional and social needs. Neonatologists attended the ward to perform a ward round at 11 am every day and midwives told us that they worked well as a team.

Midwives in the service ran clinics in the antenatal clinic which received good support from the consultants and anaesthetists within the service. Staff told us about the birth choices clinic which was for women who were fearful of giving birth or had a difficult experience during a previous birth. Staff told us that the midwives, anaesthetists and consultants all worked together to ensure women had an enhanced, individualised birth plan that the woman was happy with.

The service held monthly multidisciplinary meetings to discuss women who had been identified as having a fetal abnormality during their pregnancy. These were attended by obstetricians, paediatricians, the lead screening midwife, the inpatient service manager and the neonatal unit lead. The meetings ensured that appropriate plans were in place for these women and their babies.

The service’s transitional care bay had neonatal nurses, midwives, neonatologists and obstetricians worked together to care for women and their babies.

Staff referred women for mental health assessments when they showed signs of mental ill health, depression. The service had a specialist midwife in post to support women at risk of, or with mental health conditions. Staff sought advice from the specialist midwife who provided support to women themselves or referred women to the local mental health trust’s peri-natal mental health
team. Support provided by the peri-natal mental health midwife included a weekly clinic to assess women’s peri-natal mental health needs, advanced care planning and referrals to mental health services.

Seven-day services

**Key services were available seven days a week to support timely care.**

Consultants led daily ward rounds on the labour suite and maternity ward, including weekends. Women were reviewed by consultants depending on their care pathway. All women assessed as high risk were reviewed by a consultant. A dedicated obstetric theatre team were available seven days a week and an anaesthetist was immediately available for emergencies on the labour suite.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Community midwives made home visits and held antenatal and postnatal clinics seven days a week and provided a seven-day, 24-hour home birth service.

Health promotion

**Staff gave women practical support and advice to lead healthier lives.**

The service had relevant information promoting healthy lifestyles. Community midwives referred women to a local scheme which promoted healthy lifestyles. Sessions were run at local leisure centres and included presentations on diet and mental health as well as providing exercise classes. The scheme was available to women who had a Body Mass Index over 25, were smokers or were experiencing mental health concerns.

Staff assessed each woman’s health at booking and provided support for any individual needs to live a healthier lifestyle. Women who smoked were offered smoking cessation support and all women were offered the whooping cough and flu vaccine.

The service had a parent education room in the antenatal clinic area which ran classes to prepare women and their partners for their baby these included; breastfeeding workshops, home birth classes, caesarean section classes and parenting classes.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

**Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.**

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. Staff told us of their roles and responsibilities if a woman was identified with mental health illness.

Staff gained consent from women for their care and treatment in line with legislation and guidance. Staff made sure women consented to treatment based on all the information available.

We observed staff gaining consent prior to procedures and treatments. We reviewed documented consent in medical records, for example, medical for vaginal examinations and caesarean sections. Staff clearly recorded consent in the five woman's records we reviewed for consent.
Staff understood Gillick Competence and Fraser Guidelines and supported young people who wished to make decisions about their treatment if they were under the age of 16. The Fraser guidelines refer specifically to consent for sexual health services and are an additional guideline to the Gillick competency framework that relates to consent for any healthcare intervention.

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that Mental Health Act (MHA), Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) are covered in the safeguarding adults training.

The trust set a target of 90% for the completion of safeguarding adults training.

Please note that the trust’s medical staff work across both maternity and gynaecology. They only provided training data for maternity services based at West Suffolk Hospital.

A breakdown of compliance for safeguarding adults training as of June 2019 for midwifery and medical staff working across maternity and gynaecology at West Suffolk Hospital is shown below:

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwifery staff</td>
<td>112</td>
<td>115</td>
<td>97.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical staff</td>
<td>22</td>
<td>23</td>
<td>95.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In maternity, the 90% target for safeguarding adults training was met by qualified midwifery and medical staff working across maternity and gynaecology.

(Source: Routine Provider Information Request – Training tab)

Midwifery and medical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff compliance exceeded the trust’s target of 90%.

**Is the service caring?**

**Compassionate care**

Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way. We observed all staff caring for women and partners with compassion.

Women said staff treated them well and with kindness. We saw thank you cards were displayed on the labour suite which had comments about the care received during women’s stay which included:

- “you made me feel so welcome”
- “Thank you to all the team for the hard work, kindness, and help”
- “none of us will ever be able to thank you enough for the care and compassion the entire team gave to us”.
Staff followed policy to keep women’s care and treatment confidential. The labour suite had light up signs on the doors to ensure women were not disturbed unnecessarily when in labour.

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude when caring for or discussing women with mental health needs. All staff that we spoke with were aware of the support from the perinatal midwife and were passionate about ensuring women’s mental health was a priority in the service.

Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs. Staff told us that if women required further support they could refer them to an appropriate specialist midwife including the perinatal mental health or bereavement support midwife.

Staff demonstrated kindness and compassion when dealing with women who had experienced a stillbirth. We saw from a serious incident report from July 2019 that following a stillbirth a woman was transferred to the intensive care unit due to a large post-partum haemorrhage. The senior midwife then attended the intensive care unit with the baby in a cold cot to provide bereavement support and complete a memory box and keepsakes with the woman.

Women were cared for in a subsequent pregnancy if they had previously suffered a bereavement by the birth choices antenatal clinic and the bereavement midwife. The bereavement midwife arranged early viability scans for women to help ease any anxieties. Staff could give us examples of providing additional support to these women including the bereavement midwife making bi-monthly appointments with a woman, so she could listen to the fetal heartbeat to support the woman.

Friends and family test performance (antenatal), West Suffolk NHS Foundation Trust

![Graph]

From July 2018 to November 2018 the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar or better than the England average.

In December 2018 and January 2019 there were fewer than five responses and so the rates were suppressed to protect patient confidentially while, from February to June 2019, the trust did not report on Friends and Family Test (antenatal) performance.

Friends and family test performance (birth), West Suffolk NHS Foundation Trust
During July and August 2018, the trust’s maternity Friends and Family Test (birth) performance (% recommended) was better than the England averages. In September and October 2018, there were fewer than five responses and so the rates were suppressed to protect patient confidentiality while, from November 2018 to June 2019, the trust did not report on Friends and Family Test (birth) performance.

Friends and family test performance (postnatal ward), West Suffolk NHS Foundation Trust

From July 2018 to November 2018 and from January to February 2019, the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to the England average.

In December 2018, there was fewer than five responses and so the rate was suppressed to protect patient confidentiality while the trust did not report on Friends and Family Test (postnatal ward) performance from March 2019 to June 2019.

Friends and family test performance (postnatal community), West Suffolk NHS Foundation Trust

From July 2018 to June 2019 the trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average.

(Source: Friends and Family Test – NHS England)

CQC Survey of women’s experiences of maternity services 2018
The trust performed better than other trusts for three out of the 19 questions, and about the same as other trusts for the remaining 16 questions in the CQC maternity survey 2018.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score (0-10)</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Labour and birth</strong></td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>9.2</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>7.7</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>9.4</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.9</td>
<td>Better</td>
</tr>
<tr>
<td><strong>Staff during labour and birth</strong></td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.6</td>
<td>Better</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>7.7</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>8.4</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If attention was needed during labour and birth, did a staff member help you within a reasonable amount of time</td>
<td>9.2</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.7</td>
<td>Better</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>8.6</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.3</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>9.1</td>
<td>About the same</td>
</tr>
<tr>
<td><strong>Care in hospital after the birth</strong></td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>7.6</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Looking back, was there a delay in being discharged from hospital?</td>
<td>4.8</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about response time, if attention was needed after the birth, did a member of staff help within a reasonable amount of time?</td>
<td>7.6</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>8.0</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>8.7</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your stay in hospital, was your partner who was involved in your care able to stay with you as much as you wanted?</td>
<td>5.1</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>9.3</td>
<td>About the same</td>
</tr>
</tbody>
</table>
Emotional support

**Staff provided emotional support to women, families and carers to minimise their distress. They understood women's personal, cultural and religious needs.**

Staff gave women and those close to them help, emotional support and advice when they needed it. Staff supported women emotionally throughout their pregnancy. Support services were available, and staff could refer women for counselling. We saw from the service’s serious incident reports that women who had experienced inter-uterine deaths had received ongoing support from the bereavement midwife.

Staff undertook training on bereavement and demonstrated empathy when having difficult conversations. Bereavement sessions were part of the service mandatory training programme and were facilitated by the service’s bereavement midwife and the trust’s chaplain.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Staff we spoke with were passionate about supporting women at all stages of their pregnancy.

The antenatal midwives had introduced reflections and birth choices clinics. The reflections clinics provided women with the ability to debrief after a traumatic birth and gave them the opportunity to speak with an obstetrician and a midwife and ask questions about their experiences. The birth choices clinic was for women who were fearful of giving birth and provided women with emotional support. The service also ran a perennial trauma clinic for women who had suffered third- and fourth-degree tears during labour. A tear involves the skin and muscle of the perineum which is the area between the vagina and back passage, a third-degree tear extends downwards from the vagina through the perineum to the anal sphincter (muscle around the back passage). A fourth-degree tear extends down to the anal canal (into the back passage). The midwives who ran the clinics had received additional training in counselling skills.

Staff told us about one occasion where a woman wanted her partner present at her birth choices clinic, but they could only come at the weekend. To ensure that the woman received the support and care she wanted staff arranged for a weekend session on their day off to meet her needs.

The bereavement midwife supported women and their families through stillbirth and maternal death. The bereavement midwife told us that they spoke regularly with women and their families on the phone to provide emotional support and arranged case reviews, coordinated any genetic testing results and assisted with funeral arrangements.

Understanding and involvement of patients and those close to them

**Staff supported women, families and carers to understand their condition and make decisions about their care and treatment. However, women and their families were not always given the opportunity to provide feedback on the service and their treatment.**

Staff made sure women and those close to them understood their care and treatment. All women we spoke with told us that staff had taken their time to explain care and that they were clear on their treatment plans.

Staff supported women to make advanced decisions about their care. Women were given the opportunity of making an informed choice about the available birth settings that were appropriate...
and safe for their clinical need and risk. Dependant on their risk women decided between 36 and 40 weeks of pregnancy whether they wanted to deliver at home, on the birthing unit or on the labour suite.

Staff supported women to make informed decisions about their care. Staff told us that they were passionate about being advocates for women and encouraged them to make choices based on all the information available.

Women and their families were not always given the opportunity to provide feedback on the service and their treatment. Data had not been collected for the friends and family test for the labour suite and birthing unit since October 2018 and no data had been returned for F11 ward since February 2019.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. Since our previous inspection, the service had implemented a communication hub which was ran by midwives, women could ring in and speak to a midwife if they had any concerns or to book appointments.

Service administrators tried to ensure that women saw the same consultant at all of their antenatal appointments to improve continuity of care. The service had recently introduced a continuity of care service for women who were having elective caesarean sections. This meant that the same midwife attended antenatal appointments, the caesarean section and cared for the woman postnatally.

Facilities and premises were appropriate for the services being delivered. The trust’s website offered virtual tours to help orientate women before they attended the service.

Staff we spoke with in the antenatal clinic told us that they had a private room designated for breaking bad news in the clinic with comfier chairs and tissues.

The service had cold cots so that stillborn babies could be kept with their parents for longer. The service also had facilities to create memory boxes and hands and feet mould keepsakes for parents.

Staff could access emergency mental health support 24 hours a day 7 days a week for women with mental health problems and learning disabilities. Staff had access to the service’s peri-natal mental health midwife and the local peri-natal mental health team from the local mental health trust within working hours. Out of hours staff knew to contact the areas crisis support team.

The service had systems to help care for women in need of additional support or specialist intervention. Women were booked by a midwife to lead their care, if identified as high-risk women were allocated a consultant obstetrician to share the care. Women identified with complex pregnancies who required fetal medicine investigations were referred to the antenatal screening midwife and the consultant responsible for fetal medicine.
The service had introduced sessions to assist women in their choices on where to give birth, which included a monthly home birth group hosted by midwives who discussed the home birth process with women.

The antenatal service ran clinics to give women additional support if they were fearful about giving birth, had experienced a traumatic birth and vaginal birth after caesarean section clinics. The birth choices clinics provided women with the opportunity to discuss their birth options in greater detail and create an enhanced birth plan with the midwife.

Managers ensured that women who did not attend appointments were contacted. Women who did not attend antenatal appointments were contacted by telephone and had a subsequent appointment arranged. In instances where a woman was not contactable or repeatedly missed appointments, staff told us that a safeguarding referral would be completed.

The service ensured continuity of care and support on transition between antenatal, labour and birth and postnatal care by using a nationally recognised handover method.

**Bed Occupancy**

From October 2017 to March 2019 the bed occupancy levels for maternity were consistently lower than the England average, with the trust having 25.4% occupancy in 2018/19 quarter 4 (January to March 2019) compared to the England average of 56.5%.

The chart below shows the occupancy levels compared to the England average over the period.

(Source: NHS England)

**Meeting people’s individual needs**

The service was inclusive and took account of women’s individual needs and preferences. Staff made reasonable adjustments to help women access services.

Staff made sure women living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Community midwives told us that they were
allocated extra time for antenatal appointments for vulnerable women to ensure their needs are met.

The perinatal mental health midwife worked alongside women and the local mental health trust to create individualised birth plans for women with mental health needs using the service.

Staff supported women living with learning disabilities by using ‘This is me’ documents and patient passports. Staff understood and applied the policy on meeting the information and communication needs of women with a disability or sensory loss. During our inspection, a woman with a sensory loss was staying on F11, staff had ensured that she had been seen by the trust’s sensory team, that she had an individualised care plan, allocated a side room to suit her needs and allowed her partner to stay to support her.

Staff within the service told us about the trusts learning disabilities nurse and how they would make a referral to them if they needed additional support.

Managers made sure staff, women and their loved ones and carers could get help from interpreters or signers when needed. Staff we spoke with knew how to access these services which included telephone and face to face interpreters.

The service had information leaflets available in languages spoken by the women and local community. Staff told us that these could be accessed on the service’s intranet pages.

Women were given a choice of food and drink to meet their cultural and religious preferences. We saw that menus provided offered a range of choices to suit cultural and religious needs.

Staff had access to communication aids to help women become partners in their care and treatment. The trust’s sensory team could be contacted to provide additional support and sensory aids.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards.

Women accessed care and treatment 24 hours a day on the labour suite and the midwifery led unit. Women who were assessed as being in labour were directed immediately to the area that they were risk assessed and booked to give birth.

Community midwives provided an on-call service 24 hours a day, for those women booked for a home birth. However, staff told us that the on-call midwives were often called in to support the labour suite as part of the escalation policy. Midwives told us of one occasion where a woman was unable to have a home birth as the community midwife had been called into the main hospital.

The delivery suite had no closures from September 2018 to September 2019. Closures were monitored by the senior leadership team on the service’s maternity dashboard.

Managers and staff worked to make sure that they started discharge planning as early as possible. Midwives sent a notification to health visiting when women were 16 weeks pregnant to ensure that the process of handover and discharge was started as early as possible.

Staff planned women’s discharge carefully, particularly for those with complex mental health and social care needs. The service’s safeguarding midwife met with social services and health visiting services monthly, at the meeting they discussed any women who required the safeguarding teams
input during or following their pregnancy and ensured plans of care were in place for women and new-borns.

**Learning from complaints and concerns**

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint. However, the service did not always complete complaint investigations complaint within timelines set in trust policy.

**Summary of complaints**

From June 2018 to May 2019, the trust received 14 complaints in relation to maternity at West Suffolk Hospital (9.2% of the total complaints received by the hospital).

For the nine complaints that had been closed at the time of data submission, the trust took an average of 28.3 working days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be closed within 25 working days.

The five complaints, that had not yet been closed, had been open for an average of 61.0 working days at the time of data submission.

A breakdown of complaints by type is shown below. One complaint was being investigated by the Healthcare Safety Investigation Branch at the time of reporting.

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>8</td>
<td>57.1%</td>
</tr>
<tr>
<td>Clinical treatment, communications</td>
<td>1</td>
<td>7.1%</td>
</tr>
<tr>
<td>Communications</td>
<td>1</td>
<td>7.1%</td>
</tr>
<tr>
<td>Facilities</td>
<td>1</td>
<td>7.1%</td>
</tr>
<tr>
<td>Clinical treatment, patient care</td>
<td>1</td>
<td>7.1%</td>
</tr>
<tr>
<td>Patient care</td>
<td>1</td>
<td>7.1%</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>1</td>
<td>7.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

The complaints related to the following teams/departments:

<table>
<thead>
<tr>
<th>Team/department</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetrics</td>
<td>7</td>
<td>50.0%</td>
</tr>
<tr>
<td>Ward F11</td>
<td>4</td>
<td>28.6%</td>
</tr>
<tr>
<td>Labour suite</td>
<td>3</td>
<td>21.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

The trust also reported three additional complaints relating to community maternity services.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Women, relatives and carers knew how to complain or raise concerns. One woman told us that she raised some scheduling concerns with her community midwife and they provided her with information on how to make a complaint to the service.
The service clearly displayed information about how to raise a concern in patient areas. We saw complaint leaflets displayed on the labour suite and maternity ward.

Staff understood the policy on complaints and knew how to handle them. Staff told us that they would direct complaints to the ward managers firstly to see if they could be resolved. If the complaint was not resolved and the woman wanted to make a formal complaint staff provided with information on the patient advice and liaison service (PALS).

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint. Women received feedback from managers following the completion of the complaint investigation. We saw that complaints were discussed in the women’s health governance meetings we reviewed.

We reviewed the service’s last three complaint responses and saw that in each response the service had apologised that women had cause to complain. The responses we reviewed demonstrated compassion and professionalism.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used feedback to improve daily practice. The service displayed you said, we did boards at the entrance to F11 ward. We saw that following feedback from women about having difficulties picking up their babies post caesarean section; the service had purchased new baby cots that fitted over the woman’s bed which made it easier for women to access their babies.

### Number of compliments made to the trust

From June 2018 to May 2019 the trust received six compliments for maternity (0.8% of all compliments received trust-wide). All of these compliments related to care received at West Suffolk Hospital.

A breakdown of compliments by department is shown below:

<table>
<thead>
<tr>
<th>Department</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetrics</td>
<td>3</td>
<td>50.0%</td>
</tr>
<tr>
<td>Labour Suite</td>
<td>2</td>
<td>33.3%</td>
</tr>
<tr>
<td>Ward F11</td>
<td>1</td>
<td>16.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

The trust noted that the majority of compliments received trust-wide related to overall care along the whole pathway; and patients and relatives thanking staff for their kindness and compassion during difficult and stressful times.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

### Is the service well-led?

#### Leadership

We were not assured that the service leaders had the skills and abilities to run the service. We were concerned that leaders within the service were not effective at implementing...
meaningful changes that improved safety culture within the organisation. However, staff told us the leaders were visible and approachable in the service for patients and staff.

Maternity services were within the women’s and children’s division in the trusts structure. There was a head of midwifery, clinical director and operations manager.

We were not assured the profile of maternity services at board level was positive. There was confusion within the department over who had executive responsibility for the service. Leaders within the service told us that they had direct access to the board through the executive chief nurse who was the professional lead for the service. However, the executive chief nurse told us that the executive lead for the service was the trust’s medical director. There was not a non-executive director with responsibility for the maternity service.

The services triumvirate leadership team met monthly to discuss performance, operational capacity and any concerns. However, these meetings were not minuted, so we were unable to see evidence of these meetings and any actions that stemmed from them.

Service leads reported a culture resistant to change within the organisation. Leaders provided several examples of where they had tried to implement new processes and had been unsuccessful, which included regular team meetings, taking breaks, staffing acuity tools, lone worker alert systems and the maternity safety thermometer. We were concerned that leaders within the service were not effective at implementing meaningful changes that improved the safety culture within the service.

We were not assured that processes were in place to ensure midwives were adequately supervised. The service did not have any midwives who ran supervisory sessions to replace the role of supervisor of midwives.

Staff consistently told us that they received good support from their managers within the service at all levels. Staff were mostly positive when speaking about the senior leaders in the service and told us that they were trusted and respected.

Medical staff we spoke with told us their leads and educational leaders were very supportive, approachable and open to challenge.

Staff spoke positively about the executive team and told us that they were visible and approachable. Staff told us that both the chief executive and executive chief nurse would regularly see them on their walk arounds.

**Vision and strategy**

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services. However, the strategy was not an agenda item in any of the services governance meetings and we did not see evidence that the strategy was regularly monitored and reviewed.

The service had displayed their values at the entrance to F11 ward which were:

- Focussed on patients
- Integrated care
- Respectful
• Staff focussed

• Two-way communication

The services’ vision was to deliver the best quality and safest care for our community. Staff we spoke with knew what the service’s vision was.

The service’s strategy was their strategic business plan. The plan detailed the service’s ambitions for the next five years including improving technology in the department, refurbishing the labour suite and improved succession planning. The strategy was aligned to the Local Maternity Board (LMB) strategy of uniting everyone in the region with the same vision. The business plan spoke of close collaborative working with the LMB throughout.

The strategy had an action plan in place with actions assigned to individual staff members. However, the strategy was not an agenda item in any of the services governance meetings and we did not see evidence that the strategy was regularly monitored and reviewed.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development.

Most staff we spoke with told us that they enjoyed working for the trust and that there was a positive culture within the service. Staff told us that they were proud to work for the service and felt that the service prioritised the care and needs of the women they looked after.

The service’s staff survey results showed that 89.1% of staff felt respected by their colleagues at work and 82.2% of staff thought their immediate manager was supportive. However only 15.2% of staff felt they had realistic time pressures and only 26.1% of staff felt there was enough staff within the organisation to do their job properly.

We observed strong multidisciplinary working between midwifery and medical teams and it was clear that there were strong working relationships, and respect for team member’s skills, from junior staff through to the most senior leaders.

The trust ran tea and empathy sessions from Monday to Friday which provided staff an opportunity to talk if they were having a difficult day. However, posters advertising these sessions detailed that they may not be confidential.

The service had an electronic system that could be used to raise positive comments and praise for good practice among members of staff. The positive comments were shared through the service’s daily take five sessions. The take five sessions were held on the ward and labour suite and involved midwifery and medical staff coming together for five minutes to be briefed on key issues or incidents in the service that week.

Governance

Leaders did not operate effective governance processes, throughout the service. However, staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
Whilst governance processes were in place these were not fully effective, there remained a lack of oversight from the senior leadership team with concerns we raised during our inspection. For example, the 23 out of date guidelines, the inconsistencies with the Modified Early Obstetric Warning Score (MEOWS) scoring, the documentation of carbon monoxide monitoring and the documentation of domestic violence monitoring.

We were concerned that the service’s audit process was not robust. We requested the service’s record audits for the last 12 months. However, we were only provided with two audits, one from September 2019 and one from August 2019. The audits showed that the service audited five sets of records a month, this was a small sample size and meant that concerns with MEOWS scoring and observation completion had not been picked up by the management team. We reviewed an audit of records and saw that in the August 2019 the audit identified an issue with MEOWS scoring for one woman, however the audit did not show if any actions were taken or if the outcomes were shared with staff.

The service’s records audit did not include auditing whether carbon monoxide (CO) monitoring was completed in line with policy. Therefore, the service’s management were unaware that CO monitoring was frequently not being completed in line with policy. The records audit also did not include ensuring that questions about domestic violence were asked in line with policy. Consequently, the service’s leader was unaware that policy was not always being followed.

The service had a formal governance structure in place. The maternity service sat within the women’s and children’s division. The governance and risk manager held responsibility for managing risk within the maternity services, including monitoring incident reports, compliance with learning outcomes, and actions resulting from serious incident reviews.

The service held monthly performance review meetings which reported into the women’s health governance business meeting and the women and children’s divisional board meeting.

We requested minutes from the monthly women’s and children’s divisional board meetings following our inspection, we reviewed three sets of minutes from March, May and July 2019. There was a set agenda which covered areas for discussion such as but not limited to; finance, governance, business planning, sector updates, top items for escalation to executives and HR updates. Actions were assigned to members of staff and recorded, actions from previous meetings were discussed as an agenda item.

The service held mortality and morbidity meetings but did not minute these meetings. This meant that actions from cases discussed were not assigned, attendance was not monitored and the learning from the meetings could not be shared among the wider team. We were concerned that there was not any evidence of robust discussion and review into mortality and morbidity cases. Senior leaders within the service told us the meetings were educational and therefore minutes were not necessary.

**Management of risk, issues and performance**

**Leaders and teams did not always use systems to manage performance effectively. However, they identified and escalated relevant risks and issues and identified actions to reduce their impact.**

We were concerned about the lack of monitoring of patient feedback within the service. Data had not been collected for the friends and family test for the labour suite and birthing unit since October 2018 and no data had been returned for F11 ward since February 2019. Consequently,
women were not provided the opportunity to give feedback and the service were not able to take action and make improvements as a result. We raised this with the senior leadership team who told us they were not aware of the gaps and therefore had not taken any action to improve collecting this information.

The service did not have a system in place to monitor obstetric theatre cancellation rates. Leaders told us that the division was unaware of cancellations that were occurring, but that they were aware that theatre activity could be moved to another theatre or time of the day to accommodate any cancellations.

There were some processes in place to identify risk. The maternity service had a risk register and we saw that risks within the service were on the risk register. Risks were recorded and managed using the trust’s electronic incident reporting system. All risks on the register were allocated to a member of staff responsible for reviewing and monitoring them. We observed the risk register and risks were in date and had been reviewed. However, we were concerned that risks that we had identified on inspection including the large number of out of date guidelines, the gaps in carbon monoxide monitoring and concerns around the use of MEOWS did not feature on the risk register.

Risks were discussed in the service’s performance review meetings. We requested the minutes of these meetings and reviewed three sets. We saw that risks were colour coded using a red, amber, green ratings to determine the level of risk.

Maternity performance measures were reported through the maternity dashboard, with red, amber, green ratings to enable staff to identify metrics that were better or worse than expected. The dashboard was not displayed in clinical areas, this meant that staff and the public were not informed of the outcomes and risks of the maternity service.

We saw that the services dashboard was reviewed as part of the monthly women’s health governance meeting. We requested the meeting minutes for these and reviewed three sets from June, July and August 2019. We saw that the meetings also discussed incidents, complaints, guidelines, the risk register, and audits.

**Information management**

**The service collected data and analysed it. However not all performance data was displayed for staff to understand, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required, we saw that staff accounts were password protected and screens were logged off when not in use.**

There were effective arrangements and named persons responsible for the timely submission of data and notifications to external bodies for national audit purposes, as required. For example, information submitted to MBRRACE-UK a national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths.

Staff had access to the information they needed to undertake their roles effectively, Policies and procedures were available and accessible through the trust’s intranet facility and the external website. Staff had access to the women’s records and diagnostic tests they needed in a timely way.

The service held a maternity dashboard to monitor performance. Exceptions (areas that were rated out of the accepted range) were raised at the women’s health Governance meetings.
However, the dashboard was not displayed in clinical areas, this meant that staff and the public were not informed of the outcomes and risks of the maternity service.

**Engagement**

Leaders did not always engage actively with staff. However, there was strong evidence that they collaborated with partner organisations to help improve services for patients.

The service did not have team meetings in place for staff on the labour suite, birthing unit or F11 ward. We asked managers why this was, and we were told that attendance was traditionally poor, and they had been difficult to embed. We were concerned that an opportunity was no longer provided for staff to participate in service design, hear updates within the service and provide feedback.

Community midwives had regular monthly meetings in which updates to the service were discussed. Service leads told us that the minutes of the meetings were sent to all community midwives to ensure that key messages were passed on to those who could not attend.

Staff on F11 ward had access to a suggestion box to share ideas for improvements or raise concerns. Staff told us they were able to feedback important messages or concerns through raising an issue to be shared at the daily take five meetings.

Leaders within the service actively participated in their local maternity (LMS) system to share best practice, improve access to services for women and to effectively implement national guidance.

Staff within the service attended a number of clinical networks to keep up to date with best practice and improve services for women. Medical staff told us that they worked closely with the local maternal medicine network which supported the transfers of high-risk women to other trusts equipped to manage high risk specialist medical conditions. The antenatal midwives attended the diabetes clinical networks quarterly meetings to ensure they were up to date with best practice for diabetes in pregnancy. Antenatal midwives also attended the fetal growth network and used the network to gain ideas on the implementation on national guidance. The service’s screening midwife attended the local screening group.

The service had an active maternity voices partnership (MVP) which is a forum for maternity service users, providers and commissioners of maternity services to come together to design services, that meet the needs of local women, parents and their families. Staff gave examples of changes made by the feedback from the MVP which included introducing a frenectomy service for babies with tongue tie. Frenectomy is a surgical procedure that removes the baby’s frenulum, therefore ensuring they are no longer tongue tied.

The trust held awards to celebrate the successes of staff such as the midwife of the year awards and the shining light trust awards.

**Learning, continuous improvement and innovation**

There was limited evidence provided to demonstrate continual learning and improvement of services.

Staff had made a start to improve the continuity of carer initiative within the service in line with NHS England Implementing Better Births: Continuity of Carer 2017. The service had implemented a continuity of carer team for a specific cohort of women. A small team of midwives were allocated...
to a woman booked to have a caesarean section throughout her pregnancy, during the birth and throughout the postnatal period. The feedback from staff and women was positive.
Outpatients

Facts and data about this service

West Suffolk NHS Foundation Trust provides its main outpatients services at West Suffolk Hospital (WSH); Sudbury Community Health Centre (SCHC); Newmarket Community Hospital (NCH), Thetford Healthy Living Centre (THLC); and Haverhill (HAV). These satellite services are managed by the same team who oversee main outpatients. We did not inspect any of the other locations during this inspection.

The main outpatient department within clinical support services supports the following specialties:

- Trauma and orthopaedics (WSH, SCHC, THLC, NCH)
- General surgery (WSH, NCH)
- Colorectal surgery (WSH, NCH)
- Vascular surgery (WSH, NCH)
- Dermatology (WSH, HAV, THLC)
- Ear, nose and throat (WSH, SCHC, NCH)
- Care of the elderly (WSH, NCH)
- Cardiology (WSH)
- Urology (WSH, THLC, NCH)
- Diabetes (WSH, NCH)
- Neurology (WSH)
- Breast (WSH)
- Plastic surgery (WSH, THLC, NCH)
- Gastroenterology (WSH, NCH)
- Rheumatology (WSH, HAV, NCH)
- Respiratory (WSH)
- Pain
- Endocrinology
- Nephrology (WSH)
- Ophthalmology (WSH, THLC, SCHC, NCH)

Patients attended 370,065 outpatient appointments across the trust’s clinic locations between June 2018 and May 2019.

(Source: Acute Routine Provider Information Request (RPIR) – Acute context tab)
Total number of first and follow up appointments compared to England

The trust had 601,339 first and follow up outpatient appointments from March 2018 to February 2019. The graph below represents how this compares to other trusts. Please note that this analysis only includes the initial and first follow up appointments.

(Source: Hospital Episode Statistics - HES Outpatients)

Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from March 2018 to February 2019. Please note that 222,902 spells were assigned to West Suffolk NHS Foundation Trust, as the site was not specified.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Suffolk Hospital</td>
<td>481,697</td>
</tr>
<tr>
<td>West Suffolk NHS Foundation Trust</td>
<td>222,902</td>
</tr>
<tr>
<td>Sudbury Community Health Centre</td>
<td>18,610</td>
</tr>
<tr>
<td>Newmarket Hospital</td>
<td>15,798</td>
</tr>
<tr>
<td>Thetford Community Healthy Living Centre</td>
<td>8,912</td>
</tr>
<tr>
<td><strong>This Trust</strong></td>
<td><strong>762,683</strong></td>
</tr>
<tr>
<td>England</td>
<td><strong>109,330,519</strong></td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

Type of appointments

The chart below shows the percentage breakdown of the type of outpatient appointments from March 2018 to February 2019.
Number of appointments at West Suffolk NHS Foundation Trust from March 2018 to February 2019 by site and type of appointment

(Source: Hospital Episode Statistics)

The main outpatient services are managed in the division of women and children’s and clinical support services. The current structure includes an associate director of operations, a clinical director and a head of nursing. They are supported by a senior operations manager and a service manager.

There are consultant, allied health professional and nurse-led outpatient clinics across a range of specialties, which are provided in the outpatients’ department and in separate dedicated clinics around the hospital. Outpatient clinics are held from Monday to Friday from 8am until 5.30pm. There are some evening weekday clinics and regular Saturday appointments provided dependant on specialty.

We carried out an announced inspection on 24, 25, and 27 September 2019 during which we visited:

- Main outpatient clinics A-D
- Physiotherapy
- Occupational Therapy
- Speech and Language Therapy
- Audiology
- Paediatric outpatient department
- Breast clinic
- Pain clinic
- Diabetes clinic
- Macmillan oncology unit
- Fracture clinic
- Respiratory and cardiology physiology department
- DVT clinic

During the inspection, we spoke with 26 staff of various grades including nurses, doctors, senior managers, allied health professionals, clinical support workers, administrative staff and volunteers.
We spoke with 11 patients and relatives. We observed interactions between patients and staff, considered the environment and looked at eight care records, including patients’ medical notes and nursing notes. We also reviewed other documentation from stakeholders and nationally published performance data for the trust.

The service was last inspected in November 2017. At that inspection, outpatients was rated good, overall.

The inspection team consisted of a lead inspector and two specialist advisors.

**Is the service safe?**

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory training**

The service provided mandatory training in key skills to all staff, however, compliance did not always meet the trust target.

Staff received mandatory training in safety systems, processes and practices.

The mandatory training was comprehensive and met the needs of patients and staff. Training covered key areas such as infection control, information governance, health and safety including risk management, fire safety, moving and handling, and equality and diversity. Training was provided through e-learning modules and face-to-face sessions. Mandatory training had recently been made more accessible and staff could complete training on a phone or outside of the trust. Staff understood their responsibility to complete mandatory training.

**Mandatory training completion rates**

The trust set a target of 90% for completion of all mandatory training with the exception of information governance which had a target of 95%.

Please note that the trust only provided training data for outpatient services based at West Suffolk Hospital.

Staff were expected to complete mandatory training according to their roles. Line managers had access to up to date training data, which showed mandatory training compliance for their staff.

Nursing staff received but did not always keep up to date with their mandatory training. A breakdown of compliance for mandatory training courses as of June 2019 for qualified nursing staff in outpatient services at West Suffolk Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
</tr>
<tr>
<td>Medicine management (refresher)</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Infection control - classroom</td>
<td>16</td>
<td>16</td>
</tr>
</tbody>
</table>
In outpatient services at West Suffolk Hospital, the targets were met for 10 of the 14 mandatory training modules for which qualified nursing staff were eligible.

Medical staff received but did not always keep up to date with their mandatory training. A breakdown of compliance for mandatory training courses as of June 2019 for medical staff in outpatient services at West Suffolk Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
<th></th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td></td>
</tr>
<tr>
<td>Security awareness</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood products &amp; transfusion processes (refresher)</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety training - classroom</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; handling – e-learning</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>MAJAX (Major accident)</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips trips falls</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood borne viruses/inoculation incidents</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control – e-learning</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety training - e-learning</td>
<td>14</td>
<td>16</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; safety / risk management</td>
<td>14</td>
<td>16</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management (refresher)</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support (adult)</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In outpatient services at West Suffolk Hospital, the targets were met for nine of the 15 mandatory training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. This training was covered in their safeguarding sessions.
Managers monitored mandatory training and alerted staff when they needed to update their training. Training uptake was reported and monitored across the division; staff were encouraged to take responsibility for completing mandatory training themselves. They were sent reminders by email to ensure they completed it on time.

**Safeguarding**

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.**

There were clear systems, processes and practices in place to safeguard patients from avoidable harm, abuse and neglect that reflected relevant legislation and local requirements.

Staff knew how to identify patients at risk of, or suffering, significant harm and were supported with comprehensive safeguarding policies that reflected relevant legislation and local requirements. Staff demonstrated a good understanding of their responsibilities in relation to safeguarding patients in vulnerable circumstances and were confident to make safeguarding referrals. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

The trust had a safeguarding lead and safeguarding team in place who provided support, supervision, training and updates for staff. Staff knew who the safeguarding lead was and had a good understanding of how to recognise safeguarding concerns.

The trust had up-to-date guidance included within safeguarding policies on female genital mutilation (FGM), which was in line with national recommendations. Clinical pathways were in place for the mandatory reporting and safeguarding of women with known, suspected and/or risk of FGM, which staff could access through the trust intranet.

Staff liaised with other professionals and agencies, such as health visitors, social workers, the police, independent domestic violence advisors, and the community mental health team, as needed. They worked well together to ensure the safety of their patients.

Staff followed safe procedures for children visiting the department. Children’s clinics were scheduled separately from the adult clinics and in appropriate areas.

**Safeguarding training completion rates**

The trust set a target of 90% for the completion of safeguarding training.

The tables below include prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

Please note that the trust only provided training data for outpatient services based at West Suffolk Hospital.

**West Suffolk Hospital**

Nursing staff received training specific for their role on how to recognise and report abuse.
A breakdown of compliance for safeguarding training courses as of June 2019 for qualified nursing staff in outpatient services at West Suffolk Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
<th></th>
<th></th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>(basic prevent awareness)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>(prevent awareness)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In outpatient services the 90% target was met for all five of the safeguarding training modules for which qualified nursing staff at West Suffolk Hospital were eligible.

Medical staff received training specific for their role on how to recognise and report abuse.

A breakdown of compliance for safeguarding training courses as of June 2019 for medical staff in outpatient services at West Suffolk Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
<th></th>
<th></th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>(prevent awareness)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>(basic prevent awareness)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In outpatient services the 90% target was met for all five of the safeguarding training modules for which medical staff at West Suffolk Hospital were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

The environment was visibly clean in all areas we visited. Data provided by the trust and patients we spoke with corroborated this.

Clinical areas had suitable furnishings which were clean and well-maintained. Chairs and examination couches were made of fabrics that could be cleaned easily. Disinfectant wipes were available in all clinical areas to clean equipment between patients. White paper rolls were used on examination couches which were changed between patients. Privacy curtains in the consulting rooms were disposable and those we checked had been replaced within the last six months, in...
line with recommendations. Patients we spoke with who visited the service regularly, said they did not have any concerns about the cleanliness of the department.

Cleaning records were up to date and demonstrated that all areas were cleaned regularly. There were specific environmental cleaning schedules in place throughout all clinical areas. Domestic staff cleaned all areas daily, and nursing/support staff cleaned between patients. Cleaning schedules were signed and dated to evidence regular cleaning took place.

There were cleaning checklists on display for the play equipment and toys available for children in the main outpatients, orthopaedic and fracture clinic areas, the ophthalmology department, and audiology, and these were signed daily.

Staff followed the trust’s infection control policy and principles. Staff were ‘arms bare below the elbow’ and had access to personal protective equipment (PPE), including aprons and gloves. The service had access to infection prevention and control nurses for support and advice.

Dispensers of hand sanitising gel or foam were available at the entrance to each department and within clinical areas. They were also available in every consulting room, alongside handwashing facilities. Paper towels were readily available in areas where people wash their hands. There were written prompts, which reminded staff, visitors and patients to decontaminate their hands. We observed staff adhering to good hand hygiene practices. We spoke with nursing and medical staff who told us that they felt confident to challenge colleagues regarding hand hygiene. Monthly audits were carried out to check compliance with hand hygiene. Compliance was 100% for all areas.

There were processes in place for clinical waste management. Clinical waste bins were foot operated and once bags were full, they were removed to a secured waste area. Waste was separated and in different coloured bags to signify the different categories of waste. This was in accordance with the Health Technical Memorandum (HTM) 07-01, control of substance hazardous to health (COSHH), health, and safety at work regulations. All sharp boxes we observed were correctly assembled, labelled, and dated. None of the bins were more than half-full, which reduced the risk of needle-stick injury. This is in accordance with HTM 07-01: Safe management of healthcare waste. All sharp bins had temporary closures in place. Temporary closures are recommended to prevent accidental spillage of sharps if the bin was knocked over and to minimise the risk of needle-stick injuries.

Spill kits for the safe cleaning of body fluids, such as blood, were readily available.

The trust used a standard three-stage wipe system for naso-endoscopes to decontaminate equipment between patients in the ear nose and throat clinic, as this was not disposable equipment. At the end of each clinic all scopes were taken to the ‘decon’ room for a deep clean de-contamination. Records were kept to enable tracking and traceability. This was in line with national guidance.

Staff reported that if they had prior knowledge of a patient with a suspected communicable disease, they would use a room in a separate area and have the room deep cleaned following the consultation.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
The design of the environment followed national guidance. The main outpatients’ department was located off the main corridor not far from the main entrance. There were dedicated areas such as the fracture and breast clinics which were well laid out and spacious. All outpatient clinics were clearly sign posted from the main reception and throughout the corridors. There was plenty of seating in all areas visited with no-one having to stand and wait.

Staff carried out daily safety checks of specialist equipment. Resuscitation equipment, for use in an emergency, was available on trolleys and in grab bags and was easily accessible in all areas inspected. We observed checks were completed daily to confirm that equipment was ready for use. Resuscitation trolleys were secured with tamper proof tags to alert staff if they had been accessed at any time. We examined the checklists of five trolleys and saw that they had been consistently completed between July and September 2019, as per trust policy.

The maintenance and use of equipment kept patients safe. Electrical appliances and equipment we checked during the inspection had been tested and serviced to ensure they were safe to use and had stickers with appropriate dates to show that this had taken place. We checked 43 pieces of equipment and all were in date. This was an improvement from the last inspection.

The service had enough suitable equipment to help them to safely care for patients. Equipment, such as vital signs monitors and weighing scales, were labelled to indicate they had been maintained in line with requirements and electrical safety checks had been completed. Staff could access bariatric equipment when requested.

In the main outpatients’ department, a ‘Room Closure Day’ audit sheet was completed at the end of each day on a daily basis (excluding days when the department was closed). This ensured that all rooms were checked, restocked and made ready for the following day. This was signed by the senior team member.

Staff disposed of clinical waste safely. There were arrangements for managing waste and clinical specimens; for example, segregation, labelling and handling of waste where appropriate. We saw that there were arrangements in place for managing specimens, such as blood samples, taken in the phlebotomy department. The process included confirming the patient’s identity and correct labelling of blood bottles. Sharps bins were dated and were not overfilled. Chemical products deemed as hazardous to health were in locked cupboards.

The service had suitable facilities to meet the needs of patient’s families. There was space within the consulting rooms if a patient was accompanied by friend or relative.

Flooring was non-slip and in good condition in all areas we visited.

All staff we asked showed an appropriate awareness of fire safety protocols throughout the unit, including demonstrating the location of the nearest fire exit. We observed fire exits were kept clear and free from obstruction.

**Assessing and responding to patient risk**

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. However, there was no effective process in place for monitoring patients requiring a follow up appointment or those on surveillance pathways.
Appropriate systems were in place to assess risk, recognise and respond to deteriorating patients within the service. Systems were in place to appropriately assess and manage patients with mental health concerns.

Staff responded promptly to any sudden deterioration in a patient’s health. Staff were familiar with the procedure to follow if a patient became unwell whilst attending the department and said they could arrange for transfer or admission if necessary. They were able to describe their role in a patient emergency. They were able to access the hospital resuscitation team if required. Staff were trained in life support techniques and had access to emergency resuscitation equipment. Doctors were available within clinics to assist in the event of medical emergencies. There was an emergency internal phone number to call if a patient had a cardiac arrest and required a specialist team to provide advanced life support.

Staff completed assessments for each patient on arrival and updated them when necessary. Staff performed basic observations such as blood pressure, pulse, weight and height for patients attending the outpatient departments.

Staff knew about and dealt with any specific risk issues. The World Health Organisation (WHO) and ‘five steps to safer surgery’ checklist was used for patients undergoing invasive procedures, such as biopsies. The checklist is a five-step process which involves team briefing, sign-in, timeout, sign-out and debriefing, and is now advocated by the National Patient Safety Agency (NPSA) for all patients in England and Wales undergoing surgical procedures. During the inspection, we asked if there were any local safety standards for invasive procedures (LocSSIPs) in place to build on the existing WHO surgical checklist and promote the effective performance of the five steps to safer surgery guidance. We were told these were in place and that local processes had been developed for invasive procedures, or LocSSIPs, to ensure practice was compliant with the national safety standards for invasive procedures (NatSSIPs) set out by NHS England in 2015. Following a never event whereby a breast cancer biopsy was taken from the wrong breast; regular audit had been implemented to improve and assure compliance with the completion of safety checklists.

The service had access to mental health liaison and specialist mental health support (if staff were concerned about a patient’s mental health). Staff confirmed that they would call the mental health liaison team if they had concerns regarding a patient’s immediate mental health. Otherwise they would contact the patient’s general practitioner to relay their concerns. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Staff shared key information to keep patients safe when handing over their care to others. The main outpatients’ department held a daily safety huddle to review staffing and any concerns about the clinic running that day. Notes from the huddles were emailed to satellite services.

During our inspection, we found there was no process in place for monitoring patients requiring a follow up appointment. Since the implementation of the electronic patient record, the trust were unable to keep track of lost to follow up patients and the reporting functions had been limited. Lost to follow up is defined as being patients who were due for follow up appointments but had been ‘lost’ as a result of lost contact/IT failure etc. The current process within main outpatients was, at each appointment, the consultant signals when they would like to see the patient next or if they were to be discharged. This information was collected on a slip and given to the receptionist following the appointment. The receptionist then books the follow up appointment, if required, in accordance with the recorded instructions, or discharges the patient on the system. If they were unable to book at the time, the slip was retained and sent, via internal post, to the relevant...
consultant secretary for booking, where they would be logged onto a database and filed. There was no internal process to track that follow up appointments had been made. Data provided by the trust stated that generally, if a patient was 'lost', then they were unaware that they were 'lost' and would unintentionally wait until the patient called querying when their next appointment was. During our inspection, we found there were a large number of vascular patients affected by lost to follow up issues, with the potential for serious harm. There was no process in place for booking and monitoring patients for follow up appointments, and for those on surveillance pathways.

During our last inspection, the paediatric outpatient department did not have lockable or security enabled external doors to prevent children leaving the department unaccompanied. This was still the case during this inspection. Staff told us that as the doors were heavy to push they would be too difficult for a small child, and that parents were expected to be responsible for their own children. There had been no risk assessment undertaken. There had been no incidents reported of children escaping from the department.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave new staff a full induction.

The service had enough nursing staff and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. We spoke with senior staff to establish how staffing requirements were ascertained, as there are no national standards or guidelines for how outpatient clinics should be staffed. They told us this was done on the demand of clinics mapped for each day. Staffing was planned four to six weeks in advance, with the aim to always include qualified nurses to coordinate the clinics. We observed that there were reception and nursing staff available to support all clinics that were running during the inspection. The number of nurses and healthcare assistants matched the planned numbers.

The main outpatient’s area employed 36 (qualified and healthcare assistant) nurses across all the general outpatient clinics, including those offered at other sites. The other outpatient areas within the West Suffolk hospital site were staffed according to local departmental need.

The manager could adjust staffing levels daily according to the needs of patients. Senior nurses said they adjusted the number of staff on duty according to the number of clinics. Managers utilised bank staff and requested staff familiar with the service. The department used no agency staff. Where staff numbers were less than required, bank staff were used.

Managers made sure all new staff had a full induction and understood the service.

Please note that the trust only provided qualified nursing staff data for outpatient services based at West Suffolk Hospital.

The table below shows a summary of the nursing staffing metrics in outpatients at West Suffolk Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Outpatients annual staffing metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>April 2018 – March 2019</strong></td>
</tr>
<tr>
<td><strong>June 2018 – May 2019</strong></td>
</tr>
<tr>
<td><strong>May 2018 – April 2019</strong></td>
</tr>
<tr>
<td><strong>Staff</strong></td>
</tr>
</tbody>
</table>

20190416 900885 Post-inspection Evidence appendix template v4 Page 244
<table>
<thead>
<tr>
<th>Group</th>
<th>average establishment</th>
<th>vacancy rate</th>
<th>turnover rate</th>
<th>sickness rate</th>
<th>bank hours (% of available hours)</th>
<th>agency hours (% of available hours)</th>
<th>unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>6%</td>
<td>10%</td>
<td>3.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>118</td>
<td>15%</td>
<td>4%</td>
<td>4.8%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>19</td>
<td>17%</td>
<td>6%</td>
<td>5.6%</td>
<td>862 (5%)</td>
<td>0 (0%)</td>
<td>296 (2%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Nurse staffing rates within outpatients at West Suffolk Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness and bank. There was no agency use for nursing staff within outpatients from May 2018 to April 2019.

**Vacancy rates**

![Vacancy rate - qualified nurses, health visitors and midwives](chart)

Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives showed a shift from October 2018 to March 2019 which could be an indicator of change.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

The service had relatively static turnover, sickness and bank rates. However, vacancy rates had increased between October and December 2018 and January and March 2019. Senior staff confirmed to us they were currently understaffed, and they were recruiting for vacancies within the department.

**Medical staffing**

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
The service had enough medical staff to keep patients safe. The medical staff matched the planned number.

Medical staffing was provided to the outpatient department by the various specialties that had clinics. Doctors who worked in outpatients were associated to the various core services rather than the outpatient department. Consultants from the trust attended outpatient clinics to carry out clinics and see patients on a regular booked clinic basis. They were supported by middle grade doctors from their team.

Medical staff were asked to give six weeks’ notice of any leave in order for clinics to be managed or adjusted.

Please note that the trust only provided medical staff data for outpatient services based at West Suffolk Hospital.

The table below shows a summary of the medical staffing metrics in outpatients at West Suffolk Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>April 2018 – March 2019</th>
<th>June 2018 – May 2019</th>
<th>May 2018 – April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annual average</td>
<td>Annual vacancy rate</td>
<td>Annual turnover rate</td>
</tr>
<tr>
<td>Target</td>
<td>6%</td>
<td>10%</td>
<td>3.5%</td>
</tr>
<tr>
<td>All staff</td>
<td>118</td>
<td>15%</td>
<td>4%</td>
</tr>
<tr>
<td>Medical staff</td>
<td>15</td>
<td>-10%</td>
<td>0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within outpatients at West Suffolk Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy and turnover. The service had low vacancy and turnover rates for medical staff.

Please note that the negative vacancy rate for medical staff in the table above indicate that the service was over-established.

There was no medical bank or locum use within outpatients from May 2018 to April 2019.

Sickness rates
Monthly sickness rates over the last 12 months for medical staff were not stable and may be subject to ongoing change. Sickness rates for medical staff were reducing.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient records were comprehensive, and all staff could access them easily. Patients’ individual care records were managed, written, and stored correctly according to best practice. Records were available electronically. This meant that patients were not seen without their medical records being available. This enabled clinicians to share information appropriately between departments.

We reviewed eight patient records. Entries were legible, dated, timed and signed and the designation of the person making the entry was recorded. We found entries were clear, with a diagnosis and treatment plan. Staff recorded discussions with patients and relatives and different professionals recorded their input contemporaneously.

When patients transferred to a new team, there were no delays in staff accessing their records as these were available electronically.

Letters to GPs following consultations were usually typed the same day. This enabled the clinician to review them prior to them being sent in a timely manner.

The electronic system was capable of using ‘flags’ to highlight patients who may have a pre-existing condition that required support such as some mental health conditions.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Suitable arrangements were in place for the safe management of medicines as outlined in the trust’s medicines policy.
Outpatient nursing staff did not administer medicines but consultants and the clinical nurse specialists working in the clinics did use some medicines, such as local anaesthetic and steroids. They followed the trust's local policies, and national guidance for these.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff could seek advice and support regarding medicines from the pharmacy department, if necessary. Patients told us their medicines were explained to them, along with the possible side effects.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicines were stored safely in locked cupboards within locked rooms. The temperature of the room and the refrigerator used to store medicines was checked daily. Records showed they were within acceptable limits. The pharmacy team checked medicines stored in the department and their expiry dates. No controlled drugs (CDs) were stored in the areas we inspected.

Prescription pads were securely stored in a locked cupboard. There was a booking out and recording process for each prescription to ensure traceability.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. These were cascaded by the pharmacy team by email and though meetings.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff reported all incidents using the trust's electronic incident reporting system. Staff were confident that action had been taken following incidents they had reported. The system was easily accessible to all staff across all clinical areas.

All staff knew what incidents to report and how to report them. Both medical and nursing staff were able to provide examples of when they had appropriately reported an incident. Staff told us they always received feedback when they had requested it on the initial reporting form. Staff were encouraged to report incidents, even when they felt they were not significant.

Managers reviewed incidents daily and where necessary, investigations were initiated to identify any themes and actions needed to minimise recurrence. Any potential serious incidents (classed as moderate or above) were escalated appropriately.

Managers debriefed and supported staff after any serious incident. The senior staff told us that they would meet with staff individually for debriefs and feedback when needed.

The service had several methods to ensure lessons were learned and shared with staff through daily safety huddles, bulletins, meetings and emails.

When things went wrong, staff apologised and gave patients honest information and suitable support. Staff were aware and understood the of the duty of candour regulation and described how they applied the principles by being open and honest with patients always and admitted any
mistakes. Staff could give us examples of instances where they would use it. 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, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were local arrangements in place for ensuring that patients were kept informed of incidents and any investigations and their outcomes.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From August 2018 to July 2019, the trust reported one never event for outpatients. The never event occurred in February 2019 and was categorised as wrong site surgery, whereby a breast cancer biopsy was taken from the wrong breast.

*(Source: Strategic Executive Information System (STEIS))*

We reviewed the investigation report following the never event, which included immediate actions taken and recommendations and actions taken to minimise the risk of recurrence. We saw evidence of patient involvement and application of duty of candour principles.

The incident highlighted the need to ensure that the safety checklist on the electronic record was completed prior to any invasive procedure taking place. Actions taken as a result of the never event included:

- Posters to remind staff to use the ‘Approved Standard for Invasive Procedures Checklist’ prior to any invasive procedure.
- Reminder on the next medical bulletin to remind teams of the above.
- Ensure that wherever possible the breast care nurse was in the room at time of checklist being completed and the procedure taking place.
- Review/update clinical guidelines for the marking of invasive sites in certain circumstances.

Managers shared learning about the never event with their staff and across the trust through safety huddles, team meetings, clinical governance meetings and the trust’s shared learning event. Staff we spoke with were aware of the changes made following the incident.

**Breakdown of serious incidents reported to STEIS**

Staff reported serious incidents clearly and in line with trust policy.

In accordance with the Serious Incident Framework 2015, the trust reported four serious incidents (SIs) in outpatient services which met the reporting criteria set by NHS England from August 2018 to July 2019. This represented 7.7% of all serious incidents reported by the trust as a whole. All of the serious incidents occurred at West Suffolk Hospital.

A breakdown of the incident types reported is shown in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
</table>

---

20190416 900885 Post-inspection Evidence appendix template v4  Page 249
Diagnostic incident including delay meeting SI criteria (including failure to act on test results) | 2 | 50.0%
Surgical/invasive procedure incident meeting SI criteria | 1 | 25.0%
Treatment delay meeting SI criteria | 1 | 25.0%
Total | 4 | 100.0%

(Source: Strategic Executive Information System (STEIS))

We reviewed a sample of the incident investigation reports for the reported serious incidents and found comprehensive investigations. The investigation reports included recommendations and actions taken to minimise the risk of recurrence.

Major incident awareness

The service planned for emergencies and staff understood their roles if one should happen.

The trust had a policy and plans in place for emergencies and other unexpected or expected events, such as adverse weather, flu outbreak or a disruption to business continuity.

There was regular testing of generators in case there was a failure of the electricity supply to the hospital. Staff were aware of the procedures for managing major incidents, winter pressures and fire safety incidents. Fire safety awareness training was a mandatory training and staff attended the training annually.

There was an effective understanding amongst staff about their roles and responsibilities during a major incident.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The service monitored safety performance. Staff collected safety information and shared it with staff, patients and visitors. This information was intended to help staff focus their attention on improving the safety of the care they provided. The trust monitored and reported outpatient monthly referral to treatment time performance levels and did not attend rates within each clinical area.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients’ subject to the Mental Health Act 1983.
Patient care was planned and delivered in line with evidenced based guidance. Staff followed National Institute for Health and Care Excellence (NICE), Royal College and other professional guidelines regarding the treatment of patients.

There was a process in place to allocate published NICE guidance to appropriate clinical leads on a monthly basis. Once approved, a baseline assessment containing the recommendations contained within the guidance was sent to the clinical lead to evaluate the service. This ensured that pathways met the NICE guidance recommendations and provided assurance that NICE guidance was being followed.

Clinical guidelines reviewed were up to date and staff followed them to plan and deliver high quality care according to best practice and national guidance.

Staff could access policies through the trust’s intranet. Trust policies were assessed to ensure guidance did not discriminate because of race, ethnic origin, nationality, gender, culture, religion or belief, sexual orientation and/or age.

Specific pathway documents were used for each procedure, for example endoscopies for outpatient clinics were carried out in line with professional guidelines, and staff used these pathways to ensure the equipment was used in the correct way.

Staff protected the rights of patients’ subject to the Mental Health Act and followed the Code of Practice. Staff we spoke with were aware of the requirements.

The service was involved in audits, and a rolling programme of audits for the current financial year was in place. We were provided with evidence of audits the service had been involved in. This included, but was not limited to, the World Health Organisation (WHO) and ‘five steps to safer surgery’ checklist audit, decontamination audit, prescription pad audit, and hand hygiene. Actions were taken to improve care and treatment where compliance was poor.

**Nutrition and hydration**

**Patients had access to water to meet their needs and improve their health.**

Patients attending the department as outpatients were in the department for a short period and were not routinely provided with food or drinks. There was a water dispenser available in all the waiting areas for patients and visitors to help themselves. This meant that patients were able to keep themselves hydrated while waiting to be seen.

There were facilities close to the main outpatient department where patients and visitors could purchase refreshments.

**Pain relief**

**Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice when needed. Patients we spoke with had not required pain relief during their attendance in the outpatient clinics. However, patients told us the consultants routinely asked them about their pain and pain management.

Staff prescribed, administered and recorded pain relief accurately. Nursing staff told us if a patient presented in pain, they would score their level of pain using a numerical pain score tool.
Appropriate pain relief medication would then be prescribed, administered and documented in the patient notes.

Patients were referred to pain management clinics if needed. The pain team, including consultants and nurses, had specialist knowledge on medication and strategies for patients dealing with chronic pain. They were committed to providing a holistic service based on symptom management and promoted self-management of symptoms by the patient. The Abbey pain scale was used for patients with dementia and those who found it difficult to verbalise. This an instrument designed to assist in the assessment of pain in patients who are unable to clearly articulate their needs.

**Patient outcomes**

*Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.*

The outpatients’ service did not generally directly participate in local or national clinical audits. These were undertaken by medical and surgical specialties. However, there was participation in organisational audits, for example of hand hygiene and decontamination.

Managers shared and made sure staff understood information from the audits. This information would be discussed at regular staff meetings.

Managers used information from the audits to improve care and treatment. Measures such as referral to treatment times and other dashboard indicators were discussed at clinical governance and operational meetings and ways in which they could be improved were discussed.

Improvements were checked and monitored. The service maintained a dashboard which managers used to monitor referral to treatment times, ‘did not attend’ rates, clinic cancellations, slot utilisation and other key measures. This performance data was discussed at weekly and monthly meetings.

A rheumatology peer review summary identified low waiting times for new referrals and also highlighted the early arthritis clinic and community-based clinics as areas of excellence. Dermatology had worked with the clinical commissioning group and primary care to introduce a ‘telederm’ service available to GPs to reduce demand. Referral to treatment performance for dermatology was the best locally at 96.9%. *(Source: Routine Provider Information Request (RPIR) – Outcomes tab)*

**Follow-up to new rate**

From March 2018 to February 2019:

- the follow up to new rate at West Suffolk NHS Foundation Trust was consistently much higher than that England average. These were appointments where the sites were not specified.
- the follow-up to new rates for West Suffolk Hospital and Sudbury Community Health Centre were consistently higher than the England average.
- the follow-up to new rate for Newmarket Hospital was generally lower than the England average.
- the follow-up to new rate for Thetford Community Healthy Living Centre fluctuated but was lower than the England average in eight of the 12 months.
Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

The service had processes in place to identify training needs and compliance, which ensured staff were confident and competent to undertake their roles. Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All clinics were run by clinicians with the appropriate experience and training in the field.

Managers gave all new staff a full induction tailored to their role before they started work, which included mandatory and role-specific training. Staff told us they had received a good induction.

Managers supported nursing and medical staff to develop through regular, constructive clinical supervision of their work.

The service provided development opportunities for staff at various grades, such as supporting nursing staff to move to the next band and the development of specialist roles. Nurses told us they were encouraged and supported to develop areas of interest and act as a source of advice for the team. Staff were also given the opportunity to undertake additional training courses that were relative to their role and specialty.

Arrangements were in place for supporting and managing staff. Staff completed an annual appraisal as part of their personal development review. Staff said they had completed an appraisal within the previous year and found it useful. Staff were encouraged to identify learning needs they had, and any training they wanted to undertake. Staff were supported to reflect, improve and develop their practice.

Appraisal rates

(Source: Hospital Episode Statistics)
Managers supported staff to develop through yearly, constructive appraisals of their work.

Please note that the trust only provided appraisal data for outpatient services based at West Suffolk Hospital.

From April 2018 to March 2019, 93.1% of staff within outpatient services at West Suffolk Hospital received an appraisal compared to a trust target of 90%. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
<td></td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>14</td>
<td>14</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>33</td>
<td>35</td>
<td>94.3%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>14</td>
<td>15</td>
<td>93.3%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>14</td>
<td>16</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>6</td>
<td>7</td>
<td>85.7%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>81</td>
<td>87</td>
<td>93.1%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

All staff groups, excluding allied health professionals and administrative clerical staff, met the trust target of 90% for appraisals (these staff groups had completion rate of 87.5% and 85.7% respectively). This was an improvement since our previous inspection where 53.4% of outpatient staff had received an appraisal.

Updated analysis for April 2019 to mid-June 2019 found that 21.8% of required staff in outpatients at West Suffolk Hospital received an appraisal compared to the trust target of 90%. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2019 to mid-June 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
<td></td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>6</td>
<td>15</td>
<td>40.0%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>4</td>
<td>16</td>
<td>25.0%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>8</td>
<td>35</td>
<td>22.9%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>1</td>
<td>14</td>
<td>7.1%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>0</td>
<td>7</td>
<td>0.0%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td>87</td>
<td>21.8%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

None of the staff groups in outpatients met the 90% target. However, this data only represents a partial year and so we would not expect a high appraisal completion rate.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff meetings were held monthly within the outpatient service. Notes of the meetings showed a wide range of issues were discussed related to improvements in the service and training completion. At our previous inspection, we found team meetings were not minuted. However, this had improved, and we found minutes of team meetings were available.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their...
line manager and were supported to develop their skills and knowledge. Staff told us their training and development needs were discussed at their appraisal.

Managers made sure staff received any specialist training for their role. Specialist nurses were available for the specific clinics, for instance; the breast care team had a nurse who was trained in micro pigmentation tattooing for women who had undergone mastectomy. Each member of staff, registered nurses and health care assistants had individual competency folders to complete and work through.

All nursing staff working in outpatients’ clinics who were required to revalidate had done so successfully. Revalidation is a process introduced in April 2016 by the Nursing and Midwifery Council to demonstrate that nurses are compliant to the nursing code. All nurses are required to revalidate every three years.

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Observation of practice, review of records and discussion with staff confirmed that all necessary clinicians were involved in assessing, planning and delivering patient care and treatment.

Staff in all areas of the outpatient service at West Suffolk Hospital told us they worked closely to make sure patients received safe and effective care. This included working closely with other departments within the trust, external organisations and healthcare professionals.

We saw evidence of multidisciplinary working, for example, nurses, porters, administration staff and medical staff working collaboratively to improve the patient experience.

Staff held regular and effective multidisciplinary (MDT) meetings to discuss patients and improve their care. There were MDT meetings held across all the specialties to provide effective assessment and treatment.

Clinical specialist nurses worked in clinics, including respiratory, rheumatology, diabetes, liver and diabetes. These staff worked closely with consultants and specialist support services to improve patient care around specific conditions.

The service was part of the clinical support services division and managers attended joint meetings to discuss performance.

Patients could see all the health professionals involved in their care at one-stop clinics. For example, the breast care unit enabled patients to attend clinics and have investigations on the same day to prevent recurrent visits.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff were able to refer patients for mental health assessments and for psychological support where necessary.

**Seven-day services**

**There was some flexibility in the provision of key services to support timely patient care as outpatient services were not seven day.**
Outpatient clinics were held at various times from 8am to 5.30pm, Monday to Friday. Clinics in the outpatient department did not routinely provide a seven day a week service. However, some clinics were held in the evenings and on Saturdays to reduce the number of patients waiting for an appointment.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests.

**Health promotion**

**Staff gave patients practical support and advice to lead healthier lives.**

The service had relevant information promoting healthy lifestyles and support in patient areas. Health promotion information leaflets and posters on subjects such as living with cancer were on display in the waiting rooms. Various information leaflets were available in all clinical areas and waiting rooms. This included, but was not limited to ‘Stroke Services’, ‘Carpel Tunnel Syndrome’, ‘Foot and Ankle Surgery for Arthritis’, and ‘Paget’s Disease of Bone’.

Staff assessed each patient’s health at every appointment and provided support for any individual needs to live a healthier lifestyle.

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

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**

The trust had up-to-date policies regarding consent and the Mental Capacity Act 2005. Staff could access these via the trust intranet. The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make decisions, any made on their behalf must be in their best interests and be as least restrictive as possible.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff understood the relevant consent and decision-making requirements of legislation and guidance and had received training on mental capacity and deprivation of liberty safeguards. They knew who to contact for advice.

Staff clearly recorded consent in the patients’ records. Staff made sure patients consented to treatment based on all the information available. Medical staff informed patients about the risks and benefits of procedures. We observed this during our inspection. Medical notes included a written consent, and we saw that these were completed and signed by the doctor outlining possible side effects and risks of procedures.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. For example, taking clinical observations or giving medication. All patients we spoke with told us staff always asked permission before providing care. When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions.
Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Mental capacity assessments had been undertaken for patients who required this.

**Mental Capacity Act and Deprivation of Liberty training completion**

All medical staff and all but one nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.

The trust reported that Mental Health Act (MHA), Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) were covered in the safeguarding adults training.

Please note that the trust only provided safeguarding training data for outpatient services based at West Suffolk Hospital.

The trust set a target of 90% for the completion of safeguarding adults training.

**West Suffolk Hospital**

A breakdown of compliance for safeguarding adults training for qualified nurses and medical staff as of June 2019 in outpatient services at West Suffolk Hospital is shown below:

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Dental</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In outpatient services the 90% target for safeguarding adults training was met by both qualified nurses and medical staff.

*(Source: Routine Provider Information Request (RPIR) – Training tab)*

Clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards achieving the trust’s target.

**Is the service caring?**

**Compassionate care**

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We observed patients being treated with respect and compassion throughout our inspection. We spoke with 11 patients and relatives. All patients we spoke with were highly complementary of the care they had received, and feedback was consistently positive throughout the inspection. Patients said staff treated them well and with kindness.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.
Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We observed positive interactions between staff, patients and their relatives. All staff we spoke with were passionate about their roles and were committed to making sure patients received the best patient-centred care.

Staff followed policy to keep patient care and treatment confidential. Patient dignity and privacy was maintained during episodes of physical and intimate care, doors were closed at all times. Results from a local patient experience survey demonstrated that between April and September 2019, 100% felt they were given enough privacy when being examined and treated. Patients who required intimate examinations were offered the option of a chaperone.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff could give us examples of when this had occurred. Staff showed empathy and understanding for people and the way their anxiety and health affected their behaviour at times.

The Friends and Family Test (FFT) is an important feedback tool that supported the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. The service obtained patient feedback through the FFT, which allowed patients to state whether they would recommend the service and give feedback on their experiences. For July, August and September 2019, 96% of patients would recommend the service, compared to the England average of 93%.

**Emotional support**

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.

Staff understood the impact that a patient’s care, treatment or condition had on their wellbeing and on their relatives, both emotionally and socially. Staff gave patients and those close to them help, emotional support and advice when they needed it.

Throughout the inspection, we saw that distressed patients were spoken to kindly. Patients, who were confused, were given clear details of the time and place, and offered reassurance of safety.

Emotional support and information was provided to patients and their relatives. Clinical nurse specialists (CNSs) were available for additional advice and support in a number of specialties including diabetes, rheumatology, liver and gastroenterology. A dementia lead nurse and a learning disability liaison nurse were available for support.

Medical and nursing staff could refer patients for mental health assessments if they were concerned about mental health conditions. Interactions were not rushed, and patients were given sufficient time to speak to staff about any concerns.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff ensured that when distressing news was going to be delivered, consideration was given to ensuring this was done in a private area where they could spend time with patients afterwards without having to hurry them.

The breast care team had a separate comfortable fitting room. A range of prostheses was available to ensure that women could be fitted with as near as possible match for the removed breast. The team sold specialist mastectomy bras and arranged for women to attend another provider for custom made prosthetics if they did not have an appropriate match.
Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. There was access to volunteers and local advisory groups to offer both practical advice and emotional support to both patients and carers.

Chaplaincy support was available. Patients’ spiritual needs were considered irrespective of any religious affiliation or belief. The chaplaincy service supported spiritual care across the services and ensured the delivery of spiritual, pastoral and religious care was adequate and appropriate.

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

**Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff communicated with patients in a way that was appropriate and respectful. Patients we spoke with corroborated this.

We observed staff asking patients what they would like to be called and introduced themselves and their role. We observed staff involving patients and their relatives during assessments and when taking observations.

Staff supported patients to make informed decisions about their care. We saw medical staff taking the time to involve patients and encouraging them to ask questions should they have any.

Patients we interviewed told us doctors and nurses informed them of their care and treatment. They were both kept informed of their current treatment and future plans. We saw therapists supporting and involving patients with their therapy on areas that we visited.

Staff recognised when patients and their relatives needed additional support to help them understand and be involved in their care and treatment and enable them to access this. We saw, and staff told us, how they could access language interpreters, sign language interpreters, specialist advice and advocates.

The chaplaincy service was available to provide spiritual and pastoral care when asked by the patient/families and medical and nursing staff. The team offered support, prayers or a listening service to people who may find it helpful to talk about their anxieties.

Patient information leaflets were widely available across the hospital, usually relating to specific conditions or illnesses. Staff encouraged patients to read leaflets to inform them of conditions and support groups.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey.

**Is the service responsive?**

**Service delivery to meet the needs of local people**
The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. The service understood the different requirements of the local people it served by ensuring that it actioned the needs of local people through the planning, design and delivery of services. Services were planned in a way which ensured flexibility and choice. Outpatient clinics were provided at West Suffolk Hospital; Sudbury Community Health Centre; Newmarket Community Hospital; Thetford Healthy Living Centre; and Haverhill. This meant patients could be seen closer to their home if the clinical specialty and capacity allowed. Patients could select where they were seen using the NHS referrals service.

The service provided clinics for 20 specialities including, dermatology, rheumatology, urology, ophthalmology and cardiology. To manage the high demand, extra clinics were held in the evening and at weekends to reduce waiting times for patients.

Facilities and premises were appropriate for the services being delivered. Outpatient clinics were clearly signposted, and volunteers were available to assist. Information was provided to patients in accessible formats before appointments. Appointment letters contained information required by the patient such as contact details, a map and directions and information about any procedures, including any preparation such as fasting was required. Car parking was available on the hospital site. Patients who had a medical or clinical condition that prevented them from attending appointments were offered a patient transport service. We observed there was enough seating for patients and those accompanying them. There were adequate toilets within the department. Toilets suitable for disabled people and baby changing facilities were also provided.

The service worked collaboratively with external agencies to improve services provided by the trust. This included working with the clinical commissioners and neighbouring NHS trusts to identify the needs for the local community and planning of clinical pathways to meet demands.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. A dementia lead nurse and learning disability liaison nurse were in post to provide support to patients, carers and staff.

The service had systems to help care for patients in need of additional support or specialist intervention. Volunteers were available in the outpatient reception to guide and accompany patients when needed. Volunteers told us they had learned to recognise those patients who were unfamiliar with the area and might need additional support. Staff checked patients in the waiting room regularly and identified those in need of additional support or intervention. They responded to the individual needs or circumstances for each patient.

Reception staff told us that they would inform patients if clinics were running excessively late. Patients were given a pager and could either to go to a coffee shop or for a walk, if there were clinic delays. Staff told us if a patient became distressed in the waiting area, they would try and take them into a consultation room as soon as possible in order to reduce their anxiety. Staff described situations when this approach had been required, for example with patients living with dementia, autism, learning disability or mental health conditions.

The breast unit offered a ‘one-stop’ clinic, whereby a multidisciplinary team including doctors, specialist nurses and radiographers worked together in one area to ensure patients had their initial consultation, diagnostic tests, investigations and their follow-up consultation on the same day. This
meant a more efficient service for patients, with fewer appointments needed, and a prompt diagnosis.

Managers monitored and took action to minimise missed appointments and ensured that patients who did not attend (DNA) appointments were contacted. All patients that did not arrive were contacted by the department and offered another appointment. If they did not attend on repeated appointments, they would be sent back to GP to be re-referred.

**Did not attend rate**

From March 2018 to February 2019, the ‘did not attend’ rates for all locations at the trust were lower than the England average, excluding Thetford Community Health Living Centre in May 2018. Please note that some appointments were assigned to West Suffolk NHS Foundation Trust, as the site was not specified.

The chart below shows the ‘did not attend’ rate over time.

**Proportion of patients who did not attend appointment, West Suffolk NHS Foundation Trust**

![Graph showing the proportion of patients who did not attend appointments over time](image)

*(Source: Hospital Episode Statistics)*

**Meeting people’s individual needs**

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Patients’ individual needs were accounted for. Staff delivered care in a way that took account of the needs of different patients on the grounds of age, disability, gender, race, religion or belief and sexual orientation. Staff had received training in equality and diversity and had a good understanding of cultural, social and religious needs of the patient and demonstrated these values in their work.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Patients in these groups were highlighted on the electronic patient record system, which enabled the booking team to allocate earlier
appointments. Staff supported patients living with dementia and learning disabilities by using patient passports.

The trust had a learning disabilities liaison nurse who attended clinics when possible. They supported the person and completed the learning disability/autism focused assessment tool. When deemed beneficial the learning disabilities liaison nurse completed this during a home visit prior to attendance/admission.

The service had introduced video consultations to make it easier and more convenient for the residents of west Suffolk to access the service. For example, the paediatric epilepsy outpatient service, as well as other specialities, offered video consultations so patients would not need to come into hospital for their appointment.

The pain clinic offered ‘first steps’ clinics which involved a group of patients. Patients were able to choose further appointments depending on their clinical needs, and these appointments were generated with other professionals such as physiotherapy etc. Patients were at the centre of care and very much chose what they wanted.

The department was able to accommodate patients in wheelchairs or who needed specialist equipment. There was sufficient space to manoeuvre and position a person using a wheelchair in a safe manner.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. During our previous inspection, we found there was no hearing loop in existence. Patients who were hard of hearing were at a disadvantage and usually required extra assistance from the nursing staff. At this inspection, we found hearing loops had been installed across all outpatient reception desks for patients with hearing difficulties.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. An interpreting service was available for non-English speaking patients. This was provided face-to-face or via a dedicated telephone translation service. All staff we spoke with knew how to access this service.

We did not see any information leaflets in different languages on display during our inspection visit and information leaflets we reviewed did not provide information as to how these could be obtained in other languages. However, staff told us these could be requested if required.

The trust sought feedback on how well they were meeting the needs of local people, for example through patient advice and liaison team and informal contact through friends and family feedback, local patient survey feedback, thank you cards, complaints, incidents or local concerns.

Access and flow

People could not always access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment varied, with some specialties better and some worse than national standards. The percentage of patients waiting more than 18 weeks from referral to treatment on non-admitted and incomplete pathways was below the England average. Delays in diagnostic test results meant that clinic appointments were often wasted.

Managers monitored waiting times but did not always ensure patients could access services and receive treatment within agreed timeframes and national targets. There were weekly access meetings to monitor performance. At these meetings, the referral to treatment position was
discussed, as well as any remedial action plans required for specialties that were not performing against national and operational standards.

Each clinical speciality was responsible for their patient waiting lists and their referral to treatment time performance. This was managed by the individual directorate or specialty managers who were responsible for monitoring the patient tracking lists using data available on a trust wide electronic system.

There was a weekly escalation process for breaches of waiting times. After discussion, any issues with patients waiting longer than two weeks and 18 weeks (as appropriate to their clinical need) were escalated accordingly.

Improvement plans were in place that clearly defined the process for both the two week and 18-week pathways and we saw recovery plans were in place to improve compliance with meeting operational and national standards.

Local leaders had developed an outline plan for delivery of additional activity to meet a target position to deliver referral to treatment (RTT) at 90% by March 2020. The intensive support team (IST) had undertaken capacity and demand analysis at speciality level to improve performance.

**Referral to treatment (percentage within 18 weeks) – non-admitted pathways**

From July 2018 to June 2019 the trust’s referral to treatment time (RTT) for non-admitted pathways declined and performance fell below the England average from February 2019 onwards.

The poorest performance was recorded in February 2019, whereby 84.6% of this group of patients were treated within 18 weeks versus the England average of 87.0%.

In the most recent month, June 2019, 85.9% of this group of patients were treated within 18 weeks versus the England average of 86.7%.

**Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, West Suffolk NHS Foundation Trust**

![Graph showing referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, West Suffolk NHS Foundation Trust.](Source: NHS England)
Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

From July 2018 to June 2019, nine specialties were above the England average for non-admitted pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatology</td>
<td>98.9%</td>
<td>85.6%</td>
</tr>
<tr>
<td>General medicine</td>
<td>97.3%</td>
<td>90.9%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>96.2%</td>
<td>87.6%</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>95.1%</td>
<td>94.9%</td>
</tr>
<tr>
<td>Other</td>
<td>92.4%</td>
<td>89.6%</td>
</tr>
<tr>
<td>Ear, nose &amp; throat (ENT)</td>
<td>91.7%</td>
<td>83.3%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>91.4%</td>
<td>88.4%</td>
</tr>
<tr>
<td>Neurology</td>
<td>86.3%</td>
<td>77.0%</td>
</tr>
<tr>
<td>Urology</td>
<td>85.1%</td>
<td>84.1%</td>
</tr>
</tbody>
</table>

Six specialties were below the England average for non-admitted pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plastic surgery</td>
<td>88.7%</td>
<td>90.1%</td>
</tr>
<tr>
<td>General surgery</td>
<td>87.6%</td>
<td>88.3%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>85.6%</td>
<td>85.9%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>82.5%</td>
<td>85.2%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>77.3%</td>
<td>80.7%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>74.3%</td>
<td>85.5%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – incomplete pathways

From July 2018 to June 2019 the trust’s referral to treatment time (RTT) for incomplete pathways declined and performance fell below the England average from January 2019.

The poorest performance was recorded in February 2019, whereby 83.6% of this group of patients were treated within 18 weeks versus the England average of 86.5%.

In the most recent month, June 2019, 85.4% of patients at the trust were treated within 18 weeks which was marginally lower than the England average of 85.8%.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, West Suffolk NHS Foundation Trust
Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

From July 2018 to June 2019, 13 specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral surgery</td>
<td>100.0%</td>
<td>82.0%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>98.6%</td>
<td>90.8%</td>
</tr>
<tr>
<td>General medicine</td>
<td>97.4%</td>
<td>91.2%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>97.0%</td>
<td>89.3%</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>96.5%</td>
<td>95.8%</td>
</tr>
<tr>
<td>Neurology</td>
<td>94.8%</td>
<td>86.2%</td>
</tr>
<tr>
<td>Other</td>
<td>93.5%</td>
<td>88.8%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>93.3%</td>
<td>82.2%</td>
</tr>
<tr>
<td>Ear, nose &amp; throat (ENT)</td>
<td>92.9%</td>
<td>83.6%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>92.3%</td>
<td>89.2%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>91.0%</td>
<td>87.7%</td>
</tr>
<tr>
<td>General surgery</td>
<td>85.5%</td>
<td>83.9%</td>
</tr>
<tr>
<td>Urology</td>
<td>85.3%</td>
<td>84.6%</td>
</tr>
</tbody>
</table>

Three specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>88.8%</td>
<td>89.3%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>80.2%</td>
<td>81.3%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>79.0%</td>
<td>86.2%</td>
</tr>
</tbody>
</table>

(Source: NHS England)
urgent GP referral (All cancers)

The trust performed worse than both the 93% operational standard for people being seen within two weeks of an urgent GP referral and the England average in quarters 2 and 3 of 2018/19. However, in 2018/19 quarter 4 and 2019/20 quarter 1, performance improved and was similar to the operational standard and the England average.

The performance over time is shown in the graph below.

Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), West Suffolk NHS Foundation Trust

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

The trust performed better than both the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat) and the England average from 2018/19 quarter 2 to 2019/20 quarter 4.

The performance over time is shown in the graph below.

Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), West Suffolk NHS Foundation Trust
Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust performed similar to the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral and better than the England average in 2018/19 quarters 2 and 4. However, in 2018/19 quarter 3 and 2019/20 quarter 1, performance was worse than the operational standard but similar to England average.

The performance over time is shown in the graph below.

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

Staff informed patients if a clinic was running late. Pagers were available if patients wanted to leave the department to buy refreshments for example.

Staff supported patients when they were referred or transferred between services. When patients became unwell in the outpatient department staff supported them and arranged for their admission to the inpatient wards or transfer to another hospital when this was necessary.

We were not assured the service minimised the number of times patients needed to attend the hospital, as they were not ensuring patients had access to the required tests on one occasion.

During our inspection, we found patients’ diagnostic test results, such as computed tomography scan results, were often not available in time for their outpatient clinic appointment. We observed clinicians were directly informing patients to contact the trust should they not have had their diagnostic imaging completed prior to their next appointment. We found there were delays in access to diagnostic tests results. This resulted in a wasted clinic appointment, both for the patient and the service. We fed this back to senior managers at the time of our inspection who informed us this would be looked into further. Data provided following the inspection showed, whilst the six week diagnostic waiting times were maintained within clinical support services at 100% for every month in 2017, more recent pressures caused a dip in performance, including equipment failure,
staffing gaps and demand. Plans were in place for recovery of this target. For example, cystoscopy performance was impacted by capacity issues. Referral processes had been changed as a result, which allowed better evaluation of demand and capacity in the diagnostic part of urology services. Further work to look at using a portable cystoscope to increase capacity at peripheral clinics was underway.

Staff told us follow up appointments were booked at the end of the previous visit where possible, thus enabling patients to have a degree of choice in their appointment date and time and enabling them to plan ahead. Patients told us they could telephone and amend their appointment time if necessary and staff tried to accommodate changes whenever possible. However, during our inspection, we found there was no process in place for monitoring patients requiring a follow up appointment. Information provided ahead of the inspection was that since the implementation of the electronic patient record, the trust were unable to keep track of lost to follow up patients and the reporting functions had been limited. They felt these figures seemed to be small but there was no qualifying data to support this. Lost to follow up is defined as being patients who were due for follow up appointments but had been 'lost' as a result of lost contact/IT failure etc. The current process within main outpatients was, at each appointment, the consultant signals when they would like to see the patient next or if they were to be discharged. This information was collected on a slip and given to the receptionist following the appointment. The receptionist then books the follow up appointment, if required, in accordance with the recorded instructions, or discharges the patient on the system. If they were unable to book at the time, the slip was retained and sent, via internal post, to the relevant consultant secretary for booking, where they would be logged onto a database and filed. There was no internal process to track that follow up appointments had been made. Data provided by the trust stated that generally, if a patient was 'lost', then they were unaware that they were 'lost' and would unintentionally wait until the patient called querying when their next appointment was.

In addition, the service were unable to provide the average waiting times for a follow up appointment as they do not have any indicator for the first follow up appointment and do not have waiting time targets for follow up appointments as patients could be followed up over many different time periods i.e. two weeks, three months, six months, 12 months.

Following us raising concerns, we were provided with information after the inspection that demonstrated each speciality held a spreadsheet that provided a list of patients requiring follow up. The trust acknowledged that there was a lack of assurance in place to monitor the follow up process. Steps were being taken to strengthen governance and ensure monitoring was appropriate. The trust was taking action to provide themselves with additional assurance through the creation of a new electronic record report that will identify patients that have been coded as requiring a follow up appointment to be completed by December 2019. The report will create a patient tracking list (PTL) of follow ups that will be added to each specialties weekly tracking meeting and therefore will provide consistency of local oversight. A programme of internal audit was also being introduced.

**Learning from complaints and concerns**

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. However, the service took longer than the trust target to investigate and close complaints.
The hospital had a clear process in place to ensure complaints were dealt with effectively. Staff understood the policy on complaints and knew how to handle them. They tried to resolve any patient concerns immediately to prevent the concerns escalating to a complaint. Staff understood the principles of duty of candour and could describe them.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Leaflets informing patients how to make a complaint or how to contact the patient advice and liaison service (PALS) were available in all outpatient areas. PALS provided advice and support to patients who wished to raise a concern or complaint. Patients knew how to make a complaint, although none of the patients we spoke with during our inspection felt the need to complain.

Managers shared feedback from complaints with staff and learning was used to improve the service. As part of the complaints process, the outcome and learning were shared with individuals involved and any action to support development put in place. Staff told us learning from complaints and feedback was shared with staff through a variety of means such as emails, daily huddles and team meetings.

**Summary of complaints**

From June 2018 to May 2019 the trust received 32 complaints in relation to outpatient services at the trust (18.5% of the total complaints received by the trust). All of these complaints related to care received at West Suffolk Hospital.

For the 20 complaints that had been closed at the time of data submission, the trust took an average of 34.9 days to investigate and close complaints. This was not in line with their complaints policy, which states complaints should be closed within 25 days.

The 12 complaints, that had not yet been closed, had been open for an average of 49.7 working days at the time of data submission.

Managers investigated complaints and identified themes.

A breakdown of complaints by type is shown below. However, please note that the trust attributed multiple subjects to some complaints and these are indicated in the table below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>12</td>
<td>37.5%</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>7</td>
<td>21.9%</td>
</tr>
<tr>
<td>Communications</td>
<td>5</td>
<td>15.6%</td>
</tr>
<tr>
<td>Clinical treatment, appointments</td>
<td>2</td>
<td>6.3%</td>
</tr>
<tr>
<td>Appointments</td>
<td>2</td>
<td>6.3%</td>
</tr>
<tr>
<td>Patient care</td>
<td>1</td>
<td>3.1%</td>
</tr>
<tr>
<td>Clinical treatment, prescribing errors</td>
<td>1</td>
<td>3.1%</td>
</tr>
<tr>
<td>Prescribing</td>
<td>1</td>
<td>3.1%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>1</td>
<td>3.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>32</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

**Number of compliments made to the trust**
From June 2018 to May 2019 there were 29 compliments about outpatients at the trust Hospital. (3.8% of the compliments received trust wide). All of these compliments related to care received at West Suffolk Hospital.

A breakdown of compliments by department is shown below:

<table>
<thead>
<tr>
<th>Department</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech and language therapy</td>
<td>12</td>
<td>41.4%</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>12</td>
<td>41.4%</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>2</td>
<td>6.9%</td>
</tr>
<tr>
<td>Phlebotomy</td>
<td>2</td>
<td>6.9%</td>
</tr>
<tr>
<td>Pain clinic</td>
<td>1</td>
<td>3.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>29</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

The trust noted that the majority of compliments received trust-wide related to overall care along the whole pathway; and patients and relatives thanking staff for their kindness and compassion during difficult and stressful times.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

**Is the service well-led?**

**Leadership**

Leaders did not always understand and manage the priorities and issues the service faced and there was a lack of ownership by senior leaders. However, leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The main outpatient services were managed in the division of women and children’s and clinical support services. The structure included an associate director of operations, a clinical director and a head of nursing. They were supported by a senior operations manager and a service manager.

We met with the senior leadership team who spoke with pride about the work and care their staff delivered on a daily basis. The team demonstrated an awareness of the service’s performance, however, did not fully understand and manage the challenges they faced. They told us that the issues with lost to follow up appointments would be addressed by each individual speciality.

The leadership team was committed to nurturing and developing a more coordinated approach and support to enable quality improvement to be embedded across the service. Senior leaders were involved in ensuring that, on a day to day basis, there was a safe and effective approach to clinical staffing and patient flow. They worked collaboratively to make improvements in the effectiveness and responsiveness of care. They supported staff to take ownership of the issues, reflect and consider their practice and be open to new ways of working.

We met with the service manager and senior sister during the inspection and found they were organised and demonstrated strong and supportive leadership. We asked staff if senior leaders were visible and approachable and received a positive response. Staff told us that local leaders in their areas were always seen and were readily available to provide advice and support. Staff were fully aware of who the divisional leads were. Staff did tell us that there was regular communication from the executive team on the intranet and through emails.
Managers arranged departmental unit meetings monthly to ensure staff were kept up-to-date with information about their department and the service. There were various methods of communication across the teams, including meetings, notice boards and e-mail. Areas covered included; patient safety, staffing and performance.

The trust provided development programmes for staff, which supported them to develop leadership and management skills. Courses were available for first line managers, middle managers and senior managers. Both internal and external programmes were available. A senior leader told us they were a member of the 2030 leadership programme.

All staff we spoke with were aware of the whistleblowing policy and many staff told us they would escalate concerns or challenge colleagues if patient safety was compromised.

**Vision and strategy**

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The clinical support services division had a strategy in place with a vision ‘to provide all our patients with safe, effective, compassionate and responsive care to the highest quality standards within available resources’. This reflected the trust’s strategic framework document ‘Our patients, our hospital, our future, together’, which outlined the trust vision, three priorities and seven ambitions.

The vision for West Suffolk NHS Foundation Trust was to ‘deliver the best quality and the safest care for our community’. The trust’s value statement was ‘Putting you FIRST’, which stood for:

- Focused on patients
- Integrated
- Respectful
- Staff focussed
- Two-way communication

The trust’s strategic framework set out their three priorities:

- Deliver for today
- Invest in quality, staff and clinical leadership
- Build a joined-up future

This included seven ambitions:

- Deliver personal care
- Deliver safe care
- Deliver joined-up care
- Support a healthy start
- Support a healthy life
• Support ageing well
• Support all our staff

All staff we spoke with, clinical and non-clinical, were aware of the vision, values and ambitions. Staff provided examples of how the values were reflected within their work, such as providing safe, effective and compassionate care. Interactions observed throughout our inspection demonstrated the trusts values.

Culture

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**

We observed a culture of commitment, teamwork and support across all departments. All staff we met were welcoming, friendly and helpful. It was evident that staff were passionate about the care they provided to people who used the service and were proud to work at the trust.

Department managers and senior management teams promoted an ‘open-door’ culture and staff were encouraged to raise concerns and share ideas for service improvement. Managers told us they were extremely proud of their staff and the service they provided.

We observed good working relationships across the service and it was evident that staff morale was good in all areas we visited. Staff spoke with pride about their role and told us they felt respected and valued by their managers and senior management team. An action plan was in place following an investigation into the outpatient service as there were reports of a poor culture 18 months prior to the inspection. Senior managers told us good progress had been made against the actions and the culture in outpatient services had significantly improved and was much more positive. Staff we spoke with corroborated this.

Multidisciplinary teams worked collaboratively and were focused on improving patient care and service provision. During our inspection, we observed positive and respectful interactions which were focused on meeting patients’ needs and providing safe care and treatment.

There were arrangements in place to promote the safety and wellbeing of staff. Staff could contact the trust’s security team for support and assistance if patients or visitors became verbally and/or physically abusive. Staff could access the trust’s occupational health and wellbeing team if they needed additional support at any time.

There were mechanisms for providing staff with the development they needed. These included personal development reviews and appraisals. From April 2018 to March 2019, 93.1% of staff within outpatient services at West Suffolk Hospital received an appraisal compared to a trust target of 90%. Staff told us they found appraisals useful.

Staff were encouraged to report incidents and felt confident in doing so. The culture encouraged openness and honesty. Processes and procedures were in place to meet the duty of candour. Where incidents had caused harm, the duty of candour was applied in accordance with the regulation.

Governance
Despite established governance processes throughout the service, we found there was lack of local ownership and oversight in some issues raised during our inspection. However, staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The governance framework in outpatient services ensured staff responsibilities were clear and quality and performance risks were understood and managed. However, despite senior staff understanding their roles in relation to governance and their level of accountability with regard to providing a safe service to patients and their families, we found there was a lack of local ownership and oversight in relation to some of the issues identified during our inspection, that had resulted in an uncoordinated and inconsistent approach.

For example, there was no effective process in place for monitoring patients requiring a follow up appointment or those on surveillance pathways. We found there were a large number of vascular patients affected by lost to follow up issues, with the potential for serious harm. The service were unaware of the number of patients who may have been lost to follow up. In addition, there was no process in place to monitor the average waiting times for a follow up appointment. We raised these concerns during and following inspection. After which steps were identified to improve and strengthen governance process to ensure monitoring and oversight would be appropriate moving forward.

All staff spoken with confirmed there was an established structure in place across the outpatient service with meetings being attended by both divisional leads and senior staff. Senior managers, clinical and non-clinical, reviewed performance in relation to patient safety, clinical effectiveness, and patient experience.

There was an established process for governance and risk management. All incidents reported through the incident reporting system were reviewed regularly. This was to ensure the service was safe and identify any immediate actions required to address safety concerns. Potential serious incidents were reviewed in more depth and were escalated when necessary.

Outpatient services’ were part of the clinical support services directorate. A directorate governance committee covered issues across the different departments within the directorate as a whole. This committee reported to the trust quality assurance committee which reported to the trust board.

Divisional and directorate governance meetings were held bi-monthly and monthly respectively. In the two sets of minutes we reviewed we saw incidents, audits, policies, risks and items for escalation were discussed, and actions agreed to address current service shortfalls.

The outpatient’s department had regular staff team meetings at which performance issues, concerns and complaints were discussed. When staff were unable to attend these meetings, steps were taken to communicate key messages to them. Staff could also access the minutes to the meeting.

Staff were able to describe the governance structure across all levels of the service and believed communication, on the whole was good. There were systems to review the National Institute for Health and Care Excellence (NICE) guidelines and other nationally recognised guidance.

Effective governance processes were established at departmental level. We were assured that emergency equipment, fridge and ambient temperatures where medicines were stored, and consumables were checked regularly. Staff were committed to improving the quality of service provision and safeguarding high standards of care.
During the 2016 inspection, a whistleblowing concern was raised. This was regarding the standards of photographic image governance. This remained an issue during the previous inspection in 2017 with regard to data protection concerns on cameras used in wards and departments. At this inspection, we found the trust had implemented a secure app to both capture patient consent and upload image data securely to trust systems.

Management of risk, issues and performance

Not all risks and issues were identified, escalated or effectively acted upon to reduce their impact. There was a lack of oversight and ownership by senior leaders within the service, despite systems to manage risk and performance being in place.

Risks were not always identified or dealt with appropriately or quickly enough. Whilst there were arrangements in place for recording and managing risks, we found that the local leadership team had not acted upon potential significant concerns in a timely manner. For example, the lack of robust systems to ensure patients on surveillance pathways, or requiring follow up, was known but actions had not been undertaken in a responsive manner. This had resulted in significant patient safety risk within the vascular service, and an extended period of time where potential risk across other specialties remained unknown.

We found that oversight and monitoring of the situation at local leadership level was poor. When we raised concerns during the inspection, the senior leadership team informed us that they felt this risk sat with individual specialties, rather than the outpatients service. There was a lack of recognition and ownership by the senior leadership team which meant that the risk management approach was not applied effectively or consistently across the service to ensure mitigations were in place, for all patients, across all specialties.

There were a number of different processes in place for the booking of future appointments, some paper, some electronic with reliance on individuals. However, this had not been risk assessed or noted on the outpatient services’ risk register, or the divisional risk register, as a potential risk, despite concerns having been raised. Senior leaders did not have sight of all risks. For example, they told us one of the main risks identified within outpatients was difficulties with opening and closing windows in the clinic rooms and effects of extreme heat in the summer months.

In response to our concerns being raised the trust responded and actions were taken to ensure that immediate patient safety risks for vascular patients had been mitigated and harm reviews were being undertaken where appropriate. A review of surveillance pathways across specialties, and processes for follow up, had been undertaken alongside sample audits to provide assurance that diagnostic interventions were happening as per pathway requirements.

We reviewed the outpatient services’ risk register. For identified risks, the register included a description of each risk, an assessment of the likelihood of the risk materialising, its possible impact and the lead person responsible for review and monitoring. We saw that risks were reviewed regularly at monthly directorate meetings and were updated when changes to mitigation had been taken

There were regular staff meetings to share learning from incidents and complaints. Where specific actions were required, they were fed back at daily safety huddles. Sharing learning from experience was also discussed at trust shared learning events and through the trust’s shared learning bulletin.
Performance review meetings were held for outpatient services monthly. The outpatient departments had a number of key performance indicators (KPI) including referrals, appointments, cancellations, did not attend (DNAs) and patient waits (for appointments). During our previous inspection, we were told a dashboard had been developed to monitor the KPIs, however, this was not live. At this inspection, senior leaders told us the dashboard to monitor KPIs was now live.

Staff were aware of the duty of candour requirements which identified the importance of sharing information with patients and families when an incident had occurred which involved them. Duty of candour principles had been applied to particular incidents we reviewed.

The trust had a policy and plans in place for emergencies and other unexpected or expected events, such as adverse weather, flu outbreak or a disruption to business continuity. There was an effective understanding amongst staff about their roles and responsibilities during a major incident.

Information management

Due to issues with the integration of various systems the accuracy of referral to treatment data could not be assured. Not all relevant information was collected or used to monitor, manage and timely report on quality and performance. However, information that was collected was readily available, in easily accessible formats, and analysed by staff to understand performance. Data or notifications were consistently submitted to external organisations as required.

Performance measures were reported and monitored. Areas of good and poor performance were highlighted and used to challenge and drive forward improvements, where indicated. Performance targets were set in line with national targets where available.

Whilst there were arrangements to report referral to treatment time (RTT) performance data we were not assured that this was accurate, valid and timely. During the previous inspection, the trust had identified difficulty in presenting accurate RTT reporting and the backlog on the patient tracking list (PTL). This was still a priority and the trust held sub divisional PTL meetings on a weekly basis. They had departmental intensive support teams (IST) in place to review and assess if patients were at risk of harm as a result of a long wait. Due to issues with the integration of various systems, senior leaders estimated that they were 9-12 months away from reliable data for RTT. Data was submitted to external bodies, such as NHS England, as required.

We were not assured that all relevant information was collected or used to monitor, manage and timely report on quality and performance. For example, in relation to issues around lost to follow up patients, there was lack of qualifying data for assumptions made in relation to this cohort of patients. However, the trust acknowledged there was a lack of assurance in place to monitor the follow up process. Steps were being taken to strengthen governance and ensure monitoring was appropriate.

Where information was available this was accessible to staff. There were arrangements in place to ensure confidentiality of patient information held electronically and we found staff were aware of how to use and store confidential information. Computer terminals were locked when not in use to prevent unauthorised persons from accessing confidential patient information.

There were sufficient computers available to enable staff to access the system when they needed to. Computers were available in all the areas we visited. All staff had secure, personal login details and had access to email and all hospital information technology systems.
The service was aware of the requirements of managing a patient’s personal information in accordance with relevant legislation and regulations. General Data Protection Regulations had been reviewed to ensure the service was operating within the regulations. Staff viewed breaches of patient personal information as a serious incident and would therefore manage this as a serious incident and escalate to the appropriate bodies.

**Engagement**

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

People’s views and experiences were gathered and acted on to shape and improve the services and culture. Service user feedback was sought to inform changes and improvements to service provision.

Patients who used outpatient services were encouraged to give feedback on the quality of service they received. For example, the service contributed to the national friends and family test (FFT). The service used feedback from the FFT, local surveys, and complaints to monitor and improve services provided. Results from FFT were consistently positive; for July, August and September 2019, 96% of patients using the service would recommend the service.

Information about the complaints procedure and patient advice and liaison service was available in all areas. Feedback was also gathered through social media forums, such as NHS Choices.

Regular emails, team meetings, notices in staff areas, and safety briefings ensured staff were informed about important updates.

The minutes of meetings we reviewed showed good staff engagement at all levels, this was an improvement from the previous inspection.

**Learning, continuous improvement and innovation**

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Staff of all disciplines were committed to improving service provision and the patient experience. Staff could provide examples of improvements and changes made to processes based on patient feedback, incidents and staff suggestion. Staff were alert to new initiatives and ways of working.

The trust were investing in optimisation and digital integration and had started to connect all the data gathered in various organisations to help improve the quality of their services. The trust were building a health information exchange, so that every professional, regardless of where they were working, could see all the relevant information about a patient’s health and social needs, rather than ask the same questions every time.

The service had also introduced video consultations, apps and other digital tools to make it easier and more convenient for the residents of West Suffolk to access the help and information they needed. For example, the paediatric epilepsy outpatient service, as well as other specialties, offered video consultations so patients would not need to come into hospital.
Pain services had been integrated across acute and community boundaries and were run by a joint management team. Waits for treatment had fallen due to a mixture of integrated working, a reduction in repeat procedures, and integrated multidisciplinary note-sharing and working between pain, physiotherapy, psychology/psychiatry and the spinal services.

Senior managers told us a video linked interpreting service was being trialled for patients whose first language was not English.

Learning from incidents and complaints was shared through a variety of forums, including the trust’s shared learning events and bulletins, and quality and governance meetings.

The service was committed to training and staff development. All staff told us they were encouraged and supported to complete additional training. The trust were a member of NHS Elect which enabled staff to access free training events. Staff were supported to attend the Open University and East of England NHS Leadership Academy courses.
Community health services

Community health services for adults

Facts and data about this service

The trust provided the following information about their community services for adults:

Community nursing teams consist of qualified and non-qualified staff who provide nursing care to patients in their own homes across the west of Suffolk. This care is largely planned but also incorporates an element of unplanned care, both during core hours and overnight.

Teams are based in various localities across the west:

- Bury Town
- Bury Rural
- Haverhill
- Sudbury
- Newmarket
- Brandon/Mildenhall

Services are led by district nurses who have achieved the specialist practitioner qualification. The teams also include occupational therapists and physiotherapists who report to one professional lead that covers acute and community.

Referrals are made via a care co-ordination centre, which can be accessed by patients, GPs and other health professionals.

A number of specialist community nursing services are provided across the county at outreach clinic settings with patients also being seen in their own homes, if appropriate. A number of these specialist nurses are non-medical prescribers (NMP) who work closely with consultant colleagues.

The speech and language therapy service is provided from four locations and patients’ homes. It links into the six different localities to ensure joined up working.

The dietetic service is provided from 17 locations and patients’ homes and includes a domiciliary enteral feed service.

(Source: Community Routine Provider Information Request (RPIR) – CHS Context)

This was the first inspection of community adult services since the trust was awarded the contract for the provision of the service in 2017.

Our inspection of West Suffolk Foundation Trust was announced. Prior to our inspection we reviewed data we held about the service along with information we requested from the trust.

During the inspection we spoke with 21 members of staff including nurses, therapists, health care assistants and non-clinical staff. We spoke with seven patients and their relatives, reviewed 21 patient records and considered other pieces of information and evidence to come to our judgement and ratings.
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

Staff had not completed mandatory training in line with the trust’s 90% mandatory training target.

Mandatory training completion rates

The trust set a target of 90% for completion of all mandatory training with the exception of information governance which had a target of 95%.

Trust level

A breakdown of compliance for mandatory training courses as of June 2019 for qualified nurses in community services for adults at trust level is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
<td></td>
</tr>
<tr>
<td>Conflict resolution – e-learning</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Infection control - classroom</td>
<td>141</td>
<td>146</td>
<td>96.6%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Fire safety training - classroom</td>
<td>132</td>
<td>146</td>
<td>90.4%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>128</td>
<td>146</td>
<td>87.7%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Health &amp; safety / risk management</td>
<td>124</td>
<td>146</td>
<td>84.9%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>98</td>
<td>132</td>
<td>74.2%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Basic life support (adult)</td>
<td>104</td>
<td>143</td>
<td>72.7%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Moving and handling - clinical</td>
<td>103</td>
<td>146</td>
<td>70.5%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Fire safety training - e-learning</td>
<td>99</td>
<td>146</td>
<td>67.8%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Information governance</td>
<td>98</td>
<td>146</td>
<td>67.1%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Security awareness</td>
<td>87</td>
<td>146</td>
<td>59.6%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Slips trips falls</td>
<td>73</td>
<td>146</td>
<td>50.0%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Blood borne viruses/inoculation incidents</td>
<td>63</td>
<td>142</td>
<td>44.4%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>MAJAX</td>
<td>59</td>
<td>146</td>
<td>40.4%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Medicine management (refresher)</td>
<td>57</td>
<td>145</td>
<td>39.3%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

In community services for adults, the targets were met for three of the 15 mandatory training modules for which qualified nurses were eligible.

The trust informed us that there were no specialist consultants within community services for adults with medical cover being provided by GPs.
A breakdown of compliance for mandatory training courses as of June 2019 for qualified allied health professionals in community services for adults at trust level is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>37</td>
</tr>
<tr>
<td>Health &amp; safety / risk management</td>
<td>37</td>
</tr>
<tr>
<td>Fire safety training - classroom</td>
<td>36</td>
</tr>
<tr>
<td>Fire safety training - e-learning</td>
<td>31</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>29</td>
</tr>
<tr>
<td>Information governance</td>
<td>28</td>
</tr>
<tr>
<td>Security awareness</td>
<td>26</td>
</tr>
<tr>
<td>Moving and handling - clinical</td>
<td>25</td>
</tr>
<tr>
<td>Basic life support (adult)</td>
<td>23</td>
</tr>
<tr>
<td>Slips trips falls</td>
<td>20</td>
</tr>
<tr>
<td>Infection control – e-learning</td>
<td>20</td>
</tr>
<tr>
<td>MAJAX</td>
<td>15</td>
</tr>
<tr>
<td>Infection control - classroom</td>
<td>0</td>
</tr>
</tbody>
</table>

In community services for adults, the targets were met for three of the 13 mandatory training modules for which qualified allied health professionals were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

During the inspection we found an improvement in the mandatory training completion rates compared to the information the trust provided before our inspection. The Newmarket team had an overall mandatory training completion rate of 89% in August 2019 and 88% in September 2019. This was just below the trust’s target of 90%. However, we saw that mandatory training completion varied across the individual teams. For example, the community neurological team had a completion rate of 100%, but Sudbury had a completion rate of 68%. In Sudbury, an additional seven members of staff had completed mandatory training since August 2019. Senior managers we spoke with told us that the trust had added extra mandatory training dates to the schedule that had enabled them to allocate training days to staff sooner than planned.

Managers and staff, we spoke with, told us that the process for mandatory training had changed from individual sessions and e-learning throughout the year to a one-day training where all mandatory training was completed. Staff told us they found it easier to attend the main hospital site for one day rather than for lots of individual sessions and the extra time for travelling. Managers told us that this system had worked better for staff and capacity planning.

Managers we spoke with told us that all staff within their teams had mandatory training booked and records we saw confirmed this.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it, however compliance was below trust target.
Staff at all levels, knew their responsibilities to safeguard patients from avoidable harm and abuse. Staff we spoke with knew how to raise safeguarding concerns and had access to a named safeguarding lead if they needed advice or support with any concerns. Staff gave a range of examples of the types of concerns they would report, such as, but not limited to, self-neglect, female genital mutilation (FGM) and unexplained injuries.

The service had systems and processes in place to identify patients at risk of abuse. Staff identified patients at risk of abuse by using flags on the electronic records system. All professionals involved in the patient’s care had access to information about safeguarding concerns.

Staff completed safeguarding training through e-learning with time set aside for e-learning during the one-day mandatory training programme.

The service provided ‘Prevent’ training (this enabled staff to recognise and report vulnerable people from being exploited and drawn into terrorism).

**Safeguarding training completion rates**

The trust set a target of 90% for the completion of safeguarding training.

The tables below include Prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

**Trust level**

A breakdown of compliance for safeguarding training courses as of June 2019 for qualified nurses in community services for adults at trust level is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>128</td>
<td>146</td>
<td>87.7%</td>
<td>90%</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2</td>
<td>125</td>
<td>146</td>
<td>85.6%</td>
<td>90%</td>
</tr>
<tr>
<td>(basic prevent awareness)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp;</td>
<td>120</td>
<td>146</td>
<td>82.2%</td>
<td>90%</td>
</tr>
<tr>
<td>5 (prevent awareness)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>99</td>
<td>146</td>
<td>67.8%</td>
<td>90%</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>95</td>
<td>146</td>
<td>65.1%</td>
<td>90%</td>
</tr>
</tbody>
</table>

In community services for adults the 90% target was not met for any of the five safeguarding training modules for which qualified nurses were eligible, although the safeguarding children level 1 module narrowly missed the target, at 87.7%.

The trust informed us that there were no specialist consultants within community services for adults with medical cover being provided by GPs.

A breakdown of compliance for safeguarding training courses as of June 2019 for registered allied health professionals in community services for adults at trust level is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20190416 900885 Post-inspection Evidence appendix template v4
<table>
<thead>
<tr>
<th>Training module</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2 (basic prevent awareness)</td>
<td>36</td>
<td>38</td>
<td>94.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5 (prevent awareness)</td>
<td>35</td>
<td>38</td>
<td>92.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>32</td>
<td>38</td>
<td>84.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>23</td>
<td>38</td>
<td>60.5%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In community services for adults the 90% target was met for two of the four safeguarding training modules for which qualified allied health professionals were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The trust had a safeguarding children policy in place for staff to follow. The policy set out the responsibility of staff at all levels and referenced relevant legislation and national guidance. The policy was within the review date and was version controlled.

The trust had an adult safeguarding policy and practice guidance procedure in place for staff to follow. The policy set out the responsibility of staff at all levels and referenced relevant legislation and national guidance. The policy was within the review date and was version controlled.

**Safeguarding referrals**

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation works to ensure the safety of the person. An assessment of the concerns is conducted to determine whether an external referral to children’s services, adult services or the police should take place.

Community services for adults made 18 safeguarding referrals from June 2018 to May 2019, all of which concerned adults.

Considering adult referrals across the 12-month period, there were peaks of three referrals in December 2018 and February 2019.

(Source: Routine Provider Information Request (RPIR) – Safeguarding tab)

Staff we spoke with told us they received feedback from the community safeguarding lead when they had reported safeguarding concerns. Staff also told us they discussed learning following safeguarding investigations.

The trust participated in a multi-agency safeguarding hub (MASH) audit for adult safeguarding in conjunction with the local authority. Community adult services had conducted no safeguarding adult reviews from June 2018 to May 2019.

The adult safeguarding committee met quarterly, chaired by the adult safeguarding lead and was attended by the named community safeguarding lead, social services representatives and the safeguarding lead from the CCG. The committee reported to the clinical safety and effectiveness committee (CSEC) every three months. The CSEC was a sub-committee of the trust board.
The service carried out three-yearly Disclosure and Barring Service (DBS) checks on all staff. These checks help to prevent unsuitable people from working with vulnerable groups, including children. Managers received this information from the human resources team.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff kept equipment and their work area visibly clean.

All patient facing staff wore uniforms with short sleeves to ensure they were bare below the elbow, to reduce the spread of healthcare associated infections.

We observed care provided in peoples’ own homes and saw that staff decontaminated their hands and used personal protective equipment appropriately. Staff we spoke with knew the measures they needed to take to prevent the spread of healthcare associated infections, such as the correct use of personal protective equipment and good hand hygiene.

The trust had an infection prevention and control policy in place for staff to follow. The policy was within the review date, version controlled and referenced relevant national guidance and legislation.

The service completed monthly hand hygiene audits, which all staff were required to participate in. The hand hygiene audit required staff to demonstrate effective hand decontamination. Data provided by the trust showed all community teams had a compliance rate of between 97-99% in the hand hygiene audit from May 2019 to July 2019.

All the clinical areas and integrated care team bases we visited were visibly clean and free from clutter. Clinic rooms where patients attended for care and assessments were clean and staff decontaminated equipment between patients appropriately.

The trust had an infection prevention and control team to provide advice and support to staff. Staff we spoke with told us that they discussed complex infection prevent and control issues with the team. Managers told us that the infection prevention and control team had provided support to change processes for transporting dressings to patients’ homes following an outbreak of a healthcare associated infection in a neighbouring county. Nurses had paper carrier bags to transport dressings which stayed in patient’s own homes to prevent the transfer of infection from nurse’s bags.

Staff completed individual risk assessments where appropriate, if there were concerns about infection prevention and control in a patient’s own home. The electronic records system alerted staff of any risks on the summary page of the patient record. The risk assessment provided information such as precautions and waste management processes. The service alerted the local council when clinical waste collections from patient homes were required.

**Environment and equipment**

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. When providing care in patients’ homes staff took precautions and actions to protect themselves and patients.
Clinics we visited had wheelchair access for people with reduced mobility. All the clinics we visited at community hospitals and health centres signposted patients to the correct area well and had easy access to free car parking nearby.

We reviewed equipment used within patient’s own homes such as ear syringing equipment, syringe drivers and bladder scanning machines. We checked 21 items of equipment and of these all were up-to-date with electrical servicing and safety testing.

The trust had an electrical and biomedical engineering department that completed equipment servicing and electrical testing. Senior staff we spoke with told us that the engineers were responsive to their needs and arranged annual visits to bases to complete equipment servicing and safety checks.

Staff managed the stock of disposable single use items well. We reviewed the storage of single use devices such as wound dressings, urinary catheters and syringes. We found cupboards were well stocked and tidy. We reviewed 51 single use devices and found 49 devices within their expiry date. We found one needle and one hand decontamination gel that were outside the expiry date. We escalated this to a member of staff who removed these items for disposal immediately.

The service had a dressings formulary for staff to order and use appropriate dressings in the care of their patients. Nursing staff took dressings from the nursing base to their patients on each visit. This minimised the waste associated with dressings held in patients’ homes.

Store rooms were well organised and stocked so that staff could easily select the items they required for patient care. We reviewed equipment storage areas that were fitted with shelving, so that no equipment was stored on the floor, to allow access for cleaning.

Staff had access to pressure relieving equipment within bases to provide equipment promptly to patients. An external organisation managed and cleaned pressure relieving equipment through a service level agreement. The company also supplied alternating air mattresses which were delivered to patients’ homes and set up during the delivery. Staff we spoke with told us that the company could provide the mattresses within four hours.

Staff used special carrying boxes for transporting specimens such as blood samples, from patients’ homes to the laboratory or GP surgery. This meant that the service reduced the risk of contamination from these samples and the spread of healthcare associated infections.

The trust had arrangements with the local authority to collect large amounts of contaminated waste where there was a risk of healthcare associated infections. Nurses disposed of small amounts of waste, for example soiled dressings, within the patient’s own domestic waste in line with the trust’s policy.

Staff disposed of contaminated used sharps such as needles appropriately. Staff kept sharps containers in patient’s own homes. Staff sealed and removed these containers once they had become full and took them to the nursing base ready for collection. Full sharps containers were collected on a weekly basis from the nursing bases.

### Assessing and responding to patient risk

**Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.**

The service had processes in place to ensure that patient referrals were assessed and allocated to staff in a safe and timely manner. All new referrals for community teams were co-ordinated by the
central contact centre (CCC). The CCC allocated assessed and allocated the referrals to the appropriate team. The community nursing teams had a captain of the day role within each team, they assessed the urgency of the referrals and were responsible for the allocation a visit.

Each patient admitted to adult community services received a holistic assessment upon their first appointment. Staff assessed patients and undertook appropriate risk assessments during this appointment. We reviewed 21 sets of electronic patient records and found that 20 records demonstrated a holistic assessment had taken place on the first appointment.

Staff completed risk assessments such as malnutrition universal scoring tool (MUST) and Waterlow pressure ulcer risk assessments. We reviewed 21 records and we found that 18 records evidenced up-to-date MUST assessments and Waterlow assessments. Therapists used the Anderson tool pressure ulcer risk assessment to screen patients for a risk of pressure ulcer development. Where patients were found to have an increased risk a full Waterlow risk assessment was completed.

The service had systems and processes in place to identify patients with signs of sepsis or deterioration. The service used the national early warning score (NEWS) which prompted staff to escalate deteriorating patients for medical review. The service had started to record baseline clinical observations for all patients who were on the community nursing caseload. Staff had received training in the sepsis six care bundle within the basic life support mandatory training module. The service was waiting for the delivery of additional thermometers and oxygen saturation probes to ensure all clinical staff had this equipment.

Staff discussed patients on their caseloads every lunchtime. Nursing staff discussed the care plans in place and forward planned care interventions, this enabled teams to plan care appropriately and identify complex needs, such as patients at the end of their life. Community matrons supported staff with the management of patients with complex long-term conditions such as respiratory disease and frailty. Staff completed Rockwood frailty scores for each patient during their initial assessment, to align care to their needs such as involving physiotherapy or occupational therapy services.

The service undertook individual risk assessments, where staff had identified concerns about the patient care environment or staff safety. Managers we spoke with told us that all lone worker risk assessments were flagged on the summary page of electronic patient records. Two managers we spoke with told us of an incident where risk assessments were implemented due to aggressive behaviour towards staff and the zero tolerance of violence towards staff was explained to the patient. The risk assessment outlined that two staff were required to visit the patient for staff safety.

The service had business continuity plan in place and managers were reviewing the plan at the time of our inspection, to ensure they had measures in place for the winter. The plan set out staff roles and responsibilities if a major incident was declared. The plan also defined the types of situations that constituted a major incident. Managers knew when to implement the plan, such as bad weather conditions, where staff prioritised the care of the patients with the highest needs.

Managers we spoke with, told us that patient visit allocations were prepared a day in advance and staff monitored weather conditions to prepare in the event of snow or flooding in the local area, to ensure essential visits were completed.

The service had an emergency intervention team based at the main hospital site in Bury St Edmunds. This team provided urgent assessments for patients in the community so that care was implemented within the patient’s own home where appropriate. This was done to avoid hospital
admission for patients creased social care needs or frailty which could be managed effectively by community based teams. Patients were seen within four hours of referral from a healthcare professional, family member or self-referral.

**Staffing**

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

District nurses were the only registered nurses that held a formal caseload. They planned according to acuity and skill mix daily, to support patients to achieve their agreed outcomes, whilst ensuring that holistic and effective care was delivered. The service aimed to provide approximately 1.0 whole time equivalent (WTE) district nurse per 20,000 practice population across the organisation, supported by a team of registered nurses.

Information provided by the trust prior to our inspection showed that the average case load per member of staff ranged from 22 to 51 patients.

All community teams we visited had a defined team of staff and service leads who were responsible for monitoring and managing caseloads. Within the community teams, caseloads were reviewed daily during lunch time handovers. This ensured that the right care was delivered in the right place, at the right time, by the appropriately skilled member of staff. It also allowed teams to forward plan and ensure that the correct skill mix of staff was available to meet the needs of patients.

Managers used paper rostering in community teams. Managers we spoke with told us that the service was reviewing electronic rostering to provide greater oversight of staffing across all of the community teams.

The service had daily escalation conference calls with representation from all community teams, to discuss staffing levels. Managers risk graded the staffing levels from one to four, a level one meant that actual staffing met the planned numbers. Level four meant the team did have enough staff to safely care for patients. We observed a daily escalation call where all teams were risk graded as level two, due to staff sickness. Managers we spoke with told us that staff were moved to support other teams where required depending on the risk levels across the community teams.

Community teams had one member of staff that worked from 8am to 4pm called the “captain of the day” to co-ordinate new referrals to the service and allocate any urgent visits. The core staff worked from 9am to 5pm, seven day per week. After 5pm the emergency intervention team completed any urgent visits until 8am the next day.

Team leads managed their vacancies well. In Newmarket the team lead told us they had no staff vacancies following interviews prior to our inspection; all vacant post had been filled. The Sudbury team had advertised for a band seven and a band six nursing post and for an occupational therapist. The team lead had appointed one band six nurse prior to our inspection.

The service did not use agency staff to fill vacant shifts, although they used bank staff to fill them. Each bank member of staff had to complete a trust induction and a mandatory training programme to ensure they were up to date with the skills and competencies required for their role. Bank staff were allocated a team lead at the base nearest their own home for the purpose of induction and
managerial oversight. The service used regular bank staff during times of high demand, to maintain consistency of care to patients.

Specialist nursing teams were managed by the lead nurse for the service who completed sickness reviews for staff. Specialist nursing services had a fixed working pattern from Monday to Friday.

Nursing staff

The table below shows a summary of the nursing staffing metrics in community services for adults at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
<th>June 2018 to May 2019</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annual average establishment</td>
<td>Annual vacancy rate</td>
<td>Annual turnover rate</td>
</tr>
<tr>
<td>Target</td>
<td>6%</td>
<td>10%</td>
<td>3.5%</td>
</tr>
<tr>
<td>All staff</td>
<td>219</td>
<td>6%</td>
<td>5%</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>115</td>
<td>7%</td>
<td>3%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Nurse staffing rates within community services for adults at trust level were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover and sickness.

The trust did not report any agency usage for qualified nurses within community services for adults at trust level.

Bank staff usage

![Bank hours - qualified nurses, health visitors and midwives](chart.png)
Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives were not stable and may be subject to ongoing change.

(Source: Routine Provider Information Request (RPIR) – Nursing bank agency tab)

Allied health professional staffing

The table below shows a summary of the allied health professional staffing metrics in community services for adults at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Community services for adults annual staffing metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff group</strong></td>
</tr>
<tr>
<td><strong>Target</strong></td>
</tr>
<tr>
<td>All staff</td>
</tr>
<tr>
<td>Allied health professionals</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Allied health professional staffing rates within community services for adults were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover.

Vacancy rates

Monthly vacancy rates over the last 12 months for allied health professionals in community services for adults at trust level were not stable and may be subject to ongoing change.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Sickness rates
Monthly sickness rates over the last 12 months for allied health professionals in community services for adults at trust level showed a shift from December 2018 to May 2019.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Suspensions and supervisions

During the reporting period from April 2018 and March 2019, community services for adults reported that there were no cases where staff had been either suspended or placed under supervision.

(Source: Routine Provider Information Request (RPIR) – P23 Suspensions or Supervised)

Quality of records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Community adult services used electronic patient records with two-point security access. Staff from different teams had access to one patient record. This meant that information, subject to patient consent, could be shared with all other services that use the system. Staff we spoke with told us that this improved patient care and increased efficiency by ensuring that information was available to the right person at the right time.

Staff had access to a patient record download system to ensure they always had access to patients records in areas of poor mobile internet connection. The records automatically uploaded to the server once staff reach an area with internet connectivity.

Information needed to deliver safe care and treatment was available to relevant staff in a timely and accessible way. Staff were able to access and update electronic patient records remotely. Staff were expected to complete electronic patient records within 24 hours of patient contact.

We reviewed 21 sets of patient records, all of which were legible and dated with an electronic staff signature. This meant staff could easily identify the clinician and the date for each entry. All the records we reviewed demonstrated the plan of care and treatment for the patients.

The trust had a record a clinical record keeping policy in place which set out the expectations of staff regarding the quality of clinical records. The policy was with the review date and referenced relevant legislation and national guidance.
Managers completed monthly records audits. Managers audited a sample of patient records and scored the completion of the documentation in line with the trust’s policy. The audit measured the completion of elements such as initial assessment, moving and handling assessments, pressure ulcer risk, nutritional needs and lone worker risk assessments.

The service completed monthly audits of patient records, this audit formed part of the trust’s perfect ward scores. Perfect ward scores were made up of audits such as hand hygiene and record keeping audits. We reviewed the perfect ward scores for June and July 2019 and we found inconsistent completion of this audit for community teams. In June 2019 only two teams out of six submitted audit data and in July 2019, there was only one. Community services compiled a staff newsletter called CREWS which updated staff about service performance broken down by team. CREWS reports showed In June 2019 the Haverhill team scored 87.1% which was below the 90% target and the Newmarket team scored 90.5%. In July 2019 Haverhill was the only team that submitted data and scored 91% for the completion of patient records.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

The trust had a policy for the use of medicines. The policy set out the roles and responsibilities of staff at all levels in the prescribing and administering medicines. The policy was with the set review date and referenced national guidance and legislation. The policy was supported by standard operating procedures for administration of medicines such as insulin and low molecular weight heparin.

The service used paper medicines records which remained in patients own homes. Managers we spoke with told us that the service had not moved to electronic medicines records, because there were areas where internet connectivity was poor, staff may not see that medicines had been given. Staff documented medicines administration within the electronic records, however signed directives were kept with the patient.

Staff administered controlled drugs such as diamorphine (strong pain relief) which is a controlled drug, to patients at end of their life. Staff did not convey medicines to patients, the patient’s family collected them from a pharmacy, or a local pharmacy delivered these medicines.

We reviewed five medicine administration records for controlled drugs, we saw the administration records were signed, dated and timed. Staff completed medicines reconciliation record for the controlled drugs in patients own homes, to monitor and prevent the misuse of these medicines. The administration documents we reviewed had patient allergies recorded. Additionally, we saw staff documented patient allergies and sensitivities in the electronic records.

Nursing staff did not routinely transport medicines to patients. However, community nursing staff administered flu vaccines to their patients which they transported from community bases to the patient homes. The vaccines were transported in specialist cool bags with a temperature probe and staff restocked supplies twice daily to prevent vaccines becoming too warm.

Staff administered medicines such as insulin to patients in their own homes and within care homes. Insulin is a medicine to regulate blood sugar levels for diabetic patients.

Some of the specialist nurses and community nursing staff were able to prescribe medicines within the scope of their practice. These staff members had completed a specialist university course in
order to prescribe medicines and medical devices for their patients. The service was member of Suffolk system wide non-medical prescriber’s forum.

**Safety performance**

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff.

The service collected information about harms for the NHS safety thermometer and investigated any service acquired harms and shared learning from these incidents with staff. Managers investigated pressure ulcer incidents and compiled root cause analysis investigation reports which were reviewed at the trust wide pressure ulcer panel. Managers we spoke with told us they provided feedback to staff individually where practice required improvement and to provide additional support.

The service displayed safety thermometer data within community bases. We observed wall displays with safety thermometer data in each of the community team bases we visited.

The service had access to support to the integrated tissue viability service in the prevention and managements of pressure ulcers. They provided education regarding patient repositioning and pressure relieving equipment.

**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.

**Community Settings**

Data from the patient safety thermometer showed that the trust reported 47 new pressure ulcers, eight falls with harm and four new catheter urinary tract infections from June 2018 to June 2019 within community settings. It was not possible to break this data down by core service.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers and falls at West Suffolk NHS Foundation Trust – community settings**
Own home Settings

Data from the patient safety thermometer showed that the trust reported one fall with harm and no new pressure ulcers or new catheter urinary tract infections from June 2018 to June 2019 within own home settings. It was not possible to break this data down by core service.
Prevalence rate (number of patients per 100 surveyed) of falls at West Suffolk NHS Foundation Trust – own home settings

Residential care home settings
Data from the patient safety thermometer showed that the trust reported no new pressure ulcers, falls with harm or new catheter urinary tract infections from June 2018 to June 2019 within residential care home settings.

Nursing home settings
Data from the patient safety thermometer showed that the trust reported no new pressure ulcers, falls with harm or new catheter urinary tract infections from June 2018 to June 2019 within nursing home settings.

(Source: NHS Safety Thermometer)

Incident reporting, learning and improvement
The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

The provider had an electronic incident reporting system in place for staff to report incidents. The system alerted managers when an incident was reported, and the named manager allocated a lead investigator for each incident. Staff received feedback about an incident they had raised through the electronic system once an investigation was completed. Staff we spoke with told us that they received verbal feedback from their managers and shared learning during team meetings.

The trust had an incident reporting and management policy, which was last reviewed in December 2018. Staff could easily access the policy and knew their responsibilities in raising an incident report, including how to categorise the incidents.

The service reported 246 incidents from May 2019 to July 2019, of these 123 were categorised as no harm, eight were negligible harm, 102 were minor harm and 13 moderate harm. Following a
review of the data provided by the trust we found 198 (84%) were incidents related to pressure ulcers. Of these 65 pressure ulcers were service acquired.

Senior managers for community and integrated services division identified an increase in service acquired pressure ulcers. The division had an action plan in place to achieve a 5% reduction of service acquired pressure ulcers by March 2020. The action plan was comprehensive, and each action had a named manager owner with review dates.

**Never events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From August 2018 to July 2019, the trust did not report any never events for community services for adults.

(Source: Strategic Executive Information System (STEIS))

**Serious Incidents**

In accordance with the Serious Incident Framework 2015, the trust did not report any serious incidents (SI) in community services for adults from August 2018 to July 2019, which met the reporting criteria set by NHS England.

(Source: Strategic Executive Information System (STEIS))

**Serious Incidents (SIRI) – Trust data**

From June 2018 to May 2019, trust staff within community services for adults did not report any serious incidents.

The number of serious incidents recorded by the trust incident reporting system was comparable with that reported to Strategic Executive Information System (STEIS). This gives us more confidence in the validity of the data.

(Source: Routine Provider Information Request (RPIR) – Serious Incidents tab)

Community adult services completed the duty of candour process on 35 occasions from May 2018 to April 2019. 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. However, the service had not reported any notifiable harms from June 2018 to May 2019.

Managers we spoke with told us they completed duty of candour for all category three and four pressure ulcers and all service acquired category four pressure ulcers were reported through STEIS as serious incidents. They reported that the service had reported two category four pressure ulcers as serious incidents prior to our inspection. The root cause analysis investigations were not completed at the time of our inspection.

The trust did not provide formalised training in relation to the duty of candour. However, information and support were provided to key staff undertaking the duty of candour process. The trust’s policy ‘being open - the duty of candour’ provided guidance to staff on how to undertake the duty of candour and what support mechanisms were available, where staff are unsure how to
proceed. Duty of candour was also included as a reference in section 9 of the trust’s incident policy. Clinical leads were responsible for providing an apology to the patient or other relevant person following a reported notifiable incident according to the principles of the duty of candour and documented any conversation with the patient or other relevant person related to the reported incident in the patient’s health record. This was followed by a written notification to the patient or other relevant person.

We saw that the service had made changes following serious incidents. One example of these changes was the sepsis training package developed in response to a clinical incident. All staff received additional training in the identification of deteriorating patients and had laminated NEWS 2 cards with the escalation process for deteriorating patients. The service had ordered additional equipment such as thermometers and oxygen saturation probes to ensure all clinical staff had the equipment required to monitor vital observations.

**Prevention of Future Death Reports**

The Chief Coroner’s Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last year, there had not been any prevention of future death reports sent to West Suffolk NHS Foundation Trust.

(Source: Routine Provider Information Request (RPIR) – Prevention of future death reports tab)

**Is the service effective?**

**Evidence-based care and treatment**

The service did not always provide care and treatment based on national guidance and evidence-based practice. Staff did not document objective pain scores to monitor the effectiveness of pain management.

The service assessed people’s physical, mental health and social needs and based their care and treatment on these needs. However, we found that staff did not record information about patients’ pain. This meant that we were not assured that staff delivered support in line with evidence-based guidance including National Institute for Health and Care Excellence (NICE) and all other expert professional bodies to achieve effective outcomes.

Staff we spoke with told us they could easily find policy and pathway information on the trust’s intranet. Staff showed us how they found policies, standard operating procedures, and guidance. The trust developed policies and procedures based on the latest guidance from the NICE.

The trust had procedures in place to allocate published National Institute for Clinical Excellence (NICE) guidance to appropriate clinical leads monthly. All guidance was reviewed by the clinical directors at the monthly clinical directors’ meeting. A baseline assessment containing the recommendations in the guidance was sent to clinical leads to evaluate the service against the NICE guidance recommendations and to provide assurance that the guidance is being applied and followed. This process is supported by the trust’s policy, “Responding to nationally issued best clinical practice publications (national reports) incorporating NICE guidance”
The service had pathways which followed national guidance such as the gold service framework and the leg ulcer pathway. However, staff did not always complete and record information about patients’ pain. The service had electronic assessment templates and care plans in place for staff to complete which reflected best practice and national guidance. The service had implemented leg ulcer healing key performance indicators (KPIs) in April 2019 to monitor patient outcomes.

The provider had a balanced scorecard for key performance indicators (KPIs) set by local commissioners. The quality scorecard provided information about measures such as the number of patients on the caseload with core care plans. The service conducted regular audits to monitor the compliance of policies and performance measures. An example of this was the monthly hand hygiene audit to monitor compliance with the infection prevention and control policy and the initial assessment with a care plan performance measure.

The trust had systems and processes in place to monitor safety alerts through the central alerting system. The trust had a designated officer in post to monitor any safety alert and disseminate this information to clinical leads.

**Nutrition and hydration**

**Staff regularly checked if patients were eating and drinking enough to stay healthy and help with their recovery. They worked with other agencies to support patients who could not cook or required support with eating.**

People’s nutrition and hydration needs were identified and met through a malnutrition universal screening tool (MUST) which was completed for all patients during their initial assessments. Staff completed personal care support plans to identify nutritional care and fluid needs of patients and how they were to be achieved.

The service referred patients with swallowing difficulties to the speech and language therapy (SALT) service if they had concerns about a patient’s ability to swallow food or fluids.

Staff could refer patients to the dietetics service if they required further advice and support with their nutritional needs.

The community dietetic service offered free monthly sessions to care home staff/community teams about malnutrition universal screening tool (MUST) completion and food fortification, to support good nutrition and hydration in the community.

**Pain relief**

**Staff did not record patient pain levels required to monitor the effectiveness of pain-relieving medicines or identify patients that required an increase in their pain-relieving medicines.**

The service did not have established processes in place to objectively monitor patient pain levels. Staff asked patients about their pain during assessments or care visits. We observed staff taking to patients about their pain levels. However, staff did not record pain score information. We reviewed 21 electronic patient records and we did not find a pain score or any reference to pain within the documented patient care.

Community nursing teams prioritised the visit requests for pain relief, and for patients undergoing palliative care. However, records we reviewed for patients at the end of their life did not include pain scores. We were not assured that staff could identify patients that required dose adjustments.
for their pain-relieving medicines or assess the effectiveness of the pain relief as staff did not record pain scores.

The service did not audit pain assessment within the record keeping audit.

Staff could request a review of pain relief if required, from the patient’s own GP. The service had positive links with GP services. Staff we spoke with told us that they were able to contact the patient’s GP to highlight concerns they had about the level of pain patients were experiencing or if they required advice with managing patients’ pain.

**Patient outcomes**

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**

Community services for adults monitored their performance against internal key performance indicators (KPIs) and those set out by the service commissioners. The community adults service had 10 KPIs agreed with local commissioners. The service had a set of eight high priority KPIs and two new KPIs for leg ulcer healing rates, which had commenced in April 2019. Data provided by the service demonstrated that the service met six of the high priority KPIs from June 2019 to August 2019. The service did not meet the 95% target of patients seen following triage within four hours in July 2019 and 95% of palliative referrals seen within two weeks of referral by the lymphoedema service in August 2019.

The admission prevention service and the early intervention team undertook urgent patient assessments to prevent unnecessary hospital admissions. The team monitored the referral to assessment rates. The admission prevention service and early intervention service completed 3217 face to face contacts with patients from June 2019 to August 2019. The service completed 100% of visits within four hours for every month except for July where one patient contact was outside the four-hour threshold.

Neighbourhood teams had internal quality benchmarks which were measured within the divisional balanced score card. An example of the service benchmarking was the number of patients with active care planning in place. Data provided by the trust showed the compliance against the 95% target from June 2019 to August 2019 had been met, with the exception of the Newmarket community team (90%) in August 2019 and the Sudbury community team (94%) in July 2019.

**Audits – changes to working practices**

The trust participated in two clinical audits in relation to this core service as part of their Clinical Audit Programme over the last 12 months.

<table>
<thead>
<tr>
<th>Audit name</th>
<th>Key successes</th>
<th>Key concerns</th>
<th>Key actions taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated services - new services</td>
<td>In most areas, such as staffing, the integration of additional community services was being treated as a whole, rather than managed by the service which was positive.</td>
<td>At a service level there was no pre-defined plan for the merging of service lines between acute and community. The community informatics team did not have access to the trust SQL databases and were reliant on Access and Excel to inform performance</td>
<td>A management action plan was agreed to address all the weaknesses found in the report.</td>
</tr>
</tbody>
</table>
reporting. Improvements were planned by the trust but, as yet there was no timescale.

Community services wheelchair services contract

The awarding of the wheelchair services contract itself had been delivered effectively. There were some minor issues in respect of reviewing and enhancing the policies and procedures in place in respect of procurement and the provision of the service, to ensure these reflected what happened in practice, but these did not pose a significant risk to the delivery of either equipment provision or repair based on the evidence reviewed.

The trust needed to ensure a clear audit trail was maintained in respect of significant decisions about service provision to ensure that these decisions were taken in the appropriate place and could be clearly evidenced.

A management action plan was agreed to address all the weaknesses found in the report.

*(Source: Routine Provider Information Request (RPIR) – Audits tab)*

**Competent staff**

**Managers had not completed annual staff appraisals in line with the trust’s completion target of 90%.**

All new substantive and bank staff were required to complete a trust induction and a local induction within their designated team. Team leads were responsible for ensuring all new staff had a local induction. Bank staff were allocated a team lead at the base nearest to their own home to complete the local induction and any required competencies.

All new staff received a trust and a local role specific induction. This was organised by the team leads, with a period where each new member of staff was supernumerary to allow orientation to the locality and core competency sign off. Staff we spoke with confirmed they had received a local induction when they started their new role and they were supported well to complete role specific competencies.

New staff had a comprehensive competency pack to complete to provide assurance that staff had the skills required for their role. All new staff had an allocated mentor to provide support and sign off competencies once the staff member had demonstrated the required skills and knowledge. Managers kept records of the staff competencies and these formed part of one to one discussions during the staff induction period.

Managers maintained regular communication within their teams to ensure that any issues were addressed, and staff were equipped to meet the needs of patients. Managers and team leads we spoke with told us that they supported staff to improve their practice when issues were identified.
They told us they would work with the human resources department if staff did not meet the standards required following additional support.

All new staff were required to complete competencies for their role, which their mentor observed and discussed with the member of staff to ensure their knowledge and skills met the required standard before sign off took place. Bank staff were also required to complete the competency pack and their assigned team lead kept a record of bank staff competencies.

Managers identified the learning needs of staff through supervision or the appraisal process. Staff felt encouraged and supported to attend additional training in areas they developed an interest in. The trust offered management level staff support to attend leadership training. Staff we spoke with had regular group supervision, they told us that clinical supervision included topics such as incident learning and infection prevention and control issues.

**Clinical Supervision**

The trust provided the following information about their clinical supervision process:

Clinical supervision of nursing teams occurs during the activities below on an informal basis:

- Daily/shift handover of patient care within teams: this process allows team members to review practice and reflect on the personal and professional response to their care.
- Regular team meetings (this varies from team to team).
- Attendance of band 7 colleagues at the trust’s Nursing and Midwifery Clinical Council monthly meetings.
- Team leads attendance at monthly Operations and Performance Meetings.

On a formal basis, the trust provides:

- Nurse revalidation.
- Three and six monthly personal development reviews.
- Ward managers hold monthly 1:1s with the senior matron.
- The senior matron holds monthly 1:1s with the head of nursing.

(Source: CHS Routine Provider Information Request (RPIR) – Clin Supervision tab)

**Appraisal rates - Trust wide**

From April 2018 to March 2019, 85.6% of required staff in community services for adults trust-wide received an appraisal compared to the trust target of 90%. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Additional professional, scientific and technical</td>
<td>1</td>
</tr>
</tbody>
</table>
Additional professional, scientific and technical and allied health professional staff in community services for adults trust-wide both met the 90% target. However, only 83.2% of qualified nursing staff had received an appraisal. The trust informed us that there were no specialist consultants within community services for adults with medical cover being provided by GPs.

Updated analysis for April 2019 to mid-June 2019 found that 6.7% of required staff in community services for adults trust-wide received an appraisal compared to the trust target of 90%. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2019 to mid-June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>4</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>1</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>7</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>2</td>
</tr>
<tr>
<td>Additional professional, scientific</td>
<td>0</td>
</tr>
<tr>
<td>and technical</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14</strong></td>
</tr>
</tbody>
</table>

None of the staff groups in community services for adults trust-wide met the 90% target. However, this data only represents a partial year, so we would not expect a high appraisal completion rate.

(Source: Routine Provider Information Request (RPIR) – Appraisals tab)

Following our inspection, we requested the appraisal completion rate for community adult service. Data provided by the trust showed that the appraisal completion rate had improved and was 80.8% across all staff groups in September 2019. All team leads we spoke with had planned and booked staff appraisals in order to meet the trust’s target, records we reviewed confirmed this. All staff we spoke with confirmed they had participated in the appraisal process within the 12 months prior to our inspection.

Multidisciplinary working and coordinated care pathways

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Staff worked together across multiple health, social and voluntary sector organisations. The trust delivered community adult services through six integrated teams. These teams were responsible for the promotion of health and independence in the community. The teams included district nurses, staff nurses, health care assistants, occupational therapists and physiotherapists. Staff we spoke with told us that the co-location of nursing and therapy teams had encouraged multidisciplinary team working.
The admission avoidance service and the early intervention teams worked closely with social care providers and voluntary organisations to provide support to patients which enabled them to stay in their own home.

Community teams worked with other partner organisations through forums such as, the GP Practice multidisciplinary team (MDT) every four to six weeks, Gold Standards Framework meetings and the vulnerable adults and Safeguarding MDTs. The Mildenhall community team had undertaken a pilot to integrate nursing staff, therapy staff and social care and held complex patient meetings.

The monthly complex patient review meetings held in Mildenhall included staff members from the acute hospital, community teams and the continuing healthcare team. These review meetings were to plan care that met the holistic needs of patients with complex conditions or complex social needs. Senior managers we spoke with told us that the integrated approach of service delivery had a positive impact on patient experiences.

The Sudbury team were in the process of aligning staff to local GP surgeries with the plan for three staff teams. We saw the team plans which were due to take effect in October 2019. Managers we spoke to told us that it was planned to foster closer working relationships between the community teams and GP surgeries.

Matrons attended weekly palliative care MDTs linked to community teams to facilitate discharges for patients at the end of life. The service worked in partnership with local hospices to provide end of life care to patients in their own homes.

Community adult services provided care from a range of specialist teams alongside the community teams including dietetics, respiratory, tissue viability, speech and language therapy, cardiac service, and neurological conditions. Specialist services had specific referral criteria for each of the specialist teams and all referrals were checked and streamed by the central contact centre. They worked with other service such as the admission prevention team and the early intervention team for urgent patient assessments and neighbourhood teams to provide additional support in the management of long-term conditions.

**Health promotion**

**Staff gave patients practical support and advice to lead healthier lives.**

During our inspection we observed nursing staff providing health promotion to their patients. An example of this was during a discussion about the need for six monthly doppler assessment of particular patients’ legs and application of compression hosiery to prevent the recurrence of leg ulcers. We observed nursing staff explaining the intervention and that patient required a doppler assessment every six months and renewal of their compression stockings.

Specialist teams provided health promotion advice and support to patients. We observed staff providing information and patient teaching sessions to self-manage condition such as chronic obstructive pulmonary disease (COPD). We observed physiotherapists helping a patient with a self-exercise programme which was individualised to their abilities and needs.

Staff were able to direct patients to outside organisation for help and support. We saw that staff had access to information provided by the British Heart Foundation and Age UK with additional information about dementia and heart disease.
Community services for adults were a member of the Suffolk Alliance which promoted closer working with other service providers such as mental health services. Staff we spoke with told us they could refer patients with mental health needs to the local mental health NHS trust or request a GP review dependent of the concerns.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff completed mental capacity assessments for patients who lacked capacity and were unable to consent to a treatment plan, to enable the core components of care to take place. This was completed in the patient’s best interests and enabled staff to undertake a range of interventions that patients may have been unable to provide informed consent for.

Staff provided end of life care and followed do not attempt cardio-pulmonary resuscitation (DNACPR) directives that were in place. Managers and staff we spoke with told us patients often had DNACPR directives in place when they were referred to the service. If staff identified a patient in the last year of their life, they worked with local hospice teams, patient GPs and the trust’s palliative care team to ensure patients had a plan of care in place including DNACPR directives.

Staff understood their responsibilities in relation to gaining patient consent to provide care and treatment. During our inspection we observed four staff and patient interactions, staff gained consent from patients either implied or verbally. Staff we spoke with knew their responsibilities in relation patient consent. However, staff did not always document that consent had been asked for and given, in the patient records. Managers monitored patient records to ensure staff recorded patient consented their care and treatment. We reviewed the balanced score card results from June 2019 to August 2019 which showed that staff did not consistently record consent in patient records, none of the community teams met the trust 95% target for recording patient consent. Consent recording varied from 31% to 75% across the community teams.

Mental Capacity Act and Deprivation of Liberty training completion

The trust reported that Mental Health Act (MHA), Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) are covered in the safeguarding adults training.

The trust set a target of 90% for the completion of safeguarding adults training.

Trust level

A breakdown of compliance for safeguarding adults training for qualified nurses and allied health professionals as of June 2019 in community services for adults at trust level is shown below:

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing and midwifery staff</td>
<td>95</td>
<td>146</td>
<td>65.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>23</td>
<td>38</td>
<td>60.5%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
In community services for adults at trust level the 90% target for safeguarding adults training was not met by either qualified nurses or allied health professionals.

The trust informed us that there were no specialist consultants within community services for adults with medical cover being provided by GPs.

(Source: Routine Provider Information Request – Training tab)

Staff received training about the Mental Capacity Act, which formed part of their mandatory training programme. However, the community adult service had not always completed this training in line with the trust’s internal target for its completion. Managers we spoke with had plans in place to meet the trust targets for mandatory training completion.

Community adult services provided care in patients’ own homes or provided visits to patients in care homes and therefore did not deprive patients of their liberty.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness and respected their privacy and dignity.

Staff demonstrated strong, caring, respectful and supportive relationships with their patients and those close to them. We observed staff delivering care in patients’ homes. Their interactions were professional, friendly, and kind. Staff demonstrated an understanding of the importance of treating patients and those who were important to them in a caring and sensitive manner.

Staff treated patients with privacy, respect, and dignity and we saw this when they protected patients from cold and exposure, using blankets to cover exposed parts of the body whilst administering physical and or intimate care whilst in their own homes.

The staff respected the confidentiality of patients and did not discuss or display confidential information in the hearing of others. Staff shared information appropriately with each other either during handover or within the secure electronic records systems.

The trust participated in the NHS friends and family test. We reviewed the integrated quality performance report for May 2019 which showed 98% of community patients recommend the service to their friends and family from May 2018 to May 2019.

Feedback from those who used the service was continuously positive about the way staff treated people. Patients consistently praised the care they received from staff. Patients and their carers we spoke with consistently praised the service. One patient and their relative told us “staff are very good, we could not ask for more”. Another patient told us that staff were friendly, “they are marvellous”.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal and cultural needs.

Staff supported their patients either face to face or through telephone calls. Patients we spoke with told us they knew how to contact staff and raise any worries or concerns. We observed a
telephone call between a member of staff and a patient, the member of staff reassured the patients and offered a visit the same day.

Managers we spoke with told us of how a member of staff had stayed with a relative of patient to support them following an unexpected death of the patient. The staff member had stayed with the relative to provide emotional support as they had no other family members close by.

Staff could signpost patients or their relatives to other service such as bereavement counselling and patient support groups when they required additional support emotional with their condition or situation.

The service had associated support groups for patients with long term conditions. An example of this was the lymphoedema support group where patients and their relatives could gain peer support and raise any concerns.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff took time to involve patients in their care and included them in decisions about their care. We observed staff explaining care throughout their appointment or home visit in a way that patients and their relatives understood. Patients we spoke with told us that staff explained their care well and they felt decisions about their care and treatment were made in partnership with them.

Staff understood the social and psychological impact that patient’s conditions had on their wellbeing. Staff in Sudbury had found a separate space for the leg ulcer waiting room in response to patient feedback that they felt self-conscious of their wounds especially in hot weather. Staff had sensitively found a solution to this feedback.

We observed a member of staff discussing options for wound care with their patients and taking the patient’s opinion into account when making treatment decisions.

Is the service responsive?

Planning and delivering services which meet people’s needs

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The design of buildings met the needs of people using the service. The design of the building we visited, which held patient clinics met the needs of patients. All buildings used for patient clinics we visited, could be accessed by patients using mobility aids.

The trust worked together with commissioners and other organisations across Suffolk to plan and meet the needs of the local population. The service planned and provided services, delivered by district nursing teams, specialist nursing teams and therapists. The trust worked with other NHS organisations within the local sustainability and transformation partnership (STP) to develop new services to help keep patients well at home. The trust worked with the local STP to provide services such as respiratory and heart failure to provide that reflected the needs of the local population.
The trust had integrated acute and community services across West Suffolk. The integration of respiratory service worked in a way that facilitated admission avoidance and reduced hospital length of stay.

The trust was a member of the Suffolk Alliance with other providers within the STP. The alliance brought together GP services, acute NHS trusts, community services, mental health services, social care providers and voluntary service together to meet the needs of patients. The west alliance steering group had a systems approach to care across West Suffolk. The service had undertaken a pilot of the ‘Buurtzorg’ model of care. Nurses worked in small self-managed teams to deliver holistic care and worked closely with their formal (GPs) and informal (social services and voluntary services) networks so individuals could stay in their homes and communities for as long as possible.

Managers for the service met with their commissioners regularly. The service had action plans in place extend or improve the provision of care and treatment. Managers worked in collaboration with their stakeholders and commissioners to extend the service provision where the service did not meet the needs of local people.

**Meeting the needs of people in vulnerable circumstances**

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The community nurses worked closely with the wider multidisciplinary team for example social workers and GPs to ensure patients in vulnerable circumstances had support to remain independent or stay in their own homes.

The community service for adults supported patients with frailty in their own homes. Physiotherapists and occupational therapists provided care and treatment in patients their own homes in falls prevention and aid rehabilitation.

Community services for adults had an admission avoidance team and early intervention team. These were rapid response services staffed by nurses, therapists and paramedic practitioners. The team provided an acute health response supporting people to stay at home safely, who were otherwise at risk of being admitted to an acute hospital unnecessarily. The service operated seven days a week from 7am to 7pm. The service accepted referrals from health professionals, relatives and patients themselves.

The trust worked with other organisations such as hospices and local NHS hospitals to provide end of life care that reflected patients’ needs. Staff had completed advanced care plans with patients about their care preferences for end of life care. We saw these care plans within electronic patients records and patient hand-held records. The records were kept in this way to ensure all professionals involved with the patient’s care had access to their care plans.

Staff showed us the yellow folders they used for patients with complex needs. They included advanced ‘my care wishes, shared care and support plan’ documents which set out care preference for patients living with dementia or learning disabilities.

Staff had access to interpreters when their patient’s first language was not English. The service had access to translation services to ensure staff could effectively communicate with their patients. The trust had access interpreting and translation services provided by partner organisations, through a service level agreement. These interpreting and translation services included
interpreting in person, over the telephone, written translations and British Sign Language interpreting, as well as provisions such as Braille.

Access to the right care at the right time

People could access the service when they needed it and received the right care in a timely way.

All referral to the services went to the central contact centre with the exception of the early intervention team. The service received patient referrals electronically, by telephone or by fax. Each team had a referral criteria and staff within central contact centre triaged all referrals and allocated them to the appropriated team according to the referral criteria. Staff prioritised the patients with the greatest need within each team.

Patients we spoke with told us that they found it easy to contact the service in the event of changes to their condition.

Community services for adults worked with local social services to provide care to homeless people in areas of Mildenhall and Brandon. Community teams worked with social services, where people had no home, to assist with temporary accommodation, to allow teams to provide the care patients required.

Accessibility

The largest ethnic minority group within the trust catchment area was white British with 90.8% of the population.

<table>
<thead>
<tr>
<th>Ethnic minority group</th>
<th>Percentage of catchment population</th>
</tr>
</thead>
<tbody>
<tr>
<td>First largest</td>
<td>White British 90.8%</td>
</tr>
<tr>
<td>Second largest</td>
<td>White: other white 3.8%</td>
</tr>
<tr>
<td>Third largest</td>
<td>Asian/Asian British: other Asian 0.6%</td>
</tr>
<tr>
<td></td>
<td>Mixed/multiple ethnic groups: White and Black Caribbean 0.6%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request – Accessibility tab)

Referrals

The trust identified the community services for adults in the table below as measured on ‘referral to initial assessment’ and ‘assessment to treatment’.

Community adult services met and exceeded most referral to treatment targets (RTT). Patients referred to the lymphoedema service had the longest waiting time of 42 days, however this was below the target of 98 days.

The trust met the referral to assessment target for all but two of the services listed from June 2018 to May 2019 (and from October 2018 to May 2019 for the lymphoedema services), with median times that were considerably lower than the targets in the main. The trust noted that the first assessment and treatment both happen at a patient’s first appointment.

<table>
<thead>
<tr>
<th>Name of hospital site or location</th>
<th>Name of inpatient ward or unit</th>
<th>Days from referral to initial assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Provider</td>
<td>Service Provided</td>
<td>National / Local Target</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>----------------------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>West Suffolk Disability Resource Centre</td>
<td>Community speech &amp; language therapy</td>
<td>126 days</td>
</tr>
<tr>
<td>West Suffolk Disability Resource Centre</td>
<td>Parkinson's disease community service</td>
<td>126 days</td>
</tr>
<tr>
<td>West Suffolk Disability Resource Centre</td>
<td>Specialist neurological nursing</td>
<td>126 days</td>
</tr>
<tr>
<td>Sudbury Health Centre</td>
<td>Heart failure service</td>
<td>126 days</td>
</tr>
<tr>
<td>Chantry Clinic</td>
<td>Environmental service</td>
<td>126 days</td>
</tr>
<tr>
<td>Woolpit Health Centre</td>
<td>Bury Rural community adult health teams</td>
<td>0 - 126 days</td>
</tr>
<tr>
<td>Darbishire House, BSE</td>
<td>Bury Town community adult health teams</td>
<td>0 - 126 days</td>
</tr>
<tr>
<td>Haverhill Health Centre</td>
<td>Haverhill community adult health teams</td>
<td>0 - 126 days</td>
</tr>
<tr>
<td>Mildenhall Health Centre (Forest Heath)</td>
<td>Brandon/Mildenhall community adult health teams</td>
<td>0 - 126 days</td>
</tr>
<tr>
<td>Newmarket Hospital</td>
<td>Newmarket community adult health teams</td>
<td>0 - 126 days</td>
</tr>
<tr>
<td>Sudbury Community Health Centre</td>
<td>Sudbury community adult health teams</td>
<td>0 - 126 days</td>
</tr>
<tr>
<td>West Suffolk Hospital</td>
<td>Admission prevention service teams</td>
<td>0 - 126 days</td>
</tr>
<tr>
<td>West Suffolk Hospital</td>
<td>Lymphoedema teams</td>
<td>14 – 98 days</td>
</tr>
</tbody>
</table>

The trust provided multiple targets for the community adult health teams, admission prevention services and lymphoedema teams. Therefore, the ranges of local targets and actual days from referral to initial assessment have been provided in the table above. The zero-day target in the table represents patients who should have been seen within four hours of referral.

The Haverhill and Sudbury community adult health teams both failed to meet the zero-day local targets, with actual (median) days from referral to initial treatment of two and six days, respectively.

(Source: CHS Routine Provider Information Request – Referrals tab)

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The trust displayed information about how to make a complaint on their public community services website. We saw that the trust provided information to make a complaint by telephone, email and by letter. The web page also provided information about escalating concerns to the parliamentary health service ombudsman.

We observed patient advocacy and liaison service (PALS) information leaflets in patient clinic areas and within the team bases. Staff gave all new patients PALS information leaflets on their
first visit. Patients we spoke with consistently praised staff, however they told us they knew how to raise concerns or make a complaint if this was required.

The trust had a formal complaints and concerns management policy. The policy had a document reference number and a named policy owner; however, the policy did not display a review date. Staff followed the complaints policy, which provided guidance on how to manage complaints efficiently. Team leads managed complaints and resolved concerns at the earliest opportunity.

Complaints
From June 2018 to May 2019, the trust received five complaints about community services for adults at trust level (2.9% of the total complaints received by the trust).

For the three complaints that had been closed at the time of data submission, the trust took 22, 39 and 279 working days, respectively to investigate and close these. In two of these cases, this was not in line with their complaints policy, which states complaints should be closed within 25 working days.

The two complaints, that had not yet been closed, had been open for 16 and 238 working days at the time of data submission.

A breakdown of complaints by subject is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communications</td>
<td>2</td>
<td>40.0%</td>
</tr>
<tr>
<td>Admin/policies/procedures (including patient record)</td>
<td>1</td>
<td>20.0%</td>
</tr>
<tr>
<td>Staff values &amp; behaviours</td>
<td>1</td>
<td>20.0%</td>
</tr>
<tr>
<td>Patient care</td>
<td>1</td>
<td>20.0%</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

The service had received low numbers of complaints. However, there was one unresolved complaint that had been open for over 270 days. We raised this with the senior managers of the division and they told us that the complaint related to equipment needs of an individual patient. Managers told us that the equipment specification requested did not exist, but managers were working with the patient to find a resolution.

We reviewed a patient complaint about the service provided and the resolution letter sent to the patient. The complaint response answered the concerns raised and gave further information about the Parliamentary Health Service Ombudsman in the event the patient was not satisfied with the trust’s response.

Compliments
From June 2018 to May 2019 the trust received 32 compliments for community services for adults (4.2% of all compliments received trust-wide).

A breakdown of compliments by department is shown below:

<table>
<thead>
<tr>
<th>Department</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
</table>

20190416 900885 Post-inspection Evidence appendix template v4
The trust noted that the majority of compliments received trust-wide related to overall care along the whole pathway; and patients and relatives thanking staff for their kindness and compassion during difficult and stressful times.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

<table>
<thead>
<tr>
<th>Community hospice team (CHT) – location unspecified</th>
<th>6</th>
<th>18.8%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sudbury CHT</td>
<td>5</td>
<td>15.6%</td>
</tr>
<tr>
<td>Cardiac rehabilitation</td>
<td>3</td>
<td>9.4%</td>
</tr>
<tr>
<td>Bury rural CHT</td>
<td>3</td>
<td>9.4%</td>
</tr>
<tr>
<td>Neurology</td>
<td>2</td>
<td>6.3%</td>
</tr>
<tr>
<td>Mildenhall CHT</td>
<td>2</td>
<td>6.3%</td>
</tr>
<tr>
<td>Haverhill CHT</td>
<td>2</td>
<td>6.3%</td>
</tr>
<tr>
<td>District nurses</td>
<td>2</td>
<td>6.3%</td>
</tr>
<tr>
<td>Brandon</td>
<td>2</td>
<td>6.3%</td>
</tr>
<tr>
<td>COPD</td>
<td>1</td>
<td>3.1%</td>
</tr>
<tr>
<td>Pulmonary rehabilitation</td>
<td>1</td>
<td>3.1%</td>
</tr>
<tr>
<td>Bury Town CHT</td>
<td>1</td>
<td>3.1%</td>
</tr>
<tr>
<td>Newmarket CHT</td>
<td>1</td>
<td>3.1%</td>
</tr>
<tr>
<td>Emergency intervention team (EIT)</td>
<td>1</td>
<td>3.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>32</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The associate director for community service and senior managers supported the board of directors in the oversight and decision making for integrated community services within the division. Staff at all levels understood their responsibilities within their roles.

A team of dedicated and proactive managers supported the services who received a high amount of praise from the staff they managed. Manager were versed in the challenges and areas they performed well within in their individual areas and were committed to making positive change. Staff stated that they felt valued and supported in their role.

Locally, staff told us their managers were routinely visible and approachable. We observed strong leadership at a local level with staff praising their local managers regarding their support and communication.

The service was in the process of transition in the structure of community teams. The service had introduced band six junior sister roles to community teams to manage caseloads and support junior staff. We observed teams at different stages of this transition. For example, we saw the Bury Town team had led on the Buurzorg pilot and had the new leadership structure in place. The Sudbury team was due to introduce this structure in October 2019. Managers we spoke with told
us that the new structure improved leadership and daily workload by releasing district nurses to work within the localities.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The vision of community adult services set out the co-ordination of service around individuals, so that felt like one service. The community services strategy was developed in collaboration with other local service providers within the West Suffolk Alliance. The West Suffolk alliance strategy set out how service would work together to meet the four agreed ambitions.

The adult community service had four ambitions within the strategy which aligned with the trust’s broader objectives. The service had a workable strategy in place to turn their vision into a reality. The four ambitions included the following goals:

- Strengthen the support for people to stay well and manage their wellbeing and health in their own communities.
- Focus with individuals on their needs and goals.
- Change both the way they worked together and how services were configured
- Effective use of resources.

The trust had a strategic framework in place which was published in 2015. The strategic framework was based on three priorities underpinned by seven ambitions. The strategy was underpinned by a set of staff values. Staff we spoke with knew the organisation core values and demonstrated in their work. We saw posters in all the bases we visited which displayed the organisational values.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

The trust encouraged staff to demonstrate candour, openness and honesty at all levels. The trust had a policy in relation to duty of candour and this was readily available to staff via the trust’s intranet.

Managers we spoke with praised their staff for their commitment and team work. Staff morale was good and staff we spoke with during the inspection confirmed that they felt valued and well supported by colleagues and managers within their roles.

Staff we spoke with told us they felt able to raise their concerns to their manager. They told us the management team supported them to raise any concerns they had, such as patient safety issues and improved ways of working. They knew about the freedom to speak up guardian, however none of the staff we spoke with felt they would need to escalate concerns to this person.
The trust had staff awards called the ‘shining lights awards’ and ‘putting you first’ awards. Staff members and teams could be nominated for an award by patients and other staff members for going the extra mile in care delivery. The division acknowledged staff who had gone the extra mile in supporting patients with a ‘putting you first’ wards. The Sudbury community team was awarded the shining light award for community clinical team of the year 2018.

Adults community services, by the nature of the work, required staff to be lone workers. The service had processes in place for staff safety in lone working. Staff we spoke with told us that they had a buddy system to communicate that they had finished their visits or if there were any safety concerns during a visit.

**Governance**

*Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.*

The service set out clear roles, responsibilities, and systems of accountability to support good governance and management of the service. Staff we spoke with described the service’s management structure and their specific roles and responsibilities.

There was a range of policies, which underpinned the governance structure. The trust reviewed policies in line with expected review dates. These included but was not limited to, the incident reporting and the safeguarding policies.

The community adult services were part of the community and integrated services division. Team leads reported to the locality area managers, through the service’s governance and operations meetings and quality meetings. We reviewed the community and integrated services senior operations meeting minutes for June and July 2019, they showed that managers discussed the strategic priorities for the division. Managers kept action logs of actions arising from the operations meeting. We saw managers had completed actions items, such as, the procurement of lone worker devices for staff, with the actions plan included regular updates from the named manager who was assigned to the action.

The community and integrated services division held monthly board meeting chaired by the associate directors for the division. Local area managers, the head of nursing for the division and senior matrons attended governance board meetings. We reviewed the meeting minutes from July 2019 to September 2019 which show that managers discussed incidents, audit results, safeguarding updates and staffing, amongst other agenda items. The minutes demonstrated that community services had reviewed and considered the adoption of initiatives developed by staff from the acute hospital. One of the initiatives was ‘gnashers at night’ developed by occupational therapists to focus on and support patients with their oral hygiene.

The trust had reporting systems in place which ensured that the board and associated committees were updated regularly on performance and quality issues. The senior leadership team for the division discussed quality, safety and performance information at divisional board meetings. The division reported key safety, quality and performance data to inform the board within the integrated quality performance reports.

Board papers demonstrated that the board had oversight of adult community services quality and performance measures such as key performance indicators. The trust had a clinical safety and
effectiveness committee which ensured that there was an effective internal audit function,
established by managers that provided appropriate, independent assurance to the Board.

The service had processes to share information within team meetings. Each team had monthly
team meeting to share key messages from the senior leadership team and to discuss learning
following incidents and complaints. The division shared information about quality, safety and
performance with staff and key messages through the CREWS newsletter. We saw copies of the
CREWS newsletter within the community bases we visited. We reviewed CREWS newsletters
from June to August 2019, which provided staff with information about learning from incidents,
complaints and performance; broken down by community team.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and
escalated relevant risks and issues and identified actions to reduce their impact. They had
plans to cope with unexpected events. Staff contributed to decision-making to help avoid
financial pressures compromising the quality of care.

The service had processes for managing risks issues and performance. There was an electronic
trust wide risk register linked to the incident reporting system. The service used risk registers
based on the potential consequence of the risk and the likelihood of the risk happening. The
service had identified six risks related to information technology (IT). Senior managers for the
directorate knew the risks to the service and had mitigated these risks appropriately.

Managers told us that IT was the biggest risk to the service as the IT contract was not held by the
trust, this meant community service had a separate intranet service to the main hospital. The
board were aware of the risks related to the IT infrastructure and this was included on the board
assurance framework risk register.

The service had a directorate risk register, team leads discussed risks for their team with their line
manager, these were added to the divisional risk register. Leaders at all levels knew the service
risks in their area of responsibility and they had plans in place to mitigate these risks. For example,
managers told us that staff had access to download patient records securely in areas with no
mobile internet access. This was in place to mitigate the risks associated with no phone/Wi-Fi
access to up-to-date patient information. Managers discussed the risks for the community and
integrated services division during the monthly divisional governance meetings. We reviewed the
meeting minutes from July 2019 to September 2019 which demonstrated that risk was a regular
agenda item. The risks discussed during the governance meetings reflected those that managers
told us about during our inspection.

The service had not identified the lack of mandatory training and appraisal completion rates as a
risk. However, we saw this was included within the divisional action logs. Community teams had
actions in place to improve the completion rate of both mandatory training and appraisals.

Staff completed individual risk assessments in circumstances such as, where patients had poor
living conditions, or they had hazards in their homes, which posed additional risks. Staff we spoke
with told us the individual risk assessments were attached to the patient records with a flagging
system to alert staff a risk assessment was in place. The risk assessments provided information to
mitigate any risks such alerting their buddy prior the visit and after to ensure they completed the
visit safely.
Managers monitored the performance of the service against key performance indicators and other quality and safety measures. Managers had started to circulate a newsletter call ‘CREWS’ in June 2019. This newsletter provided information about performance against key performance indicators to inform staff how the service was measured. The information was displayed for each team, so staff could see their team’s performance compared to other teams within the division. Managers we spoke with told us that newsletter had highlighted areas for improvement and teams were working together to make improvements to their performance.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The trust did not manage the contract for the community information technology (IT) systems. The contract was managed by another local NHS trust and the commissioners. This meant that intranet for the main hospital and the intranet used by community services were different. Senior managers recognised that IT systems required investment and the this was included in the divisional risk register. One of the directors was working with the other stakeholders to find a solution to the identified risk.

Staff across the division could access information from the intranet shared across community service in Suffolk, including policies and national guidance. Staff knew how to access information through the intranet. Managers had reviewed the policies used by community services and aligned these to the hospital policy documents as community services could not access the hospital policies through their intranet.

Staff accessed all electronic records via a two-point security log in process to prevent inappropriate access to sensitive information.

The service used the electronic records system to compile reports as evidence to their commissioners and for internal and external KPI monitoring. The service utilised a dashboard for oversight of KPIs and other quality and performance indicators such as safety thermometer data.

Engagement

Leaders and staff actively and openly engaged with patients, staff, and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Managers we spoke with had regular meetings with the local clinical commissioning group to discuss performance and key performance indicators. The service worked collaboratively with other health providers across Suffolk, set out in the Suffolk alliance strategy document.

Staff had an opportunity to provide feedback about working for the trust. Staff participated in the NHS staff survey undertaken in 2018. The service had an action plan in place to act on feedback from staff. An example actions taken by the service, was to improve training and support in appraisal completion for band six staff and more input from clinical leads to ensure learning and development plans reflected staff members’ needs.
The service held team meetings monthly and staff confirmed that there was good teamwork and engagement. We reviewed team newsletter for Mildenhall and Brandon and which captured information discussed at team meetings in July and August 2019. The newsletters included information about appraisals, mandatory training and local audits. This meant staff that had not attended the meeting could access key messages.

The trust had staff awards where staff and patients could nominate individual staff members or teams for ‘going the extra mile.’ Staff we spoke with told us about these awards and several staff members told us their team had been nominated for an award.

The service participated in the friends and family test and had an additional patient survey to gain feedback from patients that did not have access to the internet.

**Learning, continuous improvement and innovation**

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The service had completed Buurtzorg inspired pilot, which worked with third sector organisations to support patients to manage their own health conditions and remain in their own homes and communities. The service was in the process of rolling out this model of care across all teams at the time of our inspection. Managers we spoke with told us that pilot had provided an opportunity to work differently and replicate the areas of success.

The service had an admission prevention team and early intervention team in place to implement community based care and rehabilitation. This service worked with both community teams and teams based within the hospitals to reduce admissions for patients with long term conditions or frailty.

**Accreditations**

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide were reviewed and a decision made whether or not to award the service with an accreditation. A service was accredited if they were able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service needed to be re-assessed in order to continue to be accredited.

No community services for adults had been awarded an accreditation.

(Source: Routine Provider Information Request (RPIR) – Accreditations tab)
Community health services for inpatients

Facts and data about this service

Information about the sites and teams, which offer services for inpatients at this trust, is shown below:

<table>
<thead>
<tr>
<th>Location</th>
<th>Team/ward/satellite name</th>
<th>Number of inpatient beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newmarket Hospital</td>
<td>Rosemary Ward</td>
<td>19</td>
</tr>
<tr>
<td>Glastonbury Court</td>
<td>King Suite</td>
<td>20</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sites tab)

The trust provided the following information about their community inpatients services:

Rosemary Ward, Newmarket Hospital has a bed base of 19 beds and serves the population of West Suffolk in the delivery of reablement care. There was no formalised admission criteria, but patients must be over 18 and registered with a Suffolk GP. In addition, they must be medically optimised for discharge at the point of admission and have either reablement, rehabilitation, end of life or complex discharge planning needs, which cannot be met at home. Some active treatments are also available, if these are not able to be delivered in the patient’s own home.

King Suite, Glastonbury Court is a 20 bedded unit within a care home in Bury St Edmunds, which is staffed by the trust’s team members. King Suite offers similar care and support as that noted above for Rosemary Ward.

Both areas are nurse-led units with a full multidisciplinary team supporting the delivery of care. This enables patients to regain independence as appropriate or receive end of life care in a comfortable setting if home is not a suitable place of care. Close ties are retained with West Suffolk Hospital and links continue to be made with wider community health teams.

(Source: CHS Routine Provider Information Request (RPIR) – Context CHS)

Percentage of patients that are children

From May 2018 to April 2019, no patients (0%) attending community inpatient services within the last 12 months were identified as being a child aged 17 years or under.

(Source: Routine Provider Information Request (RPIR) – Children)

Care at the community hospitals is delivered by nursing, healthcare and therapy staff. The trust uses the community beds to support improved flow across the local health economy through collaborative working with local GP practices. The ward areas are nurse led and staffed with multidisciplinary teams (MDT) supporting holistic patient care. Medical cover is provided by local GPs with a once weekly consultant ward round.

Each community hospital provides nursing and therapy care with the aim of supporting patients to regain functional ability in order to return to their usual place of residence. The hospital teams work with social workers and community nursing and rehabilitation teams to support early discharge where appropriate, or to facilitate transitions into on-going care/nursing homes.

The community inpatient service has not been previously been inspected as a core service.
We carried out an announced inspection from 24 to 25 of September 2019. We visited both inpatient sites during this inspection. During our inspection we spoke with 21 staff including nurses, therapy leads, ward managers, locality leads, physiotherapy and occupational therapy staff, healthcare assistants, and housekeeping staff. We spoke with 10 patients and viewed 17 sets of patient records and 11 medicine records. We attended a multidisciplinary (MDT) team meeting. We observed meal times and patient and staff interactions. We also reviewed data provided by the trust both prior and post inspection.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

The service provided mandatory training in key skills however not all staff completed it.

Mandatory training completion rates

The trust set a target of 90% for completion of all mandatory training with the exception of information governance which had a target of 95%.

Service level

A breakdown of compliance for mandatory training courses as of June 2019 for qualified nursing staff in community inpatient services at trust level is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June, 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Infection control - classroom</td>
<td>24</td>
</tr>
<tr>
<td>Fire safety training - classroom</td>
<td>23</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>23</td>
</tr>
<tr>
<td>Health &amp; safety / risk management</td>
<td>21</td>
</tr>
<tr>
<td>Basic life support (adult)</td>
<td>20</td>
</tr>
<tr>
<td>Medicine management (refresher)</td>
<td>20</td>
</tr>
<tr>
<td>Information governance</td>
<td>20</td>
</tr>
<tr>
<td>Moving and handling - clinical</td>
<td>19</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>19</td>
</tr>
<tr>
<td>Security awareness</td>
<td>18</td>
</tr>
<tr>
<td>Slips trips falls</td>
<td>18</td>
</tr>
<tr>
<td>MAJAX (Major accident)</td>
<td>18</td>
</tr>
<tr>
<td>Fire safety training - e-learning</td>
<td>18</td>
</tr>
<tr>
<td>Blood borne viruses/inoculation incidents</td>
<td>16</td>
</tr>
</tbody>
</table>
In community inpatient services at trust level the targets were met for three of the 14 mandatory training modules for which qualified nursing staff were eligible.

The trust informed us that there were no specialist consultants within community services for adults, with medical cover being provided by GPs.

The trust did not provide any data for qualified allied health professional (AHP) staff working within community inpatients. All AHPs, for example physiotherapists and occupational therapists, worked on a rotation basis within the acute hospital and mandatory training was monitored in the acute setting.

(Source: Routine Provider Information Request (RPIR) – Training tab)

King Suite, Glastonbury Court

A breakdown of compliance for mandatory training courses as of June 2019 for qualified nursing staff in community inpatient services at King Suite, Glastonbury Court is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June, 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>MAJAX (Major accident)</td>
<td>14</td>
</tr>
<tr>
<td>Slips trips falls</td>
<td>14</td>
</tr>
<tr>
<td>Moving and handling - clinical</td>
<td>14</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>14</td>
</tr>
<tr>
<td>Information governance</td>
<td>14</td>
</tr>
<tr>
<td>Fire safety training - classroom</td>
<td>14</td>
</tr>
<tr>
<td>Medicine management (refresher)</td>
<td>14</td>
</tr>
<tr>
<td>Fire safety training - e-learning</td>
<td>14</td>
</tr>
<tr>
<td>Security awareness</td>
<td>14</td>
</tr>
<tr>
<td>Basic life support (adult)</td>
<td>14</td>
</tr>
<tr>
<td>Infection control - classroom</td>
<td>14</td>
</tr>
<tr>
<td>Health &amp; safety / risk management</td>
<td>14</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>13</td>
</tr>
<tr>
<td>Blood borne viruses/inoculation incidents</td>
<td>12</td>
</tr>
</tbody>
</table>

In community inpatient services at King Suite, Glastonbury Court the targets were met for 13 of the 14 mandatory training modules for which qualified nursing staff were eligible. The only training module where the target was not met was the blood borne viruses/inoculation incidents module, with a completion rate of 85.7%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

We saw that this had improved to 100% compliance during our inspection.

Rosemary Ward, Newmarket Hospital

A breakdown of compliance for mandatory training courses as of June 2019 for qualified nursing staff in community inpatient services at Rosemary Ward, Newmarket Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
</tr>
</thead>
</table>

### Training Completion Rates

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible Staff</th>
<th>Completion Rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection control - classroom</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety training - classroom</td>
<td>9</td>
<td>10</td>
<td>90.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>9</td>
<td>10</td>
<td>90.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety / risk management</td>
<td>7</td>
<td>10</td>
<td>70.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management (refresher)</td>
<td>6</td>
<td>10</td>
<td>60.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>6</td>
<td>10</td>
<td>60.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support (adult)</td>
<td>6</td>
<td>10</td>
<td>60.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>6</td>
<td>10</td>
<td>60.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and handling - clinical</td>
<td>5</td>
<td>10</td>
<td>50.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Slips trips falls</td>
<td>4</td>
<td>10</td>
<td>40.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Security awareness</td>
<td>4</td>
<td>10</td>
<td>40.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>MAJAX (Major incidents)</td>
<td>4</td>
<td>10</td>
<td>40.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety training - e-learning</td>
<td>4</td>
<td>10</td>
<td>40.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Blood borne viruses/ inoculation incidents</td>
<td>4</td>
<td>10</td>
<td>40.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In community inpatient services at Rosemary Ward, Newmarket Hospital the targets were met for three of the 14 mandatory training modules for which qualified nursing staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

During our inspection we saw that, although still not meeting trust targets, there had been some improvement in the mandatory training rates on Rosemary ward, for example: Security awareness was 87%, Blood borne viruses/inoculation incidents was 72% and MAJAX (Major incidents) was 68%. Staff commented that there was a drive to improve these and we saw evidence of staff being booked onto training days in the following weeks.

Training was offered through face to face and e-learning modules. Some staff highlighted issues with accessing e-learning during shifts and that there was little capacity for them to be released from their duties although they could access them at home and claim the time back.

Senior staff told us that there had been a number of challenges identified with mandatory training since January 2019 when the community staff training requirements and records transferred over to the core trust programmes and systems. The challenges revolved around ensuring mandatory training compliance was achieved due to differences identified between historical community requirements and requirements set by the trust. This included new subjects which the community have not previously had to complete. These subjects included: slips, trips and falls, security awareness and major incident. In order to address this the trust created community specific training to ensure relevance (security awareness and major incident). As part of the main mandatory training review slips, trips and falls was being reviewed as a subject for all trust staff and alternative options were being investigated.

Communication of training compliance for all staff was sent to managers monthly and staff were able to access their own training compliance via the electronic system. However, the oversight of training compliance was inconsistent, with one ward manager having good oversight on a monthly basis, and the other having difficulty locating and accessing the electronic data which meant that they did not have good oversight.

### Safeguarding
Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and knew how to apply it, however training compliance fell below trust target.

Safeguarding training completion rates

The trust set a target of 90% for the completion of safeguarding training.

The tables below include Prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

Trust level

A breakdown of compliance for safeguarding training courses as of June 2019 for qualified nursing staff in community inpatient services at trust level is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5 (prevent awareness)</td>
<td>23</td>
<td>24</td>
<td>95.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>22</td>
<td>24</td>
<td>91.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2 (basic prevent awareness)</td>
<td>22</td>
<td>24</td>
<td>91.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>17</td>
<td>24</td>
<td>70.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>17</td>
<td>24</td>
<td>70.8%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In community inpatient services at trust level the 90% target was met for three of the five safeguarding training modules for which qualified nursing staff were eligible.

The trust informed us that there were no specialist consultants within community services for adults with medical cover being provided by GPs.

The trust did not provide any data for qualified allied health professional staff working within community inpatients. All AHPs for example physiotherapists and occupational therapists worked on a rotation basis within the acute hospital and mandatory training was monitored in the acute setting.

King Suite, Glastonbury Court

A breakdown of compliance for safeguarding training courses as of June 2019 for qualified nursing staff in community inpatient services at King Suite, Glastonbury Court is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>14</td>
<td>14</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>14</td>
<td>14</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2 (basic prevent awareness)</td>
<td>14</td>
<td>14</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>14</td>
<td>14</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Preventing radicalisation - levels 3, 4 & 5 (prevent awareness)  | 13 | 14 | 92.9% | 90% | Yes

In community inpatient services at King Suite, Glastonbury Court, the 90% target was met for all five safeguarding training modules for which qualified nursing staff were eligible.

**Rosemary Ward, Newmarket Hospital**

A breakdown of compliance for safeguarding training courses as of June 2019 for qualified nursing staff in community inpatient services at Rosemary Ward, Newmarket Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5 (prevent awareness)</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2 (basic prevent awareness)</td>
<td>8</td>
<td>10</td>
<td>80.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>3</td>
<td>10</td>
<td>30.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>8</td>
<td>10</td>
<td>80.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>3</td>
<td>10</td>
<td>30.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In community inpatient services at Rosemary Ward, Newmarket Hospital the 90% target was met for one of the five mandatory training modules for which qualified nursing staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

During our inspection we saw that, although they were still not meeting trust target, there had been some improvement in safeguarding training rates with Safeguarding adults at 81%, Safeguarding children level 1 at 84% and Safeguarding children level 2 at 58%.

**Safeguarding referrals**

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each local authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the immediate safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to children’s services, adult services or the police should take place.

Community inpatient services made no safeguarding referrals for either adults or children from June 2018 to May 2019.

(Source: Routine Provider Information Request (RPIR) – Safeguarding tab)

All staff we spoke with understood and could explain their responsibilities for safeguarding patients and the process for raising concerns. They were able to describe situations when they would raise a safeguarding concern and were able to explain the actions they would take if they identified concerns.
Staff had access to the trust’s safeguarding policy and knew how to escalate concerns to the wider trust safeguarding team.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

**PLACE Assessments**

PLACE assessments aim to provide a clear message from patients on how the care environment may be improved. They are undertaken by teams of local people alongside healthcare staff and assess privacy and dignity, food, cleanliness, building maintenance and the suitability of the environment for people with disabilities and dementia.

The site which provides community inpatient services for the trust, Newmarket Hospital, was compared to other sites of the same type and the scores they received for cleanliness and for condition, appearance, and maintenance were found to be about the same as the England average in 2018.

No data was submitted for King Suite, Glastonbury Court.

*(Source: NHS Digital)*

Staff kept their uniforms, equipment and the premises clean. Staff complied with the trust’s infection prevention and control policy.

Personal protective equipment (PPE), for example, gloves and aprons were readily available throughout the inpatient units.

We saw that community inpatient staff complied with the trust’s ‘bare below the elbow’ policy. Bare below the elbow national guidelines are for all staff working in healthcare environments to follow to reduce the risk of cross contamination between staff and patients. Throughout the inspection, we observed staff adhered to good practice regarding hand washing and using hand gel between patients.

Hand sanitiser was available at the entrance to each inpatient area and clear signage was in place requesting 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.

Both clinical areas 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.

Patient trolleys, equipment, and curtains providing privacy, appeared visibly clean throughout the wards.

At the King Suite, Glastonbury Court there were carpets in the corridors, communal spaces and bedrooms and fabric covered chairs and window dressings. The trust were unable to change this as they were part of the care home environment. All environmental cleaning was performed by staff employed by the care home. We spoke with care home cleaning staff who confirmed that they did not have access to deep cleaning equipment, for example steam cleaning equipment and
instead used a commercial cleaning product which was advertised as ‘proven to kill 99% of bacteria that and also effective against viruses including Herpes, and Norovirus’.

Glastonbury Court bedrooms had en-suite patient bathrooms which had washable shower curtains and we saw cleaning schedules that showed these were exchanged and washed and each room thoroughly cleaned, including upholstery, between each patient discharge and admission.

Ward staff were responsible for cleaning clinical equipment and there were housekeeping staff employed for Rosemary ward who carried out cleaning of the environment. Housekeeping staff did a daily clean of patient bed space areas and regular deeper cleans which involved pulling out each bed and cleaning behind and underneath the beds. There was a daily cleaning schedule for the ward with a checklist which indicated when cleaning tasks had been done; we saw that this checklist was completed.

There were no incidences of hospital acquired infection on Rosemary ward and one episode of Clostridium difficile on the King Suite between April and September 2019. Following this the trust instigated a number of actions; including but not limited to; staff reminders about process and prompt submission of specimens and ensuring that the onward receiving care home was informed.

As a result of the antibiotic audits carried out at both King Suite and Rosemary Ward, discussions were held about which antibiotic guidelines the staff expect to be followed for patients in the inpatient units, whether it was the Suffolk Community Formulary followed by GPs, or the trust antibiotic audit guideline. This was raised at the trust’s Antimicrobial Management Group meeting, to be escalated for further discussion at the next trust Infection Prevention and Control Committee meeting.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The two inpatient units were very different in configuration with Rosemary ward having an eight bedded female bay, one four bedded male bay and side room and six single rooms of which three had en-suite bathrooms and could be used for either males or females, dependent on need. There was a small day room with a television and a screen which could be used for electronic games although senior staff were unsure how this worked. The ward looked generally tired with very bland decor. There were a significant number of rooms used as storage or office space which also included a light, airy day room which was not being used. Staff commented that this was due to it being too far from the rest of the ward and feeling a bit isolated. The King Suite at Glastonbury Court was a separate wing of an independent care home. There were 19 single rooms with en-suite bathrooms and televisions, a large breakfast/dining room and a large lounge. Patients described it as ‘being like a hotel’.

Resuscitation equipment was stored on a trolley on Rosemary ward and in a ‘grab bag’ on the King Suite at Glastonbury Court. The resuscitation trolley and grab bag included equipment such as defibrillators, suction equipment, oxygen, and single use items. Emergency medicines were also kept on the resuscitation trolley on Rosemary ward and in the medicines trolley at Glastonbury Court.

Two staff checked the Rosemary ward resuscitation trolley on a daily basis with one signature for each check. Daily checks included assurance that equipment such as the defibrillator and suction
machine were available and working. We reviewed the records for the period May to September 2019 and saw that there were four missing entries indicating checks had not happened.

We reviewed the contents of the resuscitation trolley and grab bag. We saw that on Rosemary ward, medicines were in date, however; a packet of sterile gloves was out of date in March 2018 and an intravenous giving set was out of date in July 2019. Both items were immediately replaced by staff when we showed them. On the King Suite at Glastonbury Court staff performed a check of the grab bag weekly and we saw that these had been consistently signed, for the period June to August 2019.

We saw that the clinical rooms contained sharps disposal bins which were date labelled and not overfilled. There was a process for collection and disposal of used sharps bins.

There were systems in place for electrically testing and calibrating equipment. We viewed a selection of equipment (14 pieces in total) at each hospital site and saw that all had maintenance stickers in place showing that testing had been carried out within the previous 12 months.

Therapy staff assessed patients to identify equipment needed to assist with their mobility. Staff said that they could access equipment for patients easily and we saw that a stock of equipment such as frames and mobility aids were stored at both inpatient locations, although storage was at the end of the main corridor at Glastonbury Court due to lack of defined storage areas. Therapy staff told us that accessing equipment for patients going home was generally straightforward.

There was inconsistent storage of controlled substances hazardous to health (CoSHH) such as cleaning products. These were safely stored at Glastonbury Court however, on Rosemary ward although the CoSHH products were stored in a locked cupboard in the dirty utility room, the key was kept in an open cupboard next to it. This meant that a patient or relative could gain access to CoSHH products. This was escalated to senior staff on site. Following our inspection, the trust confirmed that the key had been removed from the unlocked cupboard and was carried by a named team member until a key safe could be put in place.

**Assessing and responding to patient risk**

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

The community inpatient areas did not have formal inclusion/exclusion criteria in place other than admitted patients being over the age of 18, medically optimised (the term for a patient who is medically fit for discharge and defined as ‘the point at which care and assessment can safely be continued in a non-acute setting’), registered with a Suffolk GP and requiring reablement, rehabilitation, end of life or complex discharge planning needs, which could not be met at home. Staff said that each patient was assessed on an individual basis for transfer to the units and that they did not usually have patients who were confused or who had dementia. This meant that there was a risk that inappropriate patients could be transferred to the unit and accepted by staff unfamiliar with the criteria. Both units were used for ‘step down’ patients from acute care rather than ‘step up’ from the community.

Patient safety issues were raised to the trust through a daily safety huddle. The Rosemary ward manager or nurse in charge contacted the matron of the day by the trust’s telephone bleep system before 9.30am to confirm staffing details, escalate safety issues appropriately and make plans to mitigate risk.
Access to the King Suite at Glastonbury Court was through the care home and then through a key
code locked door, although the key code was displayed in a pattern on the wall next to the door. At
Rosemary ward, there was open door access once within the hospital building which was then
locked at night. Staff were alone on site at night and said that they felt unsafe at times as they did
not have sight of the main doors from the nurses’ station despite there being cameras installed at
the front door. The feed for the camera went direct to the acute trust which was approximately 20
minutes’ drive away. Staff said that if they heard someone at the front door they would have to call
the acute trust to check who was at the door. If it was a scheduled visit, for example someone
attending to see a sick patient they were directed round to the side door which was next to a
corridor with a large expanse of windows, again leaving staff feeling vulnerable. This was
escalated to the senior team who were aware of the issue, but it was not on the risk register.

We reviewed 17 sets of patient records which demonstrated that patients had received a range of
assessments which included using risk assessment tools, for example, in relation to nutrition, falls
risks, skin integrity and pressure areas. We saw that all risk scores were completed on admission
with routine re-assessments during admission. We noted that where falls or pressure area risks
were identified individual action plans were put in place. Moving and handling risk assessments
were also carried out and bed rail assessments were completed for patients at risk of falling out of
bed, to ensure that bed rails were used safely and appropriately.

Each inpatient area had a daily nursing handover at the change of shifts where staff discussed
patient’s reason for admission, levels of required assistance or supervision, need for any regular
observations, and identified the risk of falls and pressure damage. This raised awareness for staff
of those patients at risk and actions required to prevent or reduce harm. In addition, there was a
multidisciplinary team (MDT) board round/safety huddle daily which enabled therapy staff to
highlight the mobility support needs of patients.

Staff understood the processes involved in assessing and responding to patient risk. They were
knowledgeable about the introduction of the National Early Warning Score (NEWS2) being
implemented that incorporated sepsis triggers and the process of escalation. If NEWS2 scores
were outside of those expected, staff told us they would ring the GP. If the patients was scoring
very high (above 5) they would call an ambulance. We were unable to assess escalation
procedure of patients during our inspection as none of the patients at the time of our visits had a
high NEWS2 score.

Medical cover was provided by local GPs with attendance for three hours per day Monday to
Friday to review patients who required it.

**Nursing Staffing**

The service had enough staff with the right qualifications, skills, training and experience to
keep patients safe from avoidable harm and to provide the right care and treatment.
Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank,
agency and locum staff a full induction.

**Trust level**

The table below shows a summary of the nursing staffing metrics in community inpatients at trust
level compared to the trust’s targets, where applicable:
### Community inpatients annual staffing metrics

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
<th>June 2018 to May 2019</th>
<th>May 2018 to April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annual average establishment</td>
<td>Annual vacancy rate</td>
<td>Annual turnover rate</td>
</tr>
<tr>
<td>Target</td>
<td>6%</td>
<td>10%</td>
<td>3.5%</td>
</tr>
<tr>
<td>All staff</td>
<td>53</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>24</td>
<td>9%</td>
<td>9%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Nurse staffing rates within community inpatients at trust level were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover.

### Vacancy rates

Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives within community inpatients at trust level were not stable and may be subject to ongoing change.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

### Sickness rates
Monthly sickness rates over the last 12 months for qualified nurses, health visitors and midwives within community inpatients at trust level showed a shift from December 2018 to May 2019.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives within community inpatients at trust level showed a downward trend from July 2018 to January 2019, although this did not continue.
Monthly agency hours over the last 12 months for qualified nurses, health visitors and midwives were not stable within community inpatients at trust level and may be subject to ongoing change.  

(Source: Routine Provider Information Request (RPIR) – Nursing bank agency tab)

King Suite, Glastonbury Court

The table below shows a summary of the nursing staffing metrics in community inpatients at King Suite, Glastonbury Court compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
<th>June 2018 to May 2019</th>
<th>May 2018 to April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annual average establishment</td>
<td>Annual vacancy rate</td>
<td>Annual turnover rate</td>
</tr>
<tr>
<td>Target</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>27</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>12</td>
<td>2%</td>
<td>7%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Nurse staffing rates within community inpatients at King Suite, Glastonbury Court were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness and agency use.

Vacancy rates
Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives within community inpatients at King Suite, Glastonbury Court showed a shift from October 2018 to March 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Bank staff usage

Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives within community inpatients at King Suite, Glastonbury Court were not stable and may be subject to ongoing change.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Rosemary Ward, Newmarket Hospital

The table below shows a summary of the nursing staffing metrics in community inpatients at Rosemary Ward, Newmarket Hospital, compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Community inpatients annual staffing metrics</th>
<th>April 2018 to March 2019</th>
<th>June 2018 to May 2019</th>
<th>May 2018 to April 2019</th>
</tr>
</thead>
</table>

20190416 900885 Post-inspection Evidence appendix template v4
Nurse staffing rates within community inpatients at Rosemary Ward, Newmarket Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and bank use.

Vacancy rates

Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives within community inpatients at Rosemary Ward, Newmarket Hospital were not stable and may be subject to ongoing change.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Sickness rates
Monthly sickness rate over the last 12 months for qualified nurses, health visitors and midwives within community inpatients at Rosemary Ward, Newmarket Hospital showed a shift from December 2018 to May 2019.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Agency staff usage

Monthly agency hours over the last 12 months for qualified nurses, health visitors and midwives within community inpatients at Rosemary Ward, Newmarket Hospital were not stable and may be subject to ongoing change.

(Source: Routine Provider Information Request (RPIR) – Nursing bank agency tab)

The daily staffing allocation on each inpatient area was two registered nurses (RNs) and three unqualified nursing assistants (NAs) during the day, two RNs at night and one NA at night with the addition of a ‘twilight’ NA who worked until midnight. However, the community inpatient units did not use a staffing tool that assessed acuity. This meant that there was no way of knowing whether the staffing level was appropriate/safe for patient care needs and staff on Rosemary ward said that they often felt as if there were not enough staff on duty.

Data provided by the trust following our inspection showed that nursing staff fill rates were between 93.8% and 129% for the months of June, July and August 2019. (A percentage over 100% indicated there were more staff in post than planned.)
There had been a period of high vacancy rates on Rosemary ward, but this had been resolved and during our inspection staffing numbers were as below:

<table>
<thead>
<tr>
<th>Community Inpatient unit</th>
<th>Newmarket - Rosemary</th>
<th>Glastonbury Court</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget</td>
<td>Actual</td>
</tr>
<tr>
<td>Qualified Nursing</td>
<td>12.43</td>
<td>10.24</td>
</tr>
<tr>
<td>Unqualified Nursing</td>
<td>13.47</td>
<td>13.04</td>
</tr>
</tbody>
</table>

Between 1 October 2018 and 1 October 2019 Rosemary ward used 4,774 agency and 2,310 bank RN hours and 1,124 non-registered nurse hours. On King Suite the numbers were significantly lower with 125 agency, 451 bank RN and 2,599 non-registered nurses.

Staff told us that there had been a period of almost 50% vacancy rate at Rosemary ward but that they had recruited staff to fill most posts. Whilst recruiting they had to use bank and agency staff to ensure there were enough staff which accounted for the high agency and bank hours.

Information supplied by the trust following our inspection showed that sickness rates were highest on Rosemary ward in April 2019 (30%) but had fallen consistently since then to 2.7% in September 2019. Senior staff said this also coincided with the high vacancies within the unit that had since been resolved.

**Medical staffing**

The trust informed us that there were no specialist consultants within community services for adults with medical cover being provided by GPs.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Rosemary ward had a weekly consultant ward round to review patients and, on the King suite, this was shared by two consultants who each attended once weekly. The consultants that covered the inpatients wards worked for the trust.

Local GPs provided Monday to Friday medical support for three hours per day. Out of hours staff accessed medical advice by calling 111 or an in an emergency calling 999.

**Allied health professional staffing**

The trust did not provide any data for allied health professionals (AHPs) working within community inpatients.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

All AHPs who attended the community inpatient units worked on a rotational basis from the acute trust and as such were part of the acute staffing allocation.

**Suspensions and supervisions**

During the reporting period from April 2018 to March 2019 community inpatient services reported that there were no cases where staff had been either suspended or placed under supervision.
Quality of records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient records were all paper based on the King Suite at Glastonbury Court. Nursing and therapy assessments and intentional rounding records were stored by patients’ beds and multidisciplinary records were stored in a closed but unlocked trolley. The patient records were all electronic on Rosemary ward at Newmarket hospital. The change to electronic records had taken place a few weeks before our inspection and staff commented that they were still becoming familiar with them.

We reviewed 17 patient care records in both electronic and paper formats. We saw evidence of multidisciplinary team recording which provided accurate details of care pathways and treatment to ensure consistency of care. Paper records were mostly legible, although we did see some written records that were illegible. Records were mostly signed and dated by staff with signature sheets at the front of each record to denote who the signature belonged to.

Assessments and care plans were generally appropriately updated and maintained however we saw three records had incomplete assessments and not all assessments had been recently updated.

Records generally lacked any evidence of individualised care plans based on the outcomes of discussions with the patient or their relatives. For example: we did not see notes of patients’ regular habits and routines.

Documentation sample audits (five records) were performed monthly as part of the ‘Perfect ward’ audits. Between June and September 2019, the audit showed that compliance varied between 98% and 100% on King’s Suite and between 95% and 100% on Rosemary ward.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff on both inpatient units we visited stored medication in locked cupboards within secure clinical rooms.

Medicines were supplied by the trust pharmacy and a pharmacist/pharmacy technician visited the community locations on a weekly basis for medicine reconciliation, review and discharge. The pharmacy technician also supported the inpatient wards weekly by monitoring medicine stock levels. Staff reported that medicines were available on the same day as ordered and there were no issues with delays.

The trust provided a twice daily courier collection/delivery service, which transported mail/samples/medication/supplies between the main acute trust site and Rosemary Ward.

Medical gas cylinders were stored securely at each site.

We checked the expiry dates on a selection (23 items) of medicine across both the inpatient units. All medicines were within date. Staff had developed local procedures to indicate that medicines
were nearing their ‘end of use’ date. For example: on Rosemary ward staff used a red spot sticker and on the King Suite at Glastonbury Court they used a highlighter to make staff aware.

All medicine fridges were located in locked clinical rooms and were locked according to trust policy. Medicine fridge temperatures including high/low temperatures were checked daily and logged to ensure medicines were stored at the correct temperature. Staff were aware of required temperature ranges and knew how to escalate concerns if the temperature fell outside of range.

Controlled drugs (CD’s) were stored securely in locked cupboards within medicine cupboards in the clinical rooms. Controlled drugs are medicines controlled under the Misuse of Drugs legislation (and subsequent amendments). Regulations state that controlled drugs should be secured in a lockable wall mounted cupboard with only authorised staff having access to keys.

During our inspection we performed random checks of the CDs at both inpatient units. The CD records were legible and dated by nursing staff without any omissions. Staff followed their internal procedures for the storage and administration of CDs which included two signatories following each administration. We reviewed the CD log book at both community locations which confirmed CDs were correctly recorded and CDs that had expired were correctly identified as due for destruction.

We observed nursing staff administering medicines and saw that patients were supported to take their medicines and that this was in line with safe administration practices. Medicine allergies were clearly recorded on all of the 11 electronic and paper medicines charts we reviewed. Omissions were clearly recorded, and records were accurate and reflected the needs of the patients.

Staff were aware of the reporting structures for medicines errors. We saw that on Rosemary ward there had been 17 medication incidents and six on the King Suite at Glastonbury. The number and type of medication errors were reported and included as part of the quality metrics reporting to the trust board.

**Incident reporting, learning and improvement**

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

**Never events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From August 2018 to July 2019, the trust did not report any never events for community inpatient services.

(Source: Strategic Executive Information System (STEIS))

**Serious Incidents**

**Trust level**
In accordance with the Serious Incident Framework 2015, the trust did not report any serious incidents (SIs) in community inpatient services, which met the reporting criteria set by NHS England from August 2018 to July 2019.

(Source: Strategic Executive Information System (STEIS))

Serious Incidents (SiRI) – Trust data

From June 2018 to May 2019, trust staff within community inpatient services did not report any serious incidents. Therefore, the number of the serious incidents recorded by the trust incident reporting system is comparable with that reported to Strategic Executive Information System (STEIS). This gives us more confidence in the validity of the data.

(Source: Routine Provider Information Request (RPIR) – Serious Incidents tab)

Prevention of Future Death Reports (Remove before publication)

The Chief Coroner’s Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last year, there had not been any prevention of future death reports sent to West Suffolk NHS Foundation Trust.

(Source: Routine Provider Information Request (RPIR) – Prevention of future death reports)

Between September 2018 and August 2019, the community inpatient units reported a total of 371 clinical incidents on the electronic reporting system. King Suite at Glastonbury Court reported 129 and Rosemary ward at Newmarket reported 242. Of these, five were reported as moderate harm with the rest being minor or no harm. The majority of the incidents related to slips trips and falls involving patients (148), with the second most common reported being discharge, transfer and follow-up arrangements (117).

All staff knew what incidents to report and how to report them. Staff reported all incidents that they should report.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Duty of candour is a requirement under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that providers of health and social care must follow. It states that providers must be open and transparent with people who use their services and sets out specific requirements that providers must follow when things go wrong with a person’s care and treatment. This includes informing people about the incident, providing them with reasonable support, and an apology when things go wrong.

Managers investigated incidents thoroughly. Staff said they received feedback from investigation of incidents. For example: staff spoke of an incident where a patient had gone home with the wrong prescription and subsequent checks that had been instigated to prevent this happening again

Staff met to discuss the feedback and look at improvements to patient care.

Incidents were reported using the electronic reporting system. Staff gave examples of incidents they reported, including medication incidents and staffing difficulties.
Safety performance

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and the public.

Safety Thermometer - Community inpatient wards

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.

From June 2018 to June 2019, the trust reported seven new pressure ulcers, no falls with harm and three new catheter urinary tract infections within all community inpatients wards.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at West Suffolk NHS Foundation Trust – All community inpatients wards.**

![Graph showing prevalence rate of pressure ulcers and UTIs]
Safety thermometer data was displayed on wards for staff and patients to see.

Staff used the safety thermometer data to further improve services. We saw ‘Harm Free Care Action Plans’ relating to patient falls and prevention of hospital acquired pressure ulcers for both inpatient units on the King Suite that were updated monthly and red, amber, green rated for compliance.

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care. (Community)

Staff assessed patients using nationally recognised risk assessment tools. This included tools in relation to the risk of developing pressure damage, the risk of falls and the risk of developing venous thromboembolism (VTE).

Staff we spoke with said they could access trust policies and National Institute for Health and Care Excellence (NICE) guidance via the intranet or shared drive however there were still some policies held on a previous community system which meant that staff had to check both sites.

We saw evidence of staff using National Institute for Health and Care Excellence (NICE) guidelines for the assessment and treatment of pressure ulcers.

Staff followed up-to-date policies, which referenced latest guidelines, to plan and deliver care according to best practice and national guidance.

Staff protected the rights of patients’ subject to the Mental Health Act and followed the Code of Practice

Patients receiving rehabilitation had clear, 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 all described the recognised assessment tools used for patients during their rehabilitation.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

We saw care plans in place to support good nutrition and hydration in the care records that we reviewed. Staff used a nationally malnutrition screening tool to screen patients on admission for malnourishment and completed fluid and nutrition charts for patients with nutritional and hydration risks. Patients at risk of malnutrition were weighed on a weekly basis and records of this
maintained to help inform care and treatment decisions. Staff had access to dietetic advice and speech and language therapy (SALT) through referral.

Staff provided assistance to patients to eat when they were unable to do so independently and there was an alert system in use so that staff were aware of which patients required assistance and of any nutritional restrictions. Patients we spoke with said that the food was of good quality and that they had enough to eat and drink throughout the day. Staff and patients said that there was a choice of dishes at mealtimes and that food was appetising and served hot.

Staff reported that they were able to respond to patients’ religious and cultural dietary needs and that catering staff would liaise with them about meeting patients’ individual needs.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Patients we spoke with said that staff asked about their pain and responded quickly with pain relief. We saw that staff escalated ineffective pain control to medical staff in the communications book for the daily GP visit.

During our inspection, we observed staff completing pain assessments for patients and responding to patients in pain in a timely manner by administering analgesia (pain relief).

Staff could use both numerical and picture diagrams to assess pain for patients who had difficulty expressing themselves.

Feedback from patients about pain management was positive. One patient told us they receive regular medication for pain, but if they needed more, staff were quick to provide it.

Patient outcomes

Staff were unaware of the monitoring that the trust performed for the effectiveness of care and treatment. They were unable to use the findings to make improvements in outcomes for patients.

The trust did not participate in any clinical audits in relation to this core service as part of their Clinical Audit Programme over the last 12 months.

(Source: Routine Provider Information Request (RPIR) – Audits tab)

Local managers were unaware of any outcome targets or monitoring performed, for example ‘length of stay’ (LoS).

The community inpatient units used the Barthel scale to measure patient’s performance in activities of daily living (ADL). The Barthel scale measures the degree of assistance required by an individual on 10 items of mobility and self-care ADL. Senior staff we spoke with were not all aware that this was audited at the trust despite being included in monthly performance reports. This meant that staff were unable to use findings to make improvements.

Following our inspection, the trust provided information from the participation in the National Audit of Intermediate Care (NAIC) 2018. The NAIC covers services which focus on the care and support of usually frail, older people, at times of transition between different services in the health and care
system, for example, when stepping down from acute hospital care or preventing them being admitted to longer-term care, until they really need to.

The 2018 provider bespoke report for the trust inpatient units showed a number of areas which were better than the national average, for example;

- The mean average time from referral to commencement of service was two days with the England average 2.4 days. This meant that the service was meeting National Institute for Health and Care Excellence (NICE) quality standards (QS173) that recommend that service users start bed based intermediate care within 2 days of referral.
- The mean duration of stay was between 18-20 days with the England average 26 days.
- The mean bed occupancy was between 94% and 96% with the England average 89%
- England mean referral from acute 77% (WSH 95% and 100%)

The report also showed that;

- The percentage of service users discharged home from Rosemary ward (55%) was lower than the England average of 63% with the King Suite higher at 74%.
- The percentage of service users discharged back to an acute hospital was also higher from Rosemary ward (25%) than the England average of 14%, whereas the King Suite was slightly lower at 13%.

The NAIC also included a service user audit which consisted of a service user questionnaire (SUQ) and a patient reported experience measure (PREM). Within the SUQ, the Modified Barthel Index (MBI) standardised outcome measure was used to determine the service users’ level of dependency on admission to the service and again on discharge. For the MBI, a lower score means the person is more dependent. The measures were not reported for the King Suite but on Rosemary ward the admission score was 44.6 with an improvement change in score of 15.8 which was lower than both the England average score of 54.5 on admission and average improvement change in score of 19. This meant that patients admitted to Rosemary ward had more dependency on admission and less improvement than the England average.

We requested an action plan following the report, but we were not provided with this.

Therapy records we reviewed included the identification of individual patient goals and we observed discussions around this during multidisciplinary and board round meetings. Therapy staff we spoke with told us that they did not routinely audit outcome measures to monitor patients progress during rehabilitation.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

**Clinical Supervision**

The trust provided the following information about their clinical supervision process:

Clinical supervision of nursing teams occurs during the activities below on an informal basis:
• Daily/shift handover of patient care within teams: this process allows team members to review practice and reflect on the personal and professional response to their care.

• Regular team meetings (this varies from team to team).

• Attendance of band 7 colleagues at the trust's Nursing and Midwifery Clinical Council monthly meetings.

• Team leads’ attendance at monthly Operations and Performance Meetings.

On a formal basis, the trust provided:

• Nurse revalidation.

• Three and six monthly personal development reviews.

• Ward managers hold monthly 1:1s with the senior matron.

• The senior matron holds monthly 1:1s with the head of nursing.

(Source: CHS Routine Provider Information Request (RPIR) – Clin Supervision tab)

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers supported staff to develop through yearly, constructive appraisals of their work and new staff completed ‘workbooks’ to ensure that they had the skills necessary for their role.

Staff we spoke with confirmed that they received clinical supervision and registered nurse staff received support with revalidation.

Staff said that the training opportunities were good and that if they identified a specific course related to their work then they were supported to attend. Nursing staff were supported to undertake degree level studies. Healthcare assistants were supported to undertake relevant competency completion.

Managers gave all new staff a full induction tailored to their role before they started work.

We viewed records of induction checklists for new staff and saw that these had been completed. Staff we spoke with confirmed that they had received an induction and that it was relevant to their role and workplace.

In 2019 the trust performed a review of induction programmes to ensure they were appropriate for both acute and community colleagues. This meant some significant changes to both the content of training and to the delivery. Changes were made based on feedback from staff. There was a significant change to the induction layout, which the trust anticipated would balance between staff being trained appropriately and safely without sacrificing unnecessary delays in starting in the workplace. The new programme was planned to start in January 2020.

Appraisal rates - Trust wide

From April 2018 to March 2019, 87.0% of required staff in trust-wide community inpatient services received an appraisal compared to the trust target of 90%. The breakdown by staff group can be seen in the table below:
Estates and ancillary and additional clinical services staff both met the 90% target. However, only 77.3% of registered nursing staff had received an appraisal. The trust informed us that there were no specialist consultants within community inpatients with medical cover being provided by GPs.

Updated analysis for April 2019 to mid-June 2019 found that 13.0% of required staff in trust-wide community inpatient services received an appraisal compared to the trust target of 90%. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2019 to mid-June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>1</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>5</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>1</td>
</tr>
<tr>
<td>Estates and ancillary</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
</tr>
</tbody>
</table>

None of the staff groups met the 90% target. However, this data only represents a partial year, so we would not expect a high appraisal completion rate.

King Suite, Glastonbury Court

From April 2018 to March 2019, 100.0% of required staff in community inpatient services within King Suite, Glastonbury Court received an appraisal compared to the trust target of 90%. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Estates and ancillary</td>
<td>2</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>15</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>1</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
</tr>
</tbody>
</table>

All of the staff groups within community patients in King Suite, Glastonbury Court had received an appraisal. The trust informed us that there were no specialist consultants within community inpatients with medical cover being provided by GPs.
Updated analysis for April 2019 to mid-June 2019 found that 15.6% of required staff in community inpatient services within King Suite, Glastonbury Court received an appraisal compared to the trust target of 90%. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2019 to mid-June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>1</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>4</td>
</tr>
<tr>
<td>Estates and ancillary</td>
<td>0</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
</tr>
</tbody>
</table>

None of the staff groups working within community inpatients in King Suite, Glastonbury Court met the 90% target. However, this data only represents a partial year, so we would not expect a high appraisal completion rate.

Rosemary Ward, Newmarket Hospital

From April 2018 to March 2019, 68.2% of required staff in community inpatient services within Rosemary Ward, Newmarket Hospital received an appraisal compared to the trust target of 90%. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>10</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>2</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
</tr>
</tbody>
</table>

Additional clinical services staff working in Rosemary Ward met the 90% target. However, only 37.5% of registered nursing staff had received an appraisal. The trust informed us that there were no specialist consultants within community inpatients with medical cover being provided by GPs.

Updated analysis for April 2019 to mid-June 2019 found that 9.1% of required staff in community inpatient services within Rosemary Ward, Newmarket Hospital received an appraisal compared to the trust target of 90%. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2019 to mid-June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>1</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>1</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
</tr>
</tbody>
</table>
None of the staff groups working in Rosemary Ward met the 90% target. However, this data only represents a partial year, so we would not expect a high appraisal completion rate.

(Source: Routine Provider Information Request (RPIR) – Appraisals tab)

Following our inspection, the trust supplied data which showed that, in September 2019, Rosemary ward nursing staff appraisal compliance rate was 87% and the King Suite was 85% which almost met the trust target. Administrative and clerical staff was 100% and additional clinical services was 86%.

**Multidisciplinary working and coordinated care pathways**

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Each inpatient location had a team of nursing staff, and therapists who worked together to provide coordinated care. There were physiotherapists, occupational therapists and therapy assistants who attended daily Monday to Friday and provided assessment and support to patients. Staff said that the therapists were an integral part of the care team.

Multidisciplinary (MDT) meetings were attended by nursing staff, GPs, discharge coordinators, social care staff and therapists.

There was a multi-disciplinary approach to reviewing ‘Red to Green’ days; Red days are defined as those days that fail to contribute to a patient’s discharge from hospital whilst green days are value-adding days achieved by working better together (NHS Improvement April 2017). This Red to Green review process involved reviewing patients’ goals, discussing their current treatment and any barriers to discharge planning.

The team worked together to ensure that all support required was in place prior to arranging a patient discharge. Each patient was discussed in detail and consideration was given to both their physical and mental health as well as their social circumstances. This included discussions around end of life care including advance care planning.

**Health promotion**

Staff gave patients practical support and advice to lead healthier lives.

The service had appropriate information promoting healthy lifestyle choices and support on each inpatient unit.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle.

Staff encouraged patients to work towards specifically tailored goals whilst on the units. The patient goals were primarily therapy led and designed so that the patient could take a proactive in the goal setting.

We saw that leaflets and information regarding smoking cessation, healthy lifestyle, cancer awareness and stroke awareness were available for patients and visitors to read.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**
Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients’ liberty.

Mental Capacity Act and Deprivation of Liberty training completion

The trust reported that Mental Health Act (MHA), Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) are covered in the safeguarding adults training.

The trust set a target of 90% for the completion of safeguarding adults training.

Trust level

Compliance for safeguarding adults training as of June 2019 for qualified nursing staff in community inpatient services at trust level is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing staff</td>
<td>17</td>
<td>24</td>
<td>70.8%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In community inpatient services at trust level the 90% target for safeguarding adults training was not met by qualified nursing staff.

The trust informed us that there were no specialist consultants within community services for adults with medical cover being provided by GPs.

The trust did not provide any data for qualified allied health professional staff working within community inpatients. Therapy staff were supplied on a rotational basis from the acute trust and training compliance managed at the acute trust.

King Suite, Glastonbury Court

Compliance for safeguarding adults training as of June 2019 for qualified nursing staff in community inpatient services at King Suite, Glastonbury Court is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing staff</td>
<td>14</td>
<td>14</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In community inpatient services at King Suite, Glastonbury Court the 90% target for safeguarding adults training was met by qualified nursing staff.

Rosemary Ward, Newmarket Hospital

Compliance for safeguarding adults training as of June 2019 for qualified nursing staff in community inpatient services at Rosemary Ward, Newmarket Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing staff</td>
<td>14</td>
<td>14</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Qualified nursing staff | 3 | 10 | 30.0% | 90% | No

In community inpatient services at Rosemary Ward, Newmarket Hospital the 90% target for safeguarding adults training was not met by qualified nursing staff.

(Source: Routine Provider Information Request - Training tab)

Following our inspection, the trust supplied data which showed that overall compliance for Rosemary ward staff (qualified and unqualified nursing staff) had improved to 81% with 25 of the 31 eligible staff compliant and we saw duty rotas which showed that the remaining staff available (not on long term sickness or leave) had dates booked. The King Suite staff remained 100% with all 33 eligible staff compliant.

Deprivation of Liberty Safeguards

From June 2018 to May 2019, the trust reported that 322 Deprivation of Liberty Safeguard (DoLS) standard and urgent applications were made to the Local Authority. Five of these were pertinent to community inpatient services.

Two applications were made in November 2018 with one each in July 2018, February and April 2019.

Notifications of the five applications were not sent to CQC. The trust reported that, when DoLS were submitted, they had not been approved by the Multi-Agency Safeguarding Hub (MASH). Therefore, the DoLS process could not be considered complete.

A breakdown by ward is shown in the table below:

<table>
<thead>
<tr>
<th>Inpatient ward</th>
<th>Number of applications made</th>
<th>Number of applications approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rosemary Ward</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>King Suite</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – DoLS tab)

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Therapy and nursing staff sought verbal consent for care interventions and we saw evidence that staff approached patients sensitively and sought consent for care or therapy before interventions were carried out.

Staff we spoke with demonstrated an understanding of the Mental Capacity Act and the requirement to presume capacity. Staff also had an understanding of consent and supporting patients who had been identified as lacking mental capacity.

Staff we spoke with had a good understanding of best interest decision making and knew how to seek advice when patients were not able to give valid informed consent, due to a lack of mental capacity.

We reviewed a patient’s record which showed that a capacity assessment had been performed and that it was limited to a very specific decision rather than being used to denote that the patient did not have capacity for any decision.
Staff demonstrated a good understanding of advocacy services and how to access these where necessary.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them with kindness and care.

Staff interacted with patients and those close to them with kindness and consideration. During our inspection we observed staff maintaining patient’s privacy and dignity whilst providing care by closing the curtains around their beds.

We observed staff speaking with patients and relatives with compassion and sensitivity. All staff were seen to be quick to respond to patients requesting support and we saw that call bells were generally answered quickly.

We spoke with 11 patients who told us they had received good care and that staff were ‘nice and kind’ and treated them ‘very well’ and that they responded quickly to meet their needs.

We observed nursing and therapy staff speaking to patients with respect and treating them with kindness and patience.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Each community inpatient unit displayed patient thank you cards. Comments from the cards showed patients felt they had been treated with compassion.

The National Audit of Intermediate Care (NAIC) 2018 reported the Patient Reported Experience Measure (PREM) which provides an overview of patients’ experience of intermediate care. The 2018 provider bespoke report for the trust community inpatient units reported 86% of patients felt they always had confidence and trust in the staff treating them. On the King Suite 100% of service users felt they were always treated with respect and dignity. For Rosemary ward the figures were; 75% always, 19% sometimes and 6% of service users felt they were not always treated with respect and dignity. The England mean average was; 91% always, 8% sometimes and 1% not.

The community inpatient units collected data for the national Family and Friends (FFT) test. The test asks a simple question, “How likely are you to recommend our ward to friends and family if they needed similar care or treatment?” There is a descriptive six-point response scale to answer with graded positive or negative answers. Between August 2018 and August 2019-19 Rosemary ward scored between 80% and 100% positive responses with an average of 92% of patients recommending them. The King’s Suite scores were consistently 100% positive apart from August 2019 when it was 95% with the overall score being 99%.

PLACE - data in relation to privacy, dignity and wellbeing
The site which provided community inpatient services for the trust, Newmarket hospital, was compared to other sites of the same type and the scores they received for privacy, dignity and wellbeing were found to be about the same as the England average in 2018.

No data was submitted for King Suite, Glastonbury Court.

(Source: NHS Digital)

**Emotional support**

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.

We saw staff treating patients with awareness and understanding of their emotional and social needs as well as the physical. Staff appeared to have a good understanding or the potential impact of emotions on physical wellbeing, in particular in relation to those patients being supported to become more independent before discharge home.

We observed staff across the trust providing comfort and support to patients who were anxious or distressed.

Staff understood that patients who were admitted for a period of rehabilitation or reablement prior to discharge home required additional input to help build their confidence. For example, we saw a therapy assistant supporting and encouraging a patient to walk.

We heard about staff going out of their way to support a patient, who was near to the end of their life, wish to experience Christmas. When it became apparent that they were not going to be able to do that, staff swiftly organised an early Christmas for the patient and their relatives with a tree, wrapped gifts and food.

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

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Patients told us that they felt involved in their care. They knew that they had care and treatment plans in place and said they had been involved in them.

Staff communicated with people so that they understood their care, treatment and condition. There was recognition of the need to involve patients and those close to them in their treatment and care. We observed staff explaining treatment to patients and saw that staff took extra time to do this when needed to ensure understanding.

Family involvement was noted in many key areas of decision making. For example, we heard staff speaking with a relative to confirm if they wanted to be contacted if the patients discharge plans changed.

We observed a multidisciplinary meeting where discussions about patient discharges showed the involvement of family members.
Planning and delivering services which meet people’s needs

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

There were free, but limited, car parking facilities at both community inpatient sites. Visiting hours were 2pm till 8pm with protected mealtimes for patients.

The community inpatient units were based on the ground floor and easily accessible to those with mobility problems.

There were facilities and equipment available to meet the needs of patients. There was a range of equipment available at all the community hospitals including adjustable height beds, hoists, other manual handling aids, and walking frames. Therapy staff and discharge coordinators were able to access equipment in a timely way to support patients being discharged back into the community.

Patients and relatives were generally very happy with the environment on the King Suite and we heard from staff and patients alike on both units that they were pleased to have community inpatient services available. There were communal areas such as day rooms for activities available, although we did not see any activities provided for patients and staff confirmed that there were no planned activities. During our inspection we saw the day room on Rosemary ward being used by one patient and relative for a visit.

There were separate male and female toilet and bathroom facilities available at all community inpatient sites. These were accessible and in good order.

There was a referral criterion for admission into community hospital beds but no specific inclusion/exclusion criteria. Staff completed fact finding records at the time of referral to ensure that as much information about the patient was sought prior to a decision to admit was made. This helped to ensure that the majority of referrals to the inpatient services were appropriate.

All patients in the units at the time of our inspection were appropriate for the setting and the arrangements in place. For example: there were no patients whose care needs were higher than staff were able to provide.

There was coordination between the community inpatient units, acute services and community services to plan and deliver services to meet people’s needs.

Staff had access to interpreters for non-English speakers or signers when needed.

Patients were given a choice of food and drink from a regularly changed menu and staff commented that because food was prepared on site, that the catering staff did their best to meet patients cultural and religious preferences even if it was for something not on the menu.

Both community inpatient unit staff encouraged patients to take their meals in the dining room but admitted that patients generally preferred to eat beside their bed.

Ward moves

The trust was asked to list ward moves for a non-clinical reason during the last 12 months. For example, if a patient had to move wards several times because there was no room in the speciality ward they should be housed in.

The trust reported no ward moves for a non-clinical reason from June 2018 to May 2019 in community health inpatient services, as they stated that patients were discharged from the acute
hospital to the community inpatient wards. This would change once community inpatient areas were on the same electronic patient system.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Moves at night

The trust was asked to list ward moves between 10pm and 8am for each core service for the most recent 12 months

From June 2018 to May 2019, the trust reported that there were no moves at night for community health inpatient services.

(Source: Universal Routine Provider Information Request (RPIR) – Moves at night tab)

Mixed sex breaches

Mixed Sex Breaches are defined by CQC as a breach of same sex accommodation, as defined by the NHS Confederation definitions. Whilst these are specifically for mental health providers the same definitions apply to community health services and acute providers from a CQC perspective. 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. This means that boys and girls should not share bedrooms or bed bays and that toilets and washing facilities should be same-sex. An exception to this might be in the event of a family admission on a children’s unit, in which case brothers and sisters may, if appropriate, share bedrooms, bathrooms or shower and toilets.

The trust reported that, from June 2018 to May 2019, there were no mixed sex breaches within community inpatients services.

(Source: Routine Provider Information Request (RPIR) – Mixed sex tab)

Meeting the needs of people in vulnerable circumstances

Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. However, the service was not inclusive and took little account of patients’ individual needs and preferences.

The community inpatient units were not designed to meet the needs of patients living with dementia or a learning disability. The single room environment in the King Suite meant that it was not suitable for patients who were confused or were likely to be disorientated in their surroundings. The décor on Rosemary ward was very bland and the layout of the ward confusing with multiple unused rooms.

There were no scheduled activities on either inpatient unit. We did speak with one nursing assistant who tried to organise patient involvement and engagement and had informally got a group of patients together, who enjoyed watching a regular weekly television programme, which was running at the time of our inspection.

Staff commented that they did not often care for patients with dementia and we saw no evidence of staff using ‘This is me’ documents and patient passports to support patients living with dementia and learning disabilities.
Staff had access to limited dementia friendly items to help calm anxious patients for example: ‘twiddle muffs’ and showed us some items that were kept in the storage room, which were replaced from the acute trust if given to a patient.

There was a photograph album in the dayroom of Rosemary ward with photographs of previous staff and patients from the community hospital which went back a number of years, but this was removed when we asked about permissions as photographs are a form of patient data and as such are subject to General Data Protection Regulation (GDPR) and relevant data protection law.

There was no evidence of staff personalising care plans for example; noting patients preferred time of rising, preferred name called, or food and drink preferences.

Patient-Led Assessments of the Care Environment

The site which provide community inpatient services at the trust, Newmarket Hospital, was compared to other sites of the same type and the scores they received for disability and for dementia friendliness were found to be about the same as the England average in 2018.

No data was submitted for King Suite, Glastonbury Court.

(Source: NHS Digital)

Access to the right care at the right time

People could access the service when they needed it and received the right care promptly.

Accessibility

The largest ethnic minority group within the trust catchment area is White British with 90.8% of the population.

<table>
<thead>
<tr>
<th>Ethnic minority group</th>
<th>Percentage of catchment population</th>
</tr>
</thead>
<tbody>
<tr>
<td>First largest</td>
<td>White British</td>
</tr>
<tr>
<td>Second largest</td>
<td>White: other white</td>
</tr>
<tr>
<td>Third largest</td>
<td>Asian/Asian British: other Asian</td>
</tr>
<tr>
<td></td>
<td>Mixed/multiple ethnic groups:</td>
</tr>
<tr>
<td></td>
<td>White and Black Caribbean</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request – Accessibility tab)

Bed occupancy

The trust provided information regarding average bed occupancies from June 2018 to May 2019.

A breakdown of bed occupancy levels in May 2019 by site for community health inpatient services is shown below:
Newmarket Hospital  | Rosemary Ward  | 94.0%  
Glastonbury Court  | King Suite  | 97.0%  

(Source: Community Routine Provider Information Request (RPIR) – Bed occupancy and length of stay tab)

Bed occupancy was monitored in the monthly ‘Executive Performance Meeting Community & Integrated Services Division Report’. We saw that, in the September 2019 report which contained August 2019 data, the bed occupancy for Rosemary ward was 92% and for the King Suite was 98%.

Average length of stay data

The trust provided information for average length of stay from June 2018 to May 2019.

A breakdown of average length of stay in May 2019 by site for community health inpatient services below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Ward</th>
<th>Average length of stay in May 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newmarket Hospital</td>
<td>Rosemary Ward</td>
<td>19</td>
</tr>
<tr>
<td>Glastonbury Court</td>
<td>King Suite</td>
<td>18</td>
</tr>
</tbody>
</table>

(Source: Community Routine Provider Information Request (RPIR) – Bed occupancy and length of stay tab)

Average length of stay (LoS) was monitored in the monthly Executive Performance Meeting Community & Integrated Services Division Report. The average LoS for the community inpatient units varied between 13 days and 21 days between April and August 2019.

Referrals

The trust did not identify any community inpatient services as measured on ‘referral to initial assessment’ and ‘assessment to treatment’ from June 2018 to May 2019.

(Source: CHS Routine Provider Information Request – Referrals tab)

The acute trust used the NHS Continuing Healthcare (NHS CHC) ‘Discharge to Assess’ system which is intended to ensure that patients are assessed for eligibility for NHS CHC at the right time and in the right location once an individual’s ongoing needs are known. The NHS CHC is intended to reduce the length of stay for patients in the acute setting and in particular, delays in discharge associated with a lengthy assessment process. The community inpatient units were used to provide rehabilitation, reablement and assessment to patients who needed non medicalised care prior to discharge or transfer to another place of care.

Staff reported that while there was a clear referral criterion in place, this was relaxed during times of escalation from the acute trust. Senior staff reported that beds were mainly used in relation to ‘step down’ (from the acute trust) and palliative care. Some staff were keen to develop ‘step-up’ (from the community). However, senior staff acknowledged that further work was required with the input from commissioners and acute and primary care leads, in terms of ensuring that services continued to meet the needs of the local population.
Staff reported that although the units often operated at high occupancy rates, the community hospitals were able to respond to referrals for admissions quickly. Therapy leads told us they were moving towards a more integrated service between the community inpatient units and the community based teams.

Physiotherapy (PT) and occupational therapy services (OT) were available Monday to Friday on the community units. If a patient needed to continue their therapy treatment at the weekends, the therapy staff provided a programme to be supervised by ward staff. Staff told us that all nursing staff were able to monitor rehabilitation of patients. Speech and language therapy and dietetics services were available on request from the acute hospital.

The inpatient units used the Red to Green (R2G) system to identify barriers to discharge. Red days are defined as those days that fail to contribute to a patient's discharge from hospital whilst green days are value-adding days achieved by staff working better together (NHS Improvement April 2017). Staff on both community inpatient units held daily R2G Board Rounds to identify actions for each patient with discharge coordinator roles at each community inpatient unit to facilitate the discharge process. This included a daily review of patients waiting to be discharged, analysis of themes causing delays, monitoring of 'red to green' factors where the patient did not receive an intervention to support their pathway of care.

The senior nurse had a weekly teleconference with the patient flow lead at the acute trust for stranded patient reviews where actions were reviewed for all patients with a length of stay longer than seven days

**Delayed discharges**

From April 2018 to March 2019, there were 3,518 delayed discharges trust-wide, which amounted to 4.9% of the total discharges. The trust was unable to provide this data at core service level.

A breakdown of monthly delayed discharge rates at trust level is shown in the chart below:

**Delayed discharge trends from April 2018 to March 2019 at West Suffolk NHS Foundation Trust**
Delayed transfers of care (DTOC) was monitored as a key performance indicator (KPI) in the monthly Executive Performance Meeting Community & Integrated Services Division Report. The community inpatient units target was less than 3.5% of bed days DTOC. We viewed the July August and September 2019 reports which showed that the community inpatient units did not meet the target for any of the five months shown (April to August 2019) with performance variation above the target between 3.8% and 13.3%. There were mitigating factors, for example: transport complications recorded but no actions recorded for improvement.

**Learning from complaints and concerns**

It was easy for people to give feedback and raise concerns about care that they had received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

**Complaints**

**Rosemary Ward, Newmarket Hospital**

From June 2018 to May 2019 the trust received three complaints about community inpatient services trust wide (1.7% of the total complaints received by the trust). All three complaints related to care within Rosemary Ward, Newmarket Hospital.

For the two complaints that had been closed at the time of data submission, the trust took 24 and 73 working days, respectively to investigate and close these. In one of these cases, this was not in line with their complaints policy, which states complaints should be closed within 25 working days.

The one complaint, that had not been closed, had been open for 60 working days at the time of data submission.
Following our inspection, the trust supplied information to say that the one complaint that had not been closed and had not been responded to, as the trust had not yet received consent to do so. The trust reported that no further complaints had been received between May and September 2019.

A breakdown of complaints by subject is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient care</td>
<td>2</td>
<td>66.7%</td>
</tr>
<tr>
<td>Staff values &amp; behaviours</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

**King Suite, Glastonbury Court**

From June 2018 to May 2019 the trust did not receive any complaints about community inpatient services at King Suite, Glastonbury Court.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas. There were information posters and leaflets providing details of how patients and relatives could make a complaint.

Staff understood the policy on complaints and knew how to handle them. Staff were able to describe the complaints process and told us that concerns raised were initially dealt with on the ward by the ward manager, in order to resolve them locally where possible.

Managers investigated complaints and identified themes. Senior staff reported that although they tried to investigate complaints within the 25 working day target, this was sometimes difficult due to complexities involving multiple areas of the service.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers said that they shared feedback from complaints with staff and learning was used to improve the service, however, none of the staff that we spoke with could give any examples of learning from complaints.

**Compliments**

From June 2018 to May 2019 the trust received 40 compliments for community inpatient services (5.3% of all compliments received trust wide).

A breakdown of compliments by location is shown below:

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rosemary Ward, Newmarket Hospital</td>
<td>26</td>
<td>65.0%</td>
</tr>
<tr>
<td>King Suite, Glastonbury Court</td>
<td>14</td>
<td>35.0%</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
The trust noted that the majority of compliments received trust-wide related to overall care along the whole pathway; and patients and relatives thanking staff for their kindness and compassion during difficult and stressful times.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Staff displayed compliment letters and cards on noticeboards for both staff and patients to see.

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The community inpatient units were part of the Community and Integrated Services Division led by an associate director, divisional head of nursing, and integrated therapies manager. The board members were all relatively new in their current posts but had a clear understanding of their role and accountabilities.

Each community inpatient unit was led by a ward manager who reported to a senior matron, whose role was one of ensuring high quality, safe and timely patient care. The senior matron reported to the divisional head of nursing. The associate director for community service and senior managers supported the board of directors in the oversight and decision making for integrated community services within the division. Staff at all levels understood their responsibilities within their roles.

We found that there was some inconsistency in the level of knowledge and awareness of individual ward managers as to systems in place for monitoring or improving care. Not all managers we spoke with could clearly identify, or access, information that would support the delivery of improved care. Whilst they were supported by experienced and knowledgeable senior staff there was evidence that individual development and support at ward manager level was not consistently embedded.

Staff on the community inpatient units told us that leaders were visible, supportive and approachable. Locality managers and quality leads visited the hospitals regularly and staff knew who they were. Nursing staff reported there was good local leadership and that unit managers were accessible and approachable.

Staff were encouraged to develop and progress within the organisation. Staff described development opportunities at all levels. Staff felt encouraged to go on courses that enabled them to develop personally and professionally. Staff we spoke with reported having regular appraisals and access to one to one supervision.

Vision and strategy

The division had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders but this did not include the community inpatient service. The vision and strategy were focused on sustainability of services and aligned to
local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The Community and Integrated Services Division had a Divisional Strategic Business Plan 2019/20 as part of the ‘older people strategy’. However, the trust acknowledged a, ‘lack of inclusion in terms of the community inpatients; the beds had not formed part of the division until recently and unfortunately were not included within any other plan’. The senior leadership team were in the process of developing the divisional business strategy for 2020/21 and it was planned that the community inpatients would be included in this work.

The trust had had a strategic framework, ‘Our patients, our hospital, our future’, published in 2015. The strategic framework was underpinned by the trust vision, ‘to deliver the best quality and safest care for our community’, using five core values with seven ambitions.

Staff we spoke with knew the organisation core values and demonstrated in their work. We saw posters in both community inpatient units which displayed the organisational values.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. However, there was not a strong emphasis on the safety and well-being of staff.

Staff we spoke with reported that they felt valued and respected by managers and their colleagues. Staff said they felt confident to raise concerns and they felt valued and supported in their roles. They told us that ward managers were supportive and listened to concerns and suggestions.

Staff told us they could raise any concerns with their line manager and there was an awareness of the freedom to speak up guardian role within the trust.

All staff we spoke with told us that there was an open and honest culture. Staff were encouraged to report incidents and there was a no blame culture when incidents were reported.

Nursing and therapy staff respected each other’s roles and worked together in positive relationships towards common goals. Staff were proud and positive about working within the service.

Staff reported a positive culture in the community inpatient units. Staff were supportive of each other and there was good team ethos especially on the King Suite. During our inspection, we saw very positive examples of the whole team working together.

Managers and service leads praised staff for their team work and commitment and we saw this in the monthly performance reports.

Three staff members on Rosemary ward commented that they often felt unsafe at night as they were the only staff on site. Once the visiting hours were over, staff locked the main doors but due to the positioning of the ward they were unable to see the doors if someone knocked on them. There was a security camera at the front entrance, but the feed for this went direct to the security team based at the acute trust which was a twenty minute drive away. Staff were unclear why they were unable to have a screen installed on the ward which would have provided them with sight of any threat at the front door. One staff member recalled being very concerned as they were
unaware that the laundry delivery arrived overnight, and the driver banged on the side door near the nurses’ station.

**Governance**

**Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**

There were effective systems were in place to assess, monitor and improve the quality of care within inpatient services.

Senior leaders and ward managers demonstrated an understanding of governance arrangements. They described the actions taken to monitor patient safety and risk. This included monitoring risk dashboards, incident reporting and undertaking audits.

There was a regular audit process for the monitoring of clinical audits.

Monthly Clinical Governance Meetings took place on the inpatient units, during which patient feedback and quality outcomes were shared and discussed with the multidisciplinary team (MDT). We reviewed the meeting minutes of July, August and September 2019 and saw that there was oversight of complaints, incidents, staffing, audit results, safeguarding updates, among others. The governance meeting fed into the business meetings for each unit and into the ‘Community & Integrated Services - Senior Operations Meeting’ which then fed into the trust board meetings. This showed a direct line of governance and responsibility from ‘ward to board’.

We saw that falls, pressure ulcers and family and friends’ tests (FFTs) for the community inpatients units were specified in the trust Integrated Performance and Quality board reports indicating that these were monitored separately from the other trust inpatient wards.

**Management of risk, issues and performance**

**Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**

The service had processes for managing risks and performance. The community inpatient service had an electronic risk register linked to the incident reporting system. The risk registers recorded risk, based on the potential consequence to the service and the likelihood of the risk re-occurring. We viewed the risk register which showed that there was one active risk for each of the community inpatient units on the community inpatients risk register. These were: insecure IT access on Rosemary ward, rated amber and issues arising from information governance (IG) check on the King Suite, rated green. There were also 39 accepted risks -13 green with the rest rated amber with annual review dates. Security was rated as amber at both community inpatient sites.

Senior leaders confirmed that IT was the most significant risk to the service as the IT contract was not held by the trust. The divisional board were aware of the IT infrastructure risks and this was included on the trust board assurance framework (BAF) risk register.
Senior leaders and ward managers knew what the risks were in their area of responsibility and had action plans in place to mitigate risks. Staff regularly reviewed risks and risk was a regular agenda item in the monthly community unit governance meetings.

Senior matrons and ward managers received monthly quality performance data on their unit, allowing viewing of their performance and comparison with other units in the trust. However not all staff were aware of the systems for monitoring or improving care, for example a ward manager was unaware of community inpatient key performance indicators (KPIs) despite them being reported in the monthly performance reports. We were not assured that local processes were in place to collect, analyse and review data to improve performance and patient care. Outcome targets were not consistently monitored, and reported measures varied for the Kings Suite and Rosemary ward. As reported previously not all senior staff were aware that the Barthel scale was audited despite being included in monthly performance reports. This meant that staff were unable to use findings to make improvements. Routine audit outcome measures were not used to monitor patients progress during rehabilitation.

Staff collected data on a monthly basis for a range of compliance audits including, but not limited to; falls, pressure ulcers, record keeping, infections, medication incidents and NRLS (National Reporting and Learning Service) reportable Incidents. This data was shared in the monthly performance reports to community inpatient managers who fed the results back to staff using the ‘CREWS’ monthly newsletter. The newsletter contained updates about each community area key performance indicators so that staff could see how service was measured and their performance compared to other teams within the division. We saw copies of this were available in staff rooms during our inspection.

The senior matrons held monthly support meetings for the inpatient units which took the form of two separate meetings for each individual setting. A monthly one to one meeting took place between the divisional senior matron and each inpatient unit manager, to discuss quality and performance outcomes and issues, based upon the previous month’s data. During this forum areas of concern were discussed and plans to address difficulties developed. This was also used for congratulating good practice which was shared with the teams and for professional support.

A second triumvirate session took place between the senior matron, unit manager and the service manager, which included a review of key performance indicators such as appraisal/mandatory training rates, annual leave allocation, sickness reviews, as well as a discussion around financial positions.

Business continuity plans were in place to ensure that the service could respond effectively to incidents and emergencies that had the potential to impact on the delivery of services.

**Information management**

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff we spoke with said they had good access to information. However, staff also had access to policies that were part of the previous community services alliance, where some of the policies and guidelines were not updated. Senior staff were aware that there was still work to be done to align all community and trust policies.
The community inpatient units used a white board, containing information about patients and their care programme, which was used in patient updates, multidisciplinary (MDT) meetings and handovers. The whiteboards provided relevant ‘at a glance’ information for staff and was updated daily by the ward staff and helped staff to progress discharge planning.

Staff on Rosemary ward had access to the local GPs electronic system which meant that there was the ability to share relevant patient information.

There was a lack of oversight and knowledge of what constituted patient confidentiality. There were photograph albums in the dayroom with pictures of previous patients. However, these were removed when brought to the notice of senior staff, although there was a lack of understanding from the ward manager about previous patient confidentiality concerns.

**Engagement**

**Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

Patients’ and relatives’ views and experiences were sought, reported and acted on to improve the services. The community inpatient units used the friends and family test (FFT), which gathers data on whether patients and their relatives or carers would recommend the service to their friends or family. Results of this was displayed on the wards and reported in the ‘CREWS’ newsletter.

The Rosemary ward staff had a ‘Rosemary News’ newsletter complied by the ward manager. We viewed the newsletter available at the time of our inspection and saw that it contained information on training and courses available, reminders for resuscitation trolley checks, current performance, and reminders to book holiday leave as well as some social information. King Suite had a poster board to share information, and staff also used e-mail, text, and CREWS to share information with all staff.

Most staff felt actively engaged and listened to. However, some staff expressed concerns that decisions about staffing were made without discussion and that their concerns were not always listened to. For example: the lack of ability to view images from the front door camera at night. However, leaders did report being aware of these concerns and work was in progress to resolve the issues although there was no clear timeframe.

The trust had a staff award scheme in place. We saw examples of awards when visiting the community inpatient units. For example, a ward manager had been peer nominated for a ‘Shining Light’ staff award in both 2018 and 2019 and had also been chosen by the chief executive to attend a tea party at 10 Downing Street with the Prime Minister in recognition of their hard work.

Local schoolchildren visited Rosemary Ward for musical events, for example, 2018 Christmas Carol concert.

**Learning, continuous improvement and innovation**

**All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.**
King Suite, Glastonbury Court.
Staff used a simple system of denoting whether a patient was for active resuscitation by using red or green lettering for their names outside their rooms.

Staff encouraged patients to eat in the dining room and chose appropriate music on the CD player to listen to whilst eating.

The King suite had developed strong links with the local chiropodist enabling the patients to have their feet attended to in a timely manner.

Rosemary Ward, Newmarket Hospital
Staff fostered strong links with the local community team to undertake joint discharge visits, and joint assessments on the ward preparing patients for discharge.

There were plans for the development of a conservatory type day room, a 'quiet space visitors/relatives' room and a sensory garden, although these had not been finalised at the time of our inspection.

Senior staff were committed to workstreams for:
- Ensuring that patient care was individualised.
- Development of plans for further, structured, reablement activity, to promote a return to life outside hospital.
- Define purpose/scope of Rosemary Ward.
- Consider how to measure success more comprehensively.
- Further develop learning opportunities for staff.

Accreditations
NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

No community inpatient services had been awarded an accreditation.
(Source: Routine Provider Information Request (RPIR) – Accreditations tab)
Community health services for children, young people and families

Facts and data about this service

Community paediatric services consist of eight core paediatric services which operate as part of an integrated model of delivery primarily to children and young people with medical, developmental, neuro-disabling and cognitive disabilities and longer-term health conditions.

A service specification reflects an integrated working framework and evidences a personalised approach to the delivery of care that is responsive to the complexity of children, young people and their families’ needs.

The services are:

1. Paediatric medical team (seven locations)
2. Paediatric physiotherapy team (22 locations)
3. Paediatric occupational therapy team (five locations)
4. Paediatric speech and language therapy team (24 locations)
5. Children's community nursing team (five locations)
6. Community audiology (three locations)
7. Child and family clinical psychology service (four locations)
8. Suffolk communication aids resource centre (based at Thomas Wolsey School)

The trust’s integrated therapies team also provides paediatric dietetics at seven locations plus home enteral feed service and a physiotherapy musculoskeletal service.

(Source: Community Routine Provider Information Request (RPIR) – CHS Context; Routine Provider Information Request (RPIR) – Sites)

We inspected the service on 24 September 2019 and 25 September 2019. The inspection was announced (staff knew we were coming), to ensure that everyone we needed to talk to was available. As part of the inspection, we visited the Bury St Edmunds child development centre, the Ipswich child development centre, St Helen’s House and the Allington clinic.

During the inspection, we spoke 26 staff of various grades, including consultants, nurses, health visitors, occupational therapists, physiotherapists, audiologists, speech and language therapists, nursery nurses and administrative staff. We spoke with eight children and young people and/or their family members, observed care and treatment and looked at eight patients’ care records. We also reviewed minutes of meetings, performance information about the service and other relevant data.

This was our first inspection of the service.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff, but managers did not always make sure everyone completed it.

Mandatory Training completion

The trust set a target of 90% for completion of all mandatory training with the exception of information governance which had a target of 95%.

Nursing staff did not always receive and keep up-to-date with their mandatory training. However, completion rates were improving.

A breakdown of compliance for mandatory training courses as of June 2019 for qualified nursing staff in community services for children, young people and families at trust level is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Moving &amp; handling - e-learning</td>
<td>1</td>
</tr>
<tr>
<td>Fire safety training - classroom</td>
<td>26</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>2</td>
</tr>
<tr>
<td>Infection control - classroom</td>
<td>26</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>24</td>
</tr>
<tr>
<td>Health &amp; safety / risk management</td>
<td>23</td>
</tr>
<tr>
<td>Basic life support (adult)</td>
<td>21</td>
</tr>
<tr>
<td>Moving and handling - clinical</td>
<td>20</td>
</tr>
<tr>
<td>Fire safety training - e-learning</td>
<td>19</td>
</tr>
<tr>
<td>Information governance</td>
<td>18</td>
</tr>
<tr>
<td>Blood borne viruses/inoculation incidents</td>
<td>1</td>
</tr>
<tr>
<td>Security awareness</td>
<td>13</td>
</tr>
<tr>
<td>Conflict resolution - e-learning</td>
<td>10</td>
</tr>
<tr>
<td>MAJAX</td>
<td>8</td>
</tr>
<tr>
<td>Slips trips falls</td>
<td>6</td>
</tr>
<tr>
<td>Medicine management (refresher)</td>
<td>2</td>
</tr>
<tr>
<td>Infection control - e-learning</td>
<td>0</td>
</tr>
</tbody>
</table>

In community services for children, young people and families at trust level the targets were met for five of the 17 mandatory training modules for which qualified nursing staff were eligible, and almost met for one further training module.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Information provided by the trust in the provider information request was derived from the electronic staff record (ESR). Managers said they were achieving higher completion levels and were averaging approximately 80%. Data provided by the service following the inspection taken from local records, showed much higher levels of completion. Trust targets were achieved in 12
of the 17 modules, other modules were completed by over 75% of staff except for slips, trips and falls training, which 60% of nursing staff had completed.

Staff told us mandatory training recording on ESR had recently been implemented for community services and they were continuing to resolve issues in relation to the accuracy of the data. In addition, the arrangements for staff to update their mandatory training had changed. Staff were required to undertake the full range of trust mandatory training modules as part of their induction and there was a newly introduced, one day update for staff, to enable them to complete their annual training modules. Whilst staff felt the one day update was helpful, previously each module had been undertaken on different dates, and in the changeover to the new system, it was more likely for staff to become overdue for training in some topics. The one day mandatory training updates were held centrally at the West Suffolk Hospital; there were no local training days in other parts of the county. Staff told us there were not enough dates and places had to be booked well in advance to secure a place.

Managers told us some training topics, such as major incident training (MAJAX), had only recently been introduced for staff in the service and this was the reason for low completion levels. Several staff reported they had not completed conflict resolution training as they had experienced difficulties in getting on the course due to limited availability and sessions being fully booked.

Medical staff did not always receive and keep up-to-date with their mandatory training. A breakdown of compliance for mandatory training courses as of June 2019 for medical staff in community services for children, young people and families at trust level is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Fire safety training - classroom</td>
<td>9</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>8</td>
</tr>
<tr>
<td>Health &amp; safety / risk management</td>
<td>7</td>
</tr>
<tr>
<td>Basic life support (adult)</td>
<td>5</td>
</tr>
<tr>
<td>Information governance</td>
<td>5</td>
</tr>
<tr>
<td>Security awareness</td>
<td>5</td>
</tr>
<tr>
<td>Fire safety training - e-learning</td>
<td>5</td>
</tr>
<tr>
<td>Infection control – e-learning</td>
<td>4</td>
</tr>
<tr>
<td>MAJAX</td>
<td>3</td>
</tr>
<tr>
<td>Slips trips falls</td>
<td>3</td>
</tr>
<tr>
<td>Conflict resolution – e-learning</td>
<td>2</td>
</tr>
<tr>
<td>Medicine management (refresher)</td>
<td>0</td>
</tr>
<tr>
<td>Moving &amp; handling – e-learning</td>
<td>0</td>
</tr>
</tbody>
</table>

In community services for children, young people and families at trust level the target was met for one of the 13 mandatory training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Similar issues with the migration of data to ESR and the change in arrangements for undertaking refresher courses were identified as reasons for low reported completion rates. Low overall numbers of medical staff also meant percentage completion rates were less meaningful. Data provided by the trust following the inspection showed trust targets were met or exceeded in six of the 13 modules and over 80% of medical staff had completed a further five modules. The lowest completion rates were for basic life support and moving and handling modules.

20190416 900885 Post-inspection Evidence appendix template v4
A breakdown of compliance for mandatory training courses as of June 2019 for qualified allied health professionals in community services for children, young people and families at trust level is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
</tr>
<tr>
<td>Infection control - classroom</td>
<td>60</td>
<td>63</td>
</tr>
<tr>
<td>Fire safety training - classroom</td>
<td>97</td>
<td>102</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>96</td>
<td>102</td>
</tr>
<tr>
<td>Moving and handling - clinical</td>
<td>86</td>
<td>99</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>17</td>
<td>20</td>
</tr>
<tr>
<td>Basic life support (adult)</td>
<td>73</td>
<td>102</td>
</tr>
<tr>
<td>Fire safety training - e-learning</td>
<td>73</td>
<td>102</td>
</tr>
<tr>
<td>Information governance</td>
<td>70</td>
<td>102</td>
</tr>
<tr>
<td>Health &amp; safety / risk management</td>
<td>69</td>
<td>102</td>
</tr>
<tr>
<td>Security awareness</td>
<td>51</td>
<td>102</td>
</tr>
<tr>
<td>Infection control – e-learning</td>
<td>46</td>
<td>102</td>
</tr>
<tr>
<td>Conflict resolution – e-learning</td>
<td>43</td>
<td>100</td>
</tr>
<tr>
<td>Blood borne viruses/inoculation incidents</td>
<td>22</td>
<td>61</td>
</tr>
<tr>
<td>Slips trips falls</td>
<td>21</td>
<td>98</td>
</tr>
<tr>
<td>MAJAX (major incidents)</td>
<td>16</td>
<td>102</td>
</tr>
<tr>
<td>Moving and handling non-clinical load handler</td>
<td>5</td>
<td>64</td>
</tr>
</tbody>
</table>

In community services for children, young people and families at trust level the targets were met for three of the 16 mandatory training modules for which qualified allied health professionals were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Data provided by the trust following the inspection showed the trust target was met for all modules with the exception of MAJAX (73%), and moving and handling (88%)

The mandatory training was comprehensive and met the needs of children, young people and staff, although managers felt there were some topics included as mandatory that were acute focused and the content was of less relevance to community staff. Staff told us they had had some discussions about the relevance of some of the initial comprehensive mandatory training to community paediatric staff and the volume of required sessions. For example, slips, trips and falls training was focused on adults and in particular those in hospital. A manager told us they had attended a meeting to discuss clinical induction and had put forward a proposal for community staff, but they were told they had to conform with the rest of the trust.

Clinical staff completed training on recognising and responding to children and young people with mental health needs, learning disabilities and autism.

Managers monitored mandatory training and alerted staff when they needed to update their training. The electronic staff record alerted staff and their manager when mandatory training was due, and managers said when they logged into the system there was a table with a red, amber, green system to identify when training was due. This had enabled them to improve the compliance rates more recently. Managers were also proactive in booking places on courses in advance to
reduce the issues experienced with courses being fully booked. However, accessing courses remained an issue.

Safeguarding

Staff were not always up to date with training on how to recognise and report abuse. However, staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so.

Safeguarding Training completion

Staff received training specific for their role on how to recognise and report abuse. However, completion rates for training were below the trust targets.

The trust set a target of 90% for the completion of safeguarding training.

The tables below include Prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

A breakdown of compliance for safeguarding training courses as of June 2019 for qualified nursing staff in community services for children, young people and families at trust level is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2 (basic prevent awareness)</td>
<td>26</td>
<td>26</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>25</td>
<td>26</td>
<td>96.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5 (prevent awareness)</td>
<td>25</td>
<td>26</td>
<td>96.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>20</td>
<td>26</td>
<td>76.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>18</td>
<td>24</td>
<td>75.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>10</td>
<td>26</td>
<td>38.5%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In community services for children, young people and families at trust level the 90% target was met for three of the six safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses as of June 2019 for medical staff in community services for children, young people and families at trust level is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>9</td>
<td>10</td>
<td>90.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>9</td>
<td>10</td>
<td>90.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5 (prevent awareness)</td>
<td>7</td>
<td>10</td>
<td>70.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2 (basic prevent awareness)</td>
<td>7</td>
<td>10</td>
<td>70.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>6</td>
<td>10</td>
<td>60.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>2</td>
<td>10</td>
<td>20.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
In community services for children, young people and families at trust level the 90% target was met for two of the six safeguarding training modules for which medical staff were eligible.

A breakdown of compliance for safeguarding training courses as of June 2019 for qualified allied health professionals in community services for children, young people and families at trust level is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>93</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5</td>
<td>91</td>
</tr>
<tr>
<td>(prevent awareness)</td>
<td></td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2</td>
<td>91</td>
</tr>
<tr>
<td>(basic prevent awareness)</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>69</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>39</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>55</td>
</tr>
</tbody>
</table>

In community services for children, young people and families at trust level the 90% target was met for one of the six safeguarding training modules for which qualified allied health professionals were eligible, and almost met for a further two safeguarding training modules.

(Source: Universal Routine Provider Information Request (RPIR) – Training tab)

Following the recruitment of the current community safeguarding named nurse, training had increased in locations across the county to improve ease of access for staff. The safeguarding named nurse met with the service leads and contacted each practitioner individually if they were overdue for training. They also said that additional staff had been identified as requiring level 3 training and, in adding those to the system, this had impacted on compliance rates. The safeguarding team reported that the overall completion rate for the service was 78% at the time of the inspection and, when staff booked for attendance during September and October 2019 were added, completion was expected to be 88% by the end of October 2019. This was a significant improvement on the data above, although still did not meet the trust target of 90%.

Data provided by the trust following the inspection showed current completion rates were improving. 96% of nursing staff had completed safeguarding children level two training and 81% had completed level three training. 90% of medical staff had completed safeguarding children level 3 training and 82% had completed level 2 training. 64% had completed safeguarding adults training. Allied health professionals had achieved trust targets for safeguarding children at level two and level three and 81% had completed safeguarding adults training.

Staff received safeguarding supervision on a regular basis and ad-hoc when required.

Staff could give examples of how to protect children, young people and their families from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. During the inspection we were informed of a multi-agency meeting convened in relation to a child with continuing care needs and previous safeguarding
concerns. Staff were fully briefed, and a safety plan agreed. We also saw evidence within patient documentation of staff liaison with other agencies and multi-agency working.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They were clear of the action to take in alerting the appropriate clinicians and how to make a safeguarding referral. Staff were all aware of the role of the children’s safeguarding named nurse and said they were very accessible if they needed advice. Information about how to raise a concern and key contact information was readily available in staff areas throughout the service. We also observed information for the public was displayed in the clinics.

Staff followed safe procedures for children visiting the clinic. Staff had access to the same patient information as was used by GPs and other health services in the area. They checked all alerts on the system prior to patients being seen. It also provided links with other services to facilitate multi-agency working and communication.

**Safeguarding referrals**

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to children’s services, adult services or the police should take place.

The provider information request indicated that community health services for children, young people and families made no safeguarding referrals from June 2018 to May 2019.

*(Source: Universal Routine Provider Information Request (RPIR) – Safeguarding tab)*

However, we spoke with staff who told us of safeguarding referrals they had made within the last year. Senior staff said it was difficult to obtain accurate safeguarding referral data, as staff made electronic referrals direct to the Local Authority and the local Safeguarding Board and were unable to separate out data by trust and service. Staff were asked to inform the named nurse of safeguarding referrals; however, this was not an entirely reliable source of data, as staff did not always remember. The safeguarding team told us they were aware of three to four referrals a month on average. They said that they were raising staff awareness of the importance of notifying the trust team when they made a referral. Following the inspection, the trust informed us they were aware of 30 referrals from the service during 2018 and 32 between January and October 2019.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean. However, staff did not always complete records to show cleaning had been completed.

Clinic areas were clean and had suitable furnishings which were clean and well-maintained. We
spoke with domestic staff who regularly worked in the clinics and they were knowledgeable about the requirements and we observed them carrying out their duties diligently. Children’s furniture and toys within the waiting areas and clinical rooms at the child development centre in Ipswich, were cleaned by the domestic staff however the responsibilities were not clear. They said they were not sure if this was within their contracted duties and other staff were unsure as to where responsibility lay.

Rooms used for assessment and treatment were equipped with hand washbasins, handwash and hand sanitising gel. Low level hand washbasins were available in some rooms to enable and encourage younger children to wash their hands.

Cleaning records were not always up-to-date and did not always demonstrate that all areas were cleaned regularly. A cleaning schedule was displayed with the service areas. Domestic staff we spoke with, did not complete a cleaning checklist to indicate daily cleaning of all areas in the schedule, however, said supervisors carried out regular checks and monthly audits were completed. At the Bury St Edmunds child development centre, we saw rooms such as the nursery had a cleaning checklist for the toys displayed on the wall; although, it was not consistently completed. Our observations during the inspection showed that cleaning was being undertaken by staff after each patient and this suggested it was an issue with documentation of cleaning, rather than cleaning itself. The trust did not provide any details of audits of the cleaning of toys. The management team said they would address this to improve documentation of cleaning in the future.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff adhering to good hand hygiene practice. Data provided by the trust showed 100% compliance with hand hygiene procedures in monthly hand hygiene audits for the service in the six months from March to August 2019.

Audits of practices with a high impact on infection prevention and control such as central and peripheral cannula care also showed 100% compliance in the same time period.

Staff cleaned equipment and toys after patient contact. We observed staff using disinfectant wipes to clean equipment and toys in clinical rooms, after use by each child or young person.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe at three of the four locations we inspected. Staff were trained to use them. Staff managed clinical waste well. However, facilities for audiology assessments in the Ipswich child development centre were not fit for purpose.

Whilst a business case for development had been approved, a shortfall in funding meant a definitive date for refurbishment had not been agreed.

The design of the environment followed national guidance. Buildings were adequately maintained, and we did not observe any immediate safety concerns. Rooms used for the assessment and treatment of patients were spacious enough to accommodate those with limited mobility and wheelchairs. At the Bury St Edmunds child development centre there was a purpose built visual reinforcement audiometry room with a sound proof booth suitable for carrying out hearing assessments. There was also one such room at St Helen’s House; however, this was not sufficient to accommodate the activity and another facility had been developed which did not meet the requirements.
The Ipswich child development centre was housed within Ipswich hospital. A plan to upgrade and redevelop facilities within St Helen’s House and relocate the Ipswich child development centre on the site, had been approved and the project had been out to tender. Following this, a shortfall in funding was identified and therefore a definitive date for the work had not been agreed. However, included in the project, was an upgrade of facilities within St Helen’s House, including a new audiology facility. The lack of sufficient audiology facilities was on the risk register for the division.

Staff carried out daily safety checks of specialist equipment. Equipment had evidence of regular maintenance and safety checks; however, we identified one vital signs monitoring machine was outside its maintenance date and a room fan did not have any evidence of maintenance and safety checking.

The service had suitable facilities to meet the needs of children and young peoples’ families. The service had enough suitable equipment to help them to safely care for children and young people.

Rooms contained the equipment necessary to provide assessment and care of children and young people. There were changing facilities to accommodate older children with complex needs as well as young children and babies. There was adequate room and equipment to accommodate children and young people with additional mobility needs.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

**Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.**

Staff completed risk assessments for each child and young person on arrival and updated them when necessary and used recognised tools. Structured assessments were completed for each child on their first visit to the service and subsequent attendances. Staff were trained in identifying the unwell child or deteriorating patient.

The trust told us there was no specific trust protocol in place for children in relation to sepsis and sepsis training was not part of the trust’s training requirements for staff working in integrated paediatric, community services, However, they told us they were in the process of improving their ability to identify risk of serious illness, having reviewed the national traffic light system (NICE guideline on feverish illness in children) and Royal College of Nursing (RCN) guidelines on standards for assessing, measuring and monitoring vital signs in infants, children and young people, (RCN 2017). As a result of this they had purchased some additional oxygen saturation monitors and thermometers for the complex care nursing team.

Staff knew about and dealt with any specific risk issues. Risk factors were identified within each patient record and steps to reduce the risks were recorded. The children and young people cared for by the complex care team, had complex physical health needs and individual escalation plans were developed for each patient. For example, children with respiratory conditions, a tracheostomy or seizures had escalation plans providing specific instructions for staff on the actions to take on a step by step basis, depending on the child’s condition and response. Nursing staff also used a national paediatric early warning score (PEWS) when they completed vital signs observations, to identify early signs of deterioration in these patients. Staff also checked the patient’s skin for signs of pressure ulcers and made sure care and equipment was provided to reduce risk of pressure ulcers developing.
The service had access to mental health liaison and specialist mental health support if staff were concerned about a child or young person’s mental health. Staff were able to refer children and young people to the child and adolescent mental health service (CAMHS) and worked closely with the CAMHS teams. They told us that waiting times could be a challenge and they were working with them to re-design patient pathways. The service employed clinical psychologists who worked independently or jointly with other professionals, to support and treat children and young people referred to the service.

Staff shared key information to keep children, young people and their families safe when handing over their care to others. We observed staff reviewing children’s care and treatment in a multi-disciplinary environment with good sharing of information to ensure continuity of care. Staff also documented their contact with other services when issues or concerns were identified.

**Nursing staffing**

The service had enough staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough nursing staff of relevant grades to keep children and young people safe. Specialist nurses and specialist health visitors provided nursing care, support and training primarily to families, children and young people with medical, developmental, neuro-disabling and cognitive disabilities and long term health conditions. Managers told us complex community care nurses were difficult to recruit, although they had been successful in attracting suitable staff and were fully established.

Managers accurately calculated and reviewed the number and grade of nurses needed to meet the needs of their children and young people using the service. They negotiated and agreed staffing levels with the service commissioners. Agreement had been reached to employ an additional specialist health visitor as a result of the rising demand in the pre-school specialist pathway.

The service had low vacancy rates, turnover rates, sickness rates and bank and agency usage.

The table below shows a summary of the nursing staffing metrics in community services for children, young people and families at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Community services for children, young people and families</th>
<th>Annual staffing metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff group</td>
<td>April 2018 to March 2019</td>
</tr>
<tr>
<td>Target</td>
<td>Annual average establishment</td>
</tr>
<tr>
<td>All staff</td>
<td>176</td>
</tr>
</tbody>
</table>
Nurse staffing rates within community services for children, young people and families were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover and sickness.

Please note that the negative vacancy rates in the table above indicate that the service was over-established. For nursing bank and agency, the trust was unable to provide total hours including those covered by substantive staff and therefore, we could not calculate bank, agency and unfilled usage as a proportion of the total hours available.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Managers limited their use of bank and agency staff and requested staff familiar with the service. There was a very low rate of use of agency staff as they had a full complement of staff.

Managers made sure all bank and agency staff had a full induction and understood the service.

**Medical staffing**

The service had enough medical staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep children and young people safe. Discussions were held with the commissioners in relation to growth of the service and the staffing requirements.

The table below shows a summary of the medical staffing metrics in community services for children, young people and families at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target</strong></td>
<td></td>
<td>6%</td>
<td>10%</td>
<td>3.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>All staff</strong></td>
<td>176</td>
<td>-1%</td>
<td>5%</td>
<td>3.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medical staff</strong></td>
<td>12</td>
<td>26%</td>
<td>0%</td>
<td>0.6%</td>
<td>192 (1%)</td>
<td>1,288 (6%)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

Medical staffing rates within community services for children, young people and families were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness, bank use and locum use.
Please note that the negative vacancy rate for all staff in the table above indicates that the service was over-established.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

The service had low vacancy rates. Managers were unable to explain the data provided in the provider information request below, showing over 25% medical staff vacancies. They indicated this may be due to the low overall numbers of medical staff and data irregularities.

**Vacancy rates**

![Vacancy rate - medical staff](image)

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

They told us the service had a long term vacancy of one whole time equivalent (WTE) consultant paediatrician. However, this had been covered by a 0.8WTE agency locum. A new permanent consultant had been appointed and was due to start in the service the following month (October 2019). This was the only medical staff vacancy.

**Allied health professional staffing**

The table below shows a summary of the allied health professional staffing metrics in community services for children, young people and families at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Community services for children, young people and families annual staffing metrics</th>
<th>April 2018 to March 2019</th>
<th>June 2018 to May 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff group</strong></td>
<td><strong>Annual average establishment</strong></td>
<td><strong>Annual vacancy rate</strong></td>
</tr>
<tr>
<td><strong>Target</strong></td>
<td>-</td>
<td>6%</td>
</tr>
<tr>
<td><strong>All staff</strong></td>
<td>176</td>
<td>-1%</td>
</tr>
<tr>
<td><strong>Allied health professionals</strong></td>
<td>88</td>
<td>4%</td>
</tr>
</tbody>
</table>

Allied health professional staffing rates within community services for children, young people and
families at trust level were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Vacancy rates

Monthly vacancy rates over the last 12 months for allied health professionals within community services for children, young people and families at trust level showed a downward trend from October 2018 to March 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Fluctuations in the vacancy rates were explained by some expected retirement or re-location of staff and increases in the establishment during the reporting period. For example, increases to the number of speech and language therapists were approved due to increased activity.

Sickness rates

Monthly sickness rates over the last 12 months for allied health professionals within community services for children, young people and families at trust level showed an upward trend from August 2018 to January 2019. However, it decreased between January 2019 and May 2019 and remained within the trust target.
Suspensions and supervisions

During the reporting period from April 2018 and March 2019, community health services for children, young people and families reported that there were no cases where staff had been either suspended or placed under supervision.

(Source: Routine Provider Information Request (RPIR) – Suspensions or Supervised tab)

Quality of records

Staff kept detailed records of children and young peoples’ care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. The main patient record was kept on the electronic patient record system; however, some professions kept additional paper records, particularly when the electronic system did not have the required assessment templates. In these cases, the results and reports were scanned into the electronic system.

We reviewed eight patient records and found they contained past medical history, detailed assessments and records of care and treatment. Staff identified a clear plan for each patient and the narrative included the voice of the child. Goals were jointly agreed with the child or young person and their family. Discussions with the child and family were documented. The identity of the person making the entry and the date were recorded. There was evidence of communication with the professional making the referral and other professionals involved in the patient’s care and treatment. However, when staff visited children and young people in remote sites and in their own homes, they did not always have access to electronic records and were not able to enter their notes contemporaneously. This was on the risk register for the division; however, despite working with information technology services in the trust and with the commissioners, a solution had not been identified. When children and young people transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. Electronic systems were password protected. Paper records were stored securely and supplied to the clinic in secure bags.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Community paediatricians prescribed medicines as required; they had their own stamped prescription pads and stored them securely. The trust pharmacy provided oversight of the management of medicines. Very few medicines were used on trust sites. Those stocked were stored securely and systems were in place to ensure they were administered and recorded in line with requirements. Staff recorded daily temperature checks of the facilities used to store medicines and we saw they were within acceptable limits.
Staff reviewed children and young people’s medicines regularly and provided specific advice to children, young people and their families about their medicines. Parents said doctors explained their child’s medicines and reviewed them regularly.

Staff stored and managed medicines and prescribing documents in line with the provider’s policy.

Staff followed current national practice to check children and young people had the correct medicines. Staff followed national guidance and agreed clinical pathways for the prescription of medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely.

Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines.

Safety performance

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, children, young people, their families and visitors.

The service continually monitored safety performance.

Staff completed safety thermometer data for community services, however, the relevance to community children’s and young people’s services was limited.

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. The safety thermometer data showed the services achieved over 95% harm free care for the last 12 months. Staff told us recent discussions they had held with service commissioners had identified there had been only two pressure ulcers developed in children and young people’s community services over the last twelve years. Therefore, when there was a stage two pressure ulcer reported, this was looked at in depth and learning identified.

Community Settings

Data from the Patient Safety Thermometer showed that the trust reported 47 new pressure ulcers, eight falls with harm and four new catheter urinary tract infections from June 2018 to June 2019 within community settings. It was not possible to break this data down by core service and this data was primarily related to adult community care.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers and falls at West Suffolk NHS Foundation Trust – community settings
Own home Settings

Data from the Patient Safety Thermometer showed that the trust reported one fall with harm and no new pressure ulcers or new catheter urinary tract infections from June 2018 to June 2019 within own home settings. It was not possible to break this data down by core service.
Residential care home settings

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm or new catheter urinary tract infections from June 2018 to June 2019 within residential care home settings.

(Source: NHS Safety Thermometer)

Incident reporting, learning and improvement

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support.

Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff reported incidents that they should report. Staff gave us examples of incidents they had reported or would report. They told us they were encouraged to report incidents and they said incidents were investigated and actions agreed to prevent recurrence when possible.

Never Events

The service had no never events.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From August 2018 to July 2019, the trust did not report any never events for community services for children, young people and families.

(Source: Strategic Executive Information System (STEIS))

Managers shared learning with their staff about never events that happened elsewhere. Staff told us they received information about incidents that had occurred in other areas through their team meetings, the trust newsletter (Green sheet) and a monthly ‘CREWS’ report. The CREWS report
provided information about incidents within the division and learning from them. It also provided information on safety alerts and wider learning within the trust.

**Serious Incidents**

In accordance with the Serious Incident Framework 2015, the trust did not report any serious incidents (SIs) in community services for children, young people and families, which met the reporting criteria set by NHS England from August 2018 to July 2019.

(Source: Strategic Executive Information System (STEIS))

**Serious Incidents (SIRI) – Trust data**

From June 2018 to May 2019, trust staff within community services for children, young people and families did not report any serious incidents.

The number of serious incidents recorded by the trust incident reporting system was comparable with that reported to Strategic Executive Information System (STEIS). This gives us more confidence in the validity of the data.

(Source: Routine Provider Information Request (RPIR) – Serious Incidents tab)

Staff understood the duty of candour. They were open and transparent, and would give children, young people and their families a full explanation if and when things went wrong. Managers told us they had had no incidents that required a duty of candour to be applied, as no harm had occurred in their care that necessitated it. However, they said they would use the trust Duty of Candour template letter and adapt according to circumstances as appropriate.

Staff received feedback from investigation of incidents, both internal and external to the service. Consultants and service leads said they received information about incidents and learning from them at service management group meetings. Staff told us information was cascaded to them at their team meetings and in the CREWS report.

Staff met to discuss the feedback and look at improvements to children and young people’s care. They said incidents and improvements to the service were discussed at team meetings. They said they were encouraged to put forward their ideas and contribute at the meetings.

There was evidence that changes had been made as a result of feedback. For example, staff were aware of an incident in adult community services in relation to the use of an out of date catheter. The importance of checking of expiry dates was emphasised to staff.

Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident. Staff told us they had a de-briefing following the death of any child with complex needs whether this was an expected or unexpected death.

Managers took action in response to patient safety alerts within the deadline and monitored changes. The clinical governance department ensured managers were informed of safety alerts and action taken was reported to the department.

**Is the service effective?**
Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of children and young people subject to the Mental Health Act 1983. However, managers did not always check to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. However, the trust did not always monitor adherence to national guidance. Clinical policies and guidelines were available on the intranet and were updated in line with national guidance from organisations, including the national institute of health and care excellence (NICE) and from professional bodies. For example, the new-born screening guidelines used in audiology had been updated in line with the British Society of Audiology guidance. Staff told us they did not always assess compliance with NICE guidance; however, they had regular discussions about adhering to it.

We asked the trust for information about audits to assess compliance with NICE guidance; however they told us very few applied to community services. They provided evidence of an audit completed to assess compliance with NICE guidance on the assessment of children with cerebral palsy. This demonstrated areas for improvement and as a result, recommendations were made for the introduction of an assessment template and re-audit in two years’ time. The assessment template was being progressed.

Services had agreed formal pathways of care for consultation, assessment and intervention. These were based on best practice guidance. An audiologist told us they had audited compliance with the grommet pathway. However, the trust did not provide evidence of this.

Managers worked with commissioners and other organisations and staff worked with other professionals to implement the national healthy child programme. This is a framework of services to promote and optimise children’s health and wellbeing.

Staff protected the rights of children and young people subject to the Mental Health Act and followed the Code of Practice. Staff had a good understanding and knowledge of the Act and Code of Practice.

At multidisciplinary meetings, staff routinely referred to the psychological and emotional needs of children, young people and their families. We observed this during the inspection.

Pain relief

Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed children and young peoples’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used a range of tools suitable for the needs of the child or young person when they had pain and ensured they were prescribed pain relief when required. On follow up visits, pain management was reviewed when applicable.

Patient outcomes
Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people.

No national clinical audits relevant to the service were identified.

Managers carried out clinical audits but there was not a planned, comprehensive audit programme.

Audits – changes to working practices

The trust reported that it did not participate in any clinical audits in relation to this core service as part of their Clinical Audit Programme over the last 12 months.

(Source: Routine Provider Information Request (RPIR) – Audits tab)

However, staff made us aware of audits they had undertaken and information the trust provided following the inspection, satisfied us that audits were completed on a regular basis. The service used a wide range of patient and family feedback to assess clinical outcomes. Feedback was obtained at different points following completion of treatment. For example, the effectiveness of a pilot of the provision of sensory workshops for parents of children with autism, was completed several months after completion of the workshops. In addition, outcomes of speech and language therapy group sessions were assessed one year after completion, to assess long term outcomes. Record keeping audits and pathway audits were also undertaken.

Staff used recognised assessment tools appropriate to their service to measure children’s and young people’s development or support needs before and after their interventions to assess individual outcomes for each patient. In this way, improvements were objectively measured. The pathway lead for speech and language therapy, explained they had been looking at therapy outcome measures for some time, and the Royal College of Speech and Language Therapy had developed some agreed outcomes measures recommended for use nationally. They were booked to attend training, so these could be used going forward.

Speech and language therapists completed an evaluation of gateway training for parents of children with cerebral palsy (this training programme aims to help parents better understand cerebral palsy) and the most optimal timing for the training. As a result of the evaluations and feedback from parents, the programme was provided prior to the initial assessment rather than later in the programme.

Occupational therapists evaluated parent experience of attending a clinic for provision of an orthosis (a brace, splint, or other artificial external device serving to support the limbs or spine or to prevent or assist relative movement), and the ease of use of the orthosis both at home and at school. This showed good outcomes for children and young people in the form of reduced pain, improved posture and increased range of movement.

Physiotherapists evaluated the provision of gym groups provided in partnership with leisure centres for children with disabilities. This showed the benefits for patients and there was very positive feedback from parents in relation to the enjoyment of the children and young people and the perceived value of the sessions to the child and their family.

Competent staff
The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families. The service generally had a stable and experienced workforce. Staff told us they had access to additional training for continuing professional development. In house training was also provided at team meetings. For example, an audiologist said one of the clinical psychologists had provided some training for them at a team meeting. Consultants said they had networks in place for learning and support. They had the opportunity to attend study days and educational meetings. One consultant said they attended cross county paediatric meetings, a regional Looked After Children group, and a regional cerebral palsy network.

Managers gave all new staff a full induction tailored to their role before they started work. We spoke with three staff who had been appointed within the previous year. They told us they had a comprehensive induction, although some sessions were more relevant to staff working in the acute hospital. In addition, they had a local induction within their service. A newly qualified practitioner said they had a named preceptor and access to a preceptorship programme. They said the team were very supportive and if they had any questions or concerns they could ask.

Clinical Supervision
Managers supported staff to develop through regular, constructive clinical supervision of their work. Staff described access to regular supervision both in groups and individually. Staff said they had access to ad-hoc clinical supervision in addition to planned sessions.

Appraisal rates
Managers supported staff to develop through yearly, constructive appraisals of their work. Although the data supplied indicated the service did not meet the trust target of 90%, the small numbers of staff in some professional groupings meant that data giving percentages was less meaningful. In addition, staff had clinical supervision regularly. There was an impact on the reported appraisal rates due to maternity leave and long term sickness / absence.

Trust wide
From April 2018 to March 2019, 88.0% of required staff in community services for children, young people and families trust-wide received an appraisal, which was just below the trust target of 90%. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td>2</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>20</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>84</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>33</td>
</tr>
<tr>
<td>Additional professional, scientific and technical</td>
<td>11</td>
</tr>
</tbody>
</table>
Three staff groups in community services for children, young people and families trust-wide, including registered nurses, met the 90% target. However, only 80.0% of medical and dental staff had received an appraisal.

Updated analysis for April 2019 to mid-June 2019 found that 14.8% of required staff in community services for children, young people and families trust-wide received an appraisal compared to the trust target of 90%. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2019 to mid-June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>3</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>6</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>6</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>13</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>2</td>
</tr>
<tr>
<td>Additional professional, scientific and technical</td>
<td>1</td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>31</strong></td>
</tr>
</tbody>
</table>

None of the staff groups in community services for children, young people and families trust-wide met the 90% target. However, this data only represents a partial year, so we would not expect a high appraisal completion rate.

(Source: Routine Provider Information Request (RPIR) – Appraisals tab)

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff confirmed this during the inspection.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. Staff said they had regular opportunities to identify their training needs at personal development review meetings and told us they were able to ask at any time if they felt they needed additional support or training.

Managers identified poor staff performance promptly and supported staff to improve.

**Multidisciplinary working and coordinated care pathways**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.**

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. Weekly multi-disciplinary team meetings were held to discuss referrals, in a multi-disciplinary environment and the progress of other patients were also discussed. We observed one such meeting attended by a clinical psychologist, early years advisor, specialist
health visitor, speech and language therapist, and physiotherapist. All professions were encouraged to discuss their views and provide an input.

Staff worked across health care disciplines and with other agencies when required to care for children, young people and their families. Staff of different professions frequently worked together in the assessment and treatment of patients and a variety of joint clinics were held. For example, joint appointments with dietitians could be arranged, acute and community professionals held joint clinics and there were joint clinics with consultants from a neighbouring NHS trust.

Staff referred children and young people for mental health assessments when they showed signs of mental ill health, depression. The clinical psychologists held bi-monthly meetings with the child and adolescent mental health service (CAMHS) staff, to discuss specific patients and referral pathways. They were working closely with CAMHS in re-designing pathways in response to challenges in reducing waiting times for CAMHS.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on every unit. Posters within the clinics and child development centres gave information about healthy lifestyles, community clubs and support groups and facilities for children and young people with complex needs.

Staff assessed each child and young person’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff worked with children, young people and families to empower them and promote self-management. Staff gave them information about things they could work on between appointments, to maximise the benefits of interventions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. All staff we spoke with had a good understanding of consent, capacity, Gillick competencies and the Fraser guidelines. Gillick competencies assess a child’s capacity to consent and Fraser guidelines are used to decide if a child can consent to contraceptive or sexual health advice and treatment. They said they provided support to young people to maximise their involvement in decision making.

Staff made sure children, young people and their families consented to treatment based on all the information available. Parents said they received full explanations about their child’s care and treatment and were given time to think about the information provided, before being asked for their consent. Staff told us they worked at the pace patients and their families wanted, as they frequently needed time to come to terms with a diagnosis and the treatment proposals.

When children, young people or their families could not give consent, staff made decisions in their best interest, taking into account their wishes, culture and traditions.
Staff clearly recorded consent in the children and young peoples’ records. Six patient records we reviewed contained fully completed consent forms that recorded discussions of the options available and possible risks and benefits. Consent to information sharing with other professionals was also sought and recorded. The service did not audit consent processes, except as part of their record keeping audits. No issues with consent were recorded in the sample of record keeping audits we reviewed. The trust also provided evidence that consent had been sought for the provision of therapy services for children and young people at a special school.

Mental Capacity Act and Deprivation of Liberty training completion

Clinical staff did not always complete training on the Mental Capacity Act and Deprivation of Liberty Safeguards and did not achieve the trust’s target.

The trust reported that Mental Health Act (MHA), Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) are covered in the safeguarding adults training.

The trust set a target of 90% for the completion of safeguarding adults training.

Trust level

A breakdown of compliance for safeguarding adults training as of June 2019 in community services for children, young people and families at trust level is shown below:

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied health professionals</td>
<td>55</td>
<td>102</td>
<td>53.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>10</td>
<td>26</td>
<td>38.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>2</td>
<td>10</td>
<td>20.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In community services for children, young people and families at trust level the 90% target for safeguarding adults training was not met by qualified nursing staff, medical staff or allied health professionals. Medical and dental staff and registered nurses both had completion rates under 40%.

(Source: Routine Provider Information Request – Training tab)

Issues in the recording of mandatory training completion identified in the Safe section of this report also affected the reported training completion rates in the service. Additional safeguarding training was being provided.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Deprivation of Liberty Safeguards

From June 2018 to May 2019, the trust reported that 322 Deprivation of Liberty Safeguard (DoLS) standard and urgent applications were made to the Local Authority. None of these were pertinent to community health services for children, young people and families.
Is the service caring?

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way. All the parents we spoke with talked highly of the staff they saw and said staff gave them and their child the time they needed. Several parents said staff understood their child’s needs very well and took time to engage with them and gain their cooperation. We observed staff discreetly making enquiries and taking their cues from the child and their parents.

Children, young people and their families said staff treated them well and with kindness. We observed an appointment (with the parent’s permission) and also observed other interactions with children and young people. We saw they were conducted in a very child focused way and staff took time to listen to their patients and families. Many of the children and young people using the service had needs that made it difficult for them to focus on tasks or interact with others. Staff focused on each child or young person and responded in a way that maximised their participation, showing kindness and an understanding of their needs.

Staff followed policy to keep care and treatment confidential. All discussions took place in consultation rooms in privacy. Parents were confident about the confidentiality of information and the explanations they received about sharing of information with other professionals. A parent commented positively on the ability to feed babies in private.

Staff understood and respected the individual needs of each child and young person and showed understanding and a non-judgmental attitude when caring for or discussing those with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs. Families were consulted and felt very involved, in all discussions.

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people’s personal, cultural and religious needs.

Staff gave children, young people and their families help, emotional support and advice when they needed it. Staff provided help and support in a number of ways. For example, a therapist spoke about a parent who had needed some emotional support during their child’s treatment. They had spent a session supporting and advising the parent and re-booking the appointment, to ensure the parent was supported and to enable the child and parent to gain benefit from the treatment session.
Specialist clinical psychologists worked within the service and provided care when needed. In some instances, appointments were booked following diagnosis, when this was distressing for families. An emotional well-being care pathway had been developed, in conjunction with other services. Post diagnostic workshops were also held and specialist health visitors also offered additional support to families.

An “Early Bird” programme (developed by the National Autistic Society) was run by the psychologists in conjunction with education staff. This was a three month programme for parents and carers of pre-school children with autism spectrum disorder. The programme aimed to develop a better understanding of their child’s autism and empower them and support them. There were 12 sessions including four sessions in the home.

There was a variety of information available in the clinics for parents about local support groups; for example, “Parents and Carers Together” groups met monthly in local areas for support, education and training. Parents also said they had received a lot of help from staff in signposting them to other services that were available.

Staff supported children, young people and their families who became distressed in an open environment and helped them maintain their privacy and dignity. We did not observe this during the inspection, however, staff told us about the ways they managed this type of situation. This included providing a quiet room, or distraction aids.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff understood the emotional and social impact that a child or young person’s care, treatment or condition had on their, and their family’s wellbeing. Staff spoke about letting the child and family dictate the pace of the care provided. They recognised the emotional impact of receiving or confirming a diagnosis and that families might need time to adjust to and accept this, before being ready to engage with professionals for treatment and move forwards.

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

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure children, young people and their families understood their care and treatment. Parents said staff involved them closely and said staff used different techniques to engage with their child, so they could understand. Parents said staff spoke in ‘layman’s’ terms and didn’t use technical words and this helped them understand. They said they felt able to ask any questions and did not feel rushed. They said they were clear about the plan of care and the next steps.

Staff talked with children, young people and their families in a way they could understand, using communication aids where necessary. Staff used videos and pictures with children to support communication and understanding. We saw lots of picture cards to help aid communication and staff used the picture aid communication system to develop expressive communication. We also saw posters about Makaton and its use. Makaton uses signs and symbols to assist communication.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this. Parents and children were encouraged to provide feedback about their care. The clinical psychologists had produced a video with feedback from families based on five questions including: what it like was to come here, what was most helpful, what was
different about your experience and what would you change. Some of the patient and parent information had been revised following feedback from parents.

Staff supported patients to make advanced decisions about their care. Staff discussed and supported patients when they were reaching the end of their life, enabling them to speak about their wishes and anxieties. Staff completed an advanced care plan with children, young people and families to record their wishes and agree a care and treatment plan. This was based on national best practice guidance.

Staff supported children, young people and their families to make informed decisions about their care. Options for care and treatment were discussed with families in order for them to make informed decisions. Parents said staff listened to their point of view and engaged well with their child in order to obtain their views.

A high proportion of children, young people and their families gave positive feedback about the service in the Friends and Family Test survey.

The feedback from the Friends and Family Test was positive for all areas.

**Is the service responsive?**

**Planning and delivering services which meet people’s needs**

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. Services were provided on a large number of different sites, over the wide geographical area they served, to provide ease of access to children and young people using the service. Staff also provided care and treatment in specialist schools, clinics and the patient’s own home.

Managers worked closely with local commissioners and other stakeholders to develop services and respond to changing requirements. They engaged with local and regional groups with a remit to review services, such and the Child Health Board (part of the Suffolk Alliance). The strategic transformation programme included review of the local demographics and population health modelling and system wide planning of health and social care services.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

Facilities and premises were mostly appropriate for the services being delivered. Managers identified challenges associated with staff bases being scattered across the county in a range of facilities that were not always ideally suited to the services being delivered. At the time of the inspection, the Ipswich child development centre was based within Ipswich hospital, in premises owned by the hospital trust, who had future plans for use of the area, resulting in a need for child development services to be re-located. There were plans to re-locate the services provided in the child development centre to St Helen’s house. A plan had been developed for this, which included improvement of the facilities within St Helen’s house, to adapt them better for the services provided. Included in the re-development was the provision of a second sound proof booth for audiology. However, a timescale for this had not been agreed.
At the Bury St Edmunds child development centre in addition to consultation and assessment rooms there was a quiet room, nursery, treatment room and therapy room with gym. There was a good sized waiting area with activities and toys for a wide range of age ranges. At St Helen’s House there was a gated children’s waiting area similarly equipped and a range of other consulting rooms, assessment areas, and a gym.

Staff could access emergency mental health support for children and young people with mental health problems and learning disabilities. The clinical psychologist worked closely with the children and adolescent mental health service.

The service had systems to care for children and young people in need of additional support, specialist intervention, and planning for transition to adult services. A generic transition pathway was in place and a template from which to develop an individual transition plan. Managers told us they had participated in a review of a system wide review of transition in Suffolk in partnership with the adult hospice and other stakeholders. They were actively involved in developing Suffolk wide transition guidance.

There was established transition service for young people with attention deficit hyperactivity disorder (ADHD), to aid the transition to adult services. Staff also spoke about beginning transition as early as appropriate for young people with a long term disability, who could continue to receive input from children’s services until they reached the age of 19 years. Each service lead managed the transition for their clinical area and the associate director of integrated community paediatric services maintained an oversight.

Patients with learning disabilities or complex needs already under community paediatric care, remained under follow-up by their paediatrician until their 19th birthday as appropriate; and transition to adult services was coordinated by the community paediatrician concerned.

Managers monitored and took action to minimise missed appointments. Families were contacted, and appointments re-arranged when appointments were missed. They were flexible in terms of where care was provided and the time of appointments.

Managers ensured that children, young people and their families who did not attend appointments were contacted. There was a system in place to contact and follow up all patients when they missed an appointment.

**Meeting the needs of people in vulnerable circumstances**

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.

Staff made sure children and young people living with mental health problems, learning disabilities and long term conditions received the necessary care to meet all their needs. The purpose of the service and model of delivery was to provide integrated care primarily to children and young people with medical, developmental, neuro-disabling and cognitive disabilities and longer-term health conditions, therefore the service was designed to ensure children and young people received care to meet all their needs and staff worked closely together and with staff from other agencies to provide that care.
The service also provided additional support to families when required through Therapy Focus Suffolk. This consisted of a block of targeted therapy for children with cerebral palsy who needed specialist advice or treatment in addition to that offered by their local therapy team. This was to solve a problem or to identify a way forward when the child was having difficulties in a particular area. A week-long block of multi-disciplinary assessment and therapy for the child was provided with a session every day for approximately one and a half hours. At the end of this time families were sent a written summary and recommendations for their child’s future therapy.

Clinics were designed to meet the needs of children, young people and their families. Clinics provided child sized equipment and furniture and lots of opportunities for play. They were decorated in such a way as to reduce the clinical feel of the rooms and provide an environment suitable for children and young people.

Staff used transition plans to support young people moving on to adult services.

Staff understood and applied the policy on meeting the information and communication needs of children and young people with a disability or sensory loss. Staff were skilled at identifying ways to maximise involvement and understanding of children and young people with communication needs and disabilities.

The service did not information leaflets available on display in languages spoken by the children, young people, their families and local community. However, they were able to provide information in other languages by request.

Managers made sure staff, children, young people and their families could get help from interpreters or signers when needed. Staff had access to communication aids to help children, young people and their families become partners in their care and treatment.

Staff told us they often needed to use interpreters, and these were normally booked in advance. There was also access to a telephone interpreters where appropriate. They also used pictorial information for families where there were literacy issues.

### Access to the right care at the right time

**People could access the service when they needed it and received the right care promptly.**

Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards. However, contracted times for health assessments of children in care were not always met.

Managers monitored waiting times but did not always make sure children, young people and their families could access services when needed and receive treatment within agreed timeframes and national targets. Information provided on inspection demonstrated that referral to assessment targets were met for patients, with the exception of contracted times for health assessments of children in care which were not always met.

### Referrals

The trust identified the community health services for children, young people and families in the table below as measured on ‘referral to initial assessment’ and ‘assessment to treatment’.

The trust met the referral to assessment target of 126 days for all six of the services listed, with patients in all services having an initial assessment within 14 days, with median times that were
considerably lower than the targets. The trust noted that the first assessment and treatment both happen at a patient’s first appointment.

<table>
<thead>
<tr>
<th>Name of hospital site or location</th>
<th>Name of in-patient ward or unit</th>
<th>Days from referral to initial assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>National / Local Target</td>
</tr>
<tr>
<td>Bury Child Development Centre</td>
<td>Paediatric medical</td>
<td>126</td>
</tr>
<tr>
<td>Ipswich Child Development Centre</td>
<td>Paediatric medical</td>
<td>126</td>
</tr>
<tr>
<td>Bury Child Development Centre</td>
<td>Paediatric occupational therapy</td>
<td>126</td>
</tr>
<tr>
<td>Bury Child Development Centre</td>
<td>Paediatric physiotherapy</td>
<td>126</td>
</tr>
<tr>
<td>Bury Child Development Centre</td>
<td>Paediatric speech &amp; language therapy</td>
<td>126</td>
</tr>
<tr>
<td>Thomas Wolsey School</td>
<td>Suffolk Communication Aids Resource Centre</td>
<td>126</td>
</tr>
</tbody>
</table>

(Source: CHS Routine Provider Information Request – CHS10 Referrals)

The trust’s integrated quality and performance report provided information on assessment times for specific contracted services. From May 2018 to May 2019, the percentage of children in care for whom initial health assessments were completed within 28 days of becoming a child in care, was 36.7% against a target of 100%. Engagement and acceptance of first offered appointments and fluctuating demand were two identified challenges in achieving the target. A series of actions were identified, including the use of locum paediatricians. It was also being discussed with the service’s commissioners. The percentage of children assessed to be eligible for NHS continuing health care whose review health assessment was completed annually was 97.6% against a target of 80%.

Managers worked to keep the number of cancelled appointments to a minimum. The service was flexible, and appointments made at times to suit the patients. Parents told us they could contact the service and re-arrange their appointment easily if it was inconvenient.

When children and young people had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

Accessibility

The largest ethnic minority group within the trust catchment area is White British with 90.8% of the population.

<table>
<thead>
<tr>
<th></th>
<th>Ethnic minority group</th>
<th>Percentage of catchment population</th>
</tr>
</thead>
<tbody>
<tr>
<td>First largest</td>
<td>White British</td>
<td>90.8%</td>
</tr>
<tr>
<td>Second largest</td>
<td>White: other white</td>
<td>3.8%</td>
</tr>
<tr>
<td>Third largest</td>
<td>Asian/Asian British: other Asian</td>
<td>0.6%</td>
</tr>
<tr>
<td></td>
<td>Mixed/multiple ethnic groups: White and Black Caribbean</td>
<td>0.6%</td>
</tr>
</tbody>
</table>
Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint. However, trust targets for responding to complaints were not always met.

Summary of complaints

From June 2018 to May 2019, the trust received six complaints about community services for children, young people and families at trust level (3.5% of the total complaints received by the trust). The complaints were not split by location.

For the three complaints that had been closed at the time of data submission, the trust took 14, 28 and 34 working days, respectively to investigate and close these. In two of these cases, this was not in line with their complaints policy, which states complaints should be closed within 25 working days.

The three complaints that had not yet been closed had been open for 35, 38 and 63 working days at the time of data submission.

A breakdown of complaints by subject is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>2</td>
<td>33.3%</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>2</td>
<td>33.3%</td>
</tr>
<tr>
<td>Communications</td>
<td>1</td>
<td>16.7%</td>
</tr>
<tr>
<td>Staff values &amp; behaviours</td>
<td>1</td>
<td>16.7%</td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Children, young people and their families knew how to complain or raise concerns. Parents and young people we spoke with, said they had not received any information about how to make a complaint or raise a concern however, they said they would ask to speak to a manager or go to the patient advice and liaison service (PALS).

The service displayed information about how to raise a concern in patient areas. We saw leaflets were available in some of the clinic areas that provided information on how to raise a concern or complaint and how it would be investigated. It also provided information about what people could do if they felt their complaint was unresolved and gave contact details for the patient experience team, PALS, an NHS complaints advocacy service and the Parliamentary and Health Service Ombudsman. There was also information for families about other ways to give feedback about the service through organisations such as the Suffolk Patient Carer Network and VOICE (a voluntary group of parents, carers and young people who used or had used the service).

Staff understood the policy on complaints and knew how to handle them. Staff told us they were open with families and tried to resolve concerns on the spot. They said they would provide an information leaflet and inform families about PALS.
Managers investigated complaints and identified themes. Complaints were reported in the integrated performance dashboard for the service. Due to the low number of complaints, it was not possible to identify themes; however, managers said they tended to relate to parent expectations of what could or should be provided, as compared to the contracted service. Timescales for response to complaints were affected by the complexity of the issues and multi-agency involvement.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint. Staff said complaints and actions from complaints were fed back at team meetings and on an individual basis.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us of improvements they had made to services as a result of feedback from families. The sensory workshops reported in a previous section of this evidence appendix was an example of this.

Compliments

From June 2018 to May 2019 the trust received 60 compliments for community services for children, young people and families (7.9% of all compliments received trust-wide).

All of the compliments were attributed to paediatric care in the community and no location or department was specified.

The trust noted that the majority of compliments received trust-wide related to overall care along the whole pathway; and patients and relatives thanking staff for their kindness and compassion during difficult and stressful times.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Integrated community paediatric services were managed within the community and integrated services division of the trust. This was comprised of four service groupings.

- Adult community core services
- Adult community specialist services
- Integrated community paediatric services
- Integrated therapy services

There was also a community equipment service that supported all services within the division, as well as Suffolk County Council. This provided loan equipment for adults and children and was a
county wide service. The service was provided by an independent provider via a sub-contractual arrangement.

The integrated community paediatric service was led by an associate director, supported by business managers and service leads and a lead paediatrician. A non-executive director with an interest in paediatrics had recently left the trust and a replacement was identified. Some visits to the service were being arranged.

The senior management team said that a presentation about the service was provided for the trust board when community services joined the trust and regular updates on performance were also included in board meetings. There was representation from the service on key trust committees such as the corporate risk committee, the information governance steering group and the children’s safeguarding committee. This ensured the service had a high profile and their voice was heard within the organisation.

The associate director and service leads were visible and approachable. Staff of all grades said they were accessible and supportive. Staff told us they were kept up to date with changes and developments and managers were fair and treated everyone equally. They had confidence that if they raised a concern it would be listened to and it would be addressed.

The senior management team had a good grasp of the challenges facing the service and were forward thinking; they embraced multi-agency working and were positive about the future. They took opportunities to promote the service and seek additional funding to further develop services.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Managers were working closely with commissioners and other stakeholders to deliver a children’s and young people’s transformation programme for Suffolk and North East Essex. There were seven workstreams in the transformation programme and the service were represented on most of the workstreams. The division had a business plan for 2019/2020 which acknowledged that as a new and evolving division, the focus was initially on internal integration within the trust and external development within the wider health and care system in Suffolk.

The business plan was aligned with the trust objectives and the trust vision- “To deliver the best quality and safest care for our community.” It described the key operational components of the service model for the division for the next five years. It recognised the need for improved use of digital technology and information systems. There was also a focus on working with key stakeholders and partners in the re-design of clinical pathways and ensuring that changes to other health and social care services were reflected in service provision and planning. A review of the integrated community paediatric service was underway at the time of the inspection overseen by the children and young people’s board of the external alliance. This would influence the overarching strategy for the service going forward.

Culture
Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work. The service had an open culture where patients, their families and staff could raise concerns without fear.

There was a strong culture of team working and a commitment to achieving the best possible care and treatment for children and young people. Staff were proud of the close multi-disciplinary working within the service and were committed to cross boundary working with other organisations.

Staff were very positive about their relationships with the management team and they felt well supported. Although they worked in disparate areas, they felt part of the wider trust and valued as such. A member of staff said, “The trust are making a big effort to involve the community.” They went on to say the trust newsletter had information about the community as well as the acute hospital services and during induction a special effort was made to ensure they felt welcomed and involved.

**Governance**

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Leaders operated effective governance processes, at divisional level, although the cascade of governance issues through team meetings were not always in place and there was no clinical audit plan for the service.

A monthly service management group meeting incorporated clinical governance agenda items. Service leads for each professional group attended the meetings and in addition to operational issues, there was discussion of performance, risks, quality, training, safeguarding, incidents and complaints. Minutes from the meetings showed attendance was good and the different professions were represented. The service management group reported to the divisional clinical governance steering group. Policies were ratified through the clinical governance steering group.

The service had a number of performance indicators that were monitored at trust board committee meetings and by the commissioners. There was evidence of the service working with other healthcare providers such as the local mental health trust to manage wider performance issues such as access to mental health services.

We were told that clinical governance issues were cascaded by the service leads for each profession at regular team meetings. Staff told us they discussed performance, incidents, complaints, audits and quality improvements at these meetings. However, minutes of the meetings provided by the trust showed that governance and incidents were included on the agenda at a joint team meeting, but individual specialty meetings did not include a review of governance issues. Staff told us key information was also communicated verbally and through the trust newsletters. The trust provided copies of a monthly ‘CREWS’ report that was used to share learning, patient safety and quality information across the community and integrated services division and copies stated this should be used to share patient safety and quality in team meetings.

We asked for, but the trust did not provide, a clinical audit plan for 2019/2020.

Staff were clear about their responsibilities and the management structure. They had confidence in the management team to escalate concerns to a higher level if necessary.
Management of risk, issues and performance

Leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Leaders and teams did not always use systems to manage performance effectively. Issues with the accuracy and availability of data, affected managers’ ability to manage performance effectively at times. Mandatory training data was not always accurate, and managers did not have oversight of compliance with national clinical guidance.

An integrated performance dashboard contained some performance indicators for the integrated community paediatric service, such as times to assessment for specific patient groups. The senior management team acknowledged the dashboard was a “work in progress,” and could be developed further to be more reflective of children’s services. They spoke about the possibility of adding indicators such as referral numbers, response times and timeliness of follow up appointments.

The service maintained a risk register, which defined the severity and likelihood of risks causing harm to patients or staff. All the risks we identified during the inspection were identified in the risk register. Action was being taken to reduce the risks identified; however, the risk register did not always fully reflect this, and we noted some of the risks had been on the risk register since 2015. The senior management team had a good understanding of the risks and action being taken. They summarised the main risks as rising demand for the service, information technology and estates issues. These required significant investment and working with external partners; therefore the timescales reflected this.

Staff within the service were aware of financial pressures and worked with managers to minimise the impact on the quality of care. For example, an allied health professional spoke about the limits to the commissioned service for one patient group and the additional support they were introducing for parents to support them and improve the service provided.

Information management

The service collected data and analysed it. Data or notifications were consistently submitted to external organisations as required. However, patient information systems were not fully integrated, were not accessible and staff could not always access the records they needed.

Managers had access to information to monitor the performance of the service, however, information systems for the hospital and community services were not integrated. Two different systems were used and the interface between the two was poor.

Information technology (IT) systems were recognised as a risk on the risk register for the division. Staff spoke of the system being slow and difficulties in logging on to and accessing the system. Staff also spoke of a lack of hardware such as computers and mobile phones, and a lack of connectivity. This meant staff working in external clinics and in patients’ own homes, did not have access to patient records and telephone contact was not always possible. As a result, staff were not able to make contemporaneous records unless they created a paper record. They spoke of transferring the notes to the IT system when they were back at base and then destroying the paper notes. A new member of staff also identified that the system was not being used as effectively as it could, due to inconsistencies in staff training. An emerging theme from the review...
of the service, underway at the time of the inspection, was issues with IT, including lack of availability of mobile working solutions for some services, difficulties in accessing IT support and a historic lack of focus and investment in community IT requirements. This was identified on the risk register; however, a solution had not been identified.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff engaged with and sought feedback from families about their experience and how it could be improved. The clinical psychologists had produced a video capturing feedback from families on these topics. Managers also used the friends and family test to obtain feedback.

There was a patient experience group that discussed patient feedback and experience issues. Membership included a patient representative to provide a voice for patients. There were patient representatives on other committees and groups, for example, a children’s hearing service working group. The Suffolk Communication Aids Resource Centre had a management group with volunteers who were parents of young people who were communication aids users, as members.

The speech and language therapy service had been involved in a re-design project in collaboration with other stakeholders including the Suffolk Parent Carer Network and were reviewing the neurodevelopmental disorders pathway.

Staff told us communication across the trust was good and despite working in scattered locations geographically, they felt well supported and engaged. A member of staff said, “The trust is really supportive, they are aware of the pressures and do try to mitigate them.” Staff felt the trust management team had made a positive effort to engage with community staff following their move to the trust.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

We found a strong commitment to the development of services, to better meet the needs of children and young people in the surrounding area and working with other agencies to do so. Managers and staff spoke of the growth in numbers of children with additional health needs due to improved survival rates of pre-term babies and those with complex conditions living longer. They were working with commissioners, had been successful in gaining additional funding and following this, had recruited more staff to expand the service. Managers were members of the children’s and young people’s board which brought together the children and young people’s element of the alliances in West Suffolk, Ipswich and East Suffolk. It included health and social care services. Managers were collaborating in a review of integrated community paediatric services to re-look at the vision and service specification and it’s on-going relevance, where improvements were needed and to predict future demand.
Senior clinicians and managers were part of regional groups looking at palliative care, special educational needs and disability re-design, and transition from children’s services to adult services.

Managers provided examples of innovations and improvements to services in a number of areas. Physiotherapists from community services joined hospital ward rounds to start sharing care with the acute physiotherapists in preparation for discharge. The complex care team provided a 24 hour a day, seven day a week service that consisted of specialist nursery nurses, who were supported by registered children’s nurses, providing packages of short break care to children with varying complex care needs in their home. This enabled families to have a break during the day and night care was also provided to some families, allowing them to get some much needed rest. Many of the children had respiratory difficulties and required non-invasive ventilation and had additional complications such as cerebral palsy and epilepsy, with care involving tube feeding, tracheostomy tubes and stoma care.

Physiotherapists were linking with sports gyms in the locality to provide gym groups for five to 11 year olds and 11 to 18 year olds with cerebral palsy. There was joint working between the physiotherapists and gym staff to enable better integration into the community. This won an innovation award for sports development from the neighbouring trust.

Staff promoted the attention deficit hyperactivity disorder (ADHD) awareness month to increase understanding of ADHD and reduce stigma surrounding the diagnosis.

The communication aids resource centre reported service developments during 2018/2019 including obtaining funding for eye gaze technology and community aids service provision for young people aged 19 to 25 years of age.

The clinical psychology team published an article in the March Clinical Psychology Forum from the British Psychological Society. My child won’t sleep: A psychotherapeutic approach to sleep problems in children with complex neurodevelopmental needs was written by clinical psychologists the child and family practitioner, and an assistant psychologist.

A community paediatrician won the best doctor award in the 2017 Well Child awards run by the national charity for seriously ill children.

**Accreditations**

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

No community services for children, young people and families had been awarded an accreditation.

(Source: Routine Provider Information Request (RPIR) – Accreditations tab)