

# Ipswich Hospital NHS Trust

# Ipswich Hospital

## Quality Report

Ipswich Hospital  
Health Road  
Ipswich  
IP4 5PD  
Tel: 01473712233  
Website: [www.ipswichhospital.nhs.uk](http://www.ipswichhospital.nhs.uk)

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

### Ratings

#### Overall rating for this hospital

**Good**



Urgent and emergency services

**Outstanding**



Medical care

**Good**



Surgery

**Good**



Critical care

**Good**



Maternity and gynaecology

**Good**



Services for children and young people

**Requires improvement**



End of life care

**Good**



Outpatients and diagnostic imaging

**Good**



# Summary of findings

## Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) carried out a comprehensive inspection between the 6 and 8 January 2015. We also carried out unannounced inspections on 12 and 15 January 2015. We carried out this comprehensive inspection at Ipswich Hospital as part of our comprehensive inspection programme. Ipswich Hospital is part of Ipswich NHS Trust which was rated as being in band six of our intelligence monitoring tool and was therefore a low risk.

The hospital was first built around 1910, and has been expanded to cover 45 acres. The newest addition is the private finance initiative (PFI) wing, opened in 2007. The hospital serves around 385,000 people from Ipswich and East Suffolk. It has a relatively high deprivation score, being 83rd out of 326 (1 being the worst), and deals with significantly higher levels of depression and people living with dementia than average. There is also a higher than average number of young people with drug and alcohol-related health problems. However, the population that the trust sees has a higher than average life expectancy. We found that the trust had a relatively new executive team, who worked effectively together to highlight issues and address challenges within the hospital. We found the trust management team to be responsive and to act quickly to address issues highlighted to them during our inspection. The trust were aware of the issues of poor leadership faced on Sproughton Ward and highlighted this prior to our site visit. We also identified challenges on this ward, including poor documentation and a differing patient group than had originally been planned for this ward, and the trust took action overnight to ensure that people received safe and effective care in this ward. We returned to this ward during our announced and unannounced inspections, and found that improvements made had been sustained.

The comprehensive inspections result in a trust being assigned a rating of 'outstanding', 'good', 'requires improvement' or 'inadequate'. Each section of the service receives an individual rating, which, in turn, informs an overall trust rating. The inspection found that overall, the trust has a rating of 'Good'.

Our key findings were as follows:

- 'Never events' that had occurred were actively and imaginatively investigated, including using human factors analysis, and lessons were learnt.
- Systems in place within the emergency department were assisting to effectively tackle the Winter pressures during our inspection.
- Staff were caring and compassionate, and treated patients with dignity and respect.
- The hospital was visibly clean and well maintained. Infection control rates in the hospital were lower when compared with those of other hospitals.
- The trust performed better than average in a number of national audits, including the national hip fracture audit, the national bowel cancer audit, the national lung cancer audit data, the Sentinel stroke national audit, and the myocardial infarction national programme.
- Managers and staff responded quickly and took appropriate actions to ensure patient safety where we identified issues on one ward within the medical service.
- The trust had an ongoing recruitment and retention programme to address staffing shortfalls.
- The equipment within the diagnostic centre was aged, and whilst it was noted on the vision for the service that equipment was nearing end of its life, there were no plans or timeframe formally in place to upgrade equipment.
- The critical care pathway for children was not well defined. Improvement was needed with regards to the provision of a children's high dependency unit (HDU).

We saw several areas of outstanding practice, including:

# Summary of findings

- The emergency department trigger tool, which was in place to ensure that the responsiveness of the emergency department was maintained when the department was beginning to see increasing pressures.
- The chaplaincy service carried a trauma bleep in order to provide emotional support to relatives of trauma victims.
- Ipswich Hospital was one of only two trusts to participate in the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP), providing international benchmarking of patient outcomes.
- There was a comprehensive outreach service in place, providing full 24/7 cover including a 'patient activated' referral for the team.

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

Importantly, the trust must:

- Review the end of life care paperwork to ensure that it is more individualised and providing a holistic approach in line with National Institute of Health and Care Excellence (NICE) guidelines.
- Provide training to staff providing end of life care, on how to identify patients approaching the end of life, and on how to use the new care plans.
- Ensure that discussions with patients and families regarding end of life care, or advanced care planning decisions, are clearly recorded in the person's medical records.
- Ensure that prior to undertaking a procedure, or completing an end of life care order, the person's mental capacity is appropriately assessed in accordance with the Mental Capacity Act 2005.
- Ensure that all clinical areas in outpatients, including the equipment in rooms, are cleaned regularly, and the cleaning is evidenced.
- Ensure that the decontamination room in ear, nose and throat (ENT) outpatients is compliant with guidelines on decontamination Hospital Technical Memorandum.
- Review medicines management in the South Theatre areas to ensure medicines are stored securely.
- Clearly define a critical care pathway for children and review the provision of services for children requiring high dependency of care, including staffing numbers, competency and provision of registered sick children's nurses (RSCN).

There are areas where the trust should consider action, including:

- Review reporting incident mechanisms within the surgery division, including reviewing working arrangements to help facilitate timely reporting.
- Review monitoring equipment within surgery, with a view to standardising the equipment available.
- Review service planning and delivery within maternity, to ensure actions for service development are in line with current clinical practices, and consider the requirement of specialist lead roles.
- Ensure governance procedures and risk registers are active and maintained in children's services and critical care, and ensure a robust system of audit, including patient outcome monitoring, to improve learning.
- Review the staffing levels for the palliative care, mortuary and chaplaincy service, to ensure that there are sufficient staffing levels to meet the demand for services.
- Review the audit tools used for end of life care, including 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms, to ensure that they are more dynamic to improve learning.
- Ensure that a full review of staffing in diagnostic services is undertaken, to ensure that current staffing levels versus service demands is achievable.
- Develop and agree a reasonably timed plan for the refurbishment and upgrade of diagnostic machines, to ensure that the images meet the NICE guideline requirements.
- Review working arrangements to share learning and information across the outpatient services between the three divisions.
- Ensure that waiting times are clearly displayed in the outpatients department, to ensure that people are informed of up-to-date delays to appointments when they attend clinic.

# Summary of findings

- The trust should consider ways in which waiting times could be reduced within the outpatient department.
- Ensure that pain relief is offered to patients in the fracture clinic.

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

# Summary of findings

## Our judgements about each of the main services

### Service

#### Urgent and emergency services

Outstanding



### Why have we given this rating?

Urgent and emergency care services at Ipswich Hospital were good, with some outstanding practice in responsiveness and leadership. There was an open culture for quality improvement, and incidents were reported and learnings shared. Staffing levels and skill mix were planned, implemented and reviewed, and new staff well supported. Staff took the time to listen to patients, and gave explanations of care, to allow for patients informed involvement in decision-making. The emergency department had an escalation policy and utilised a demand trigger tool, developed by the management team, which monitored and linked patient demand to whole trust demand. This enabled a pro-active response to clinical demands. The tool triggered when the department was experiencing high demand and set in motion a series of actions to reduce the pressure on the department. This was outstanding as it maintained flow through the department and ensured admission of patients in a timely manner. The emergency department was led by operational and clinical managers, who were experienced, and strived to deliver and motivate staff to succeed.

### Medical care

Good



Medical services protected patients from avoidable harm, and were effective, caring, responsive and well-led. There were systems in place to report and review incidents, and share learning across teams. Staffing levels had been reviewed, and nurse staffing had increased in some wards to support the complex needs of frail, elderly patients. Clinical outcomes for patients were good, with better than national performance on length of stay and readmissions. Services were consultant-led with daily reviews undertaken by the multidisciplinary team to maintain patient progress and facilitate discharge. Written records were, on the whole, good. Patients were treated with dignity, compassion and respect, and were involved in planning their treatment.

# Summary of findings

There was continual pressure on the availability of beds; however, the hospital responded well to seasonal increases in activity. The trust had created flexibility through the provision of consultant-led escalation wards and appropriate staffing changes. The trust were aware of areas that required improvement (Sproughton Ward), and managers and staff acted quickly to ensure patient were protected from avoidable harm where we identified issues that were at risk of affecting patient safety or dignity. This included a medical and nursing review of each patient on the ward and a review of the skill mix within the ward.

There were clear governance arrangements in place for all levels of staff. Staff felt supported and valued.

## Surgery

Good



Surgery services at Ipswich Hospital were good; however, staff in East Theatre felt unable to report incidents due to time constraints, and believed the process to be too time consuming. Therefore, an open culture for raising safety concerns was not embedded throughout the division. This area require improvement.

Patients were monitored and reviewed promptly. Care and treatment given was evidence-based, and followed NICE guidelines. The surgical division had taken a robust approach to audit, and was benchmarking patient outcomes internationally by participating in the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP). Best practice learnings was shared across the trust.

Surgical services were planned, and surgery cancellation rates were low. The service was responsive to the needs of patients; patients were treated with compassion, kindness, dignity and respect.

The arrangement of surgical services across the site made for logistical problems and management challenges, resulting in varying leadership across the division.

## Critical care

Good



Critical care services were safe, effective, caring and responsive to meet the needs of patients and relatives, and the service was well-led. Staff cared for patients with compassion, dignity and respect. Good quality outcomes were evident, and patients received treatment that was based on national

# Summary of findings

guidelines. The overall capacity was adequate, and patients received timely care and admission to the unit; however, delayed transfers out of hours were high due to the unavailability of step down beds on the wards.

Medical and nursing staffing levels were planned, implemented and reviewed depending on patient acuity and turnover, and adhered to national guidance.

Staff competency and training arrangements were embedded, resulting in a supportive environment, and staff morale was good.

Service provision for children was primarily stabilisation prior to transfer; however, the unit treated approximately 20 children a year. There was no written policy for paediatrics in place, and no registered sick children's nurse (RSCN) employed on the intensive care unit (ICU).

The management at service level on the nursing side were clear about their roles and vision for the service; however, this was not as embedded within the medical team. The governance and risk management within critical care was not embedded. During our inspection we identified a number of aspects of care where risks had been identified; however, there were no current risks on the risk register. An example of this was the paediatric patients on the ITU. Therefore, there was no assurance that timely actions were being taken to protect people from avoidable harm.

## Maternity and gynaecology

Good



Maternity and gynaecology services provided to women and babies by Ipswich Hospital overall was good, with some improvements required in respect of the responsiveness of the service. There was a strong focus on patient safety and risk management practices. Mandatory training, including safeguarding measures, were in place, and staff recognised and responded appropriately to changes in risks to people who use services. Staff were appropriately qualified and competent, and safe staffing levels and skill mix encouraged proactive teamwork, to support a safe environment. Individual care and treatment was planned and delivered in line with current evidence-based guidance.

# Summary of findings

Patient outcomes for maternity and gynaecology were good, as was the counselling support for women undergoing termination of pregnancy and those women suffering a miscarriage. Care provided was good, and patients were treated with dignity, respect and kindness.

Service planning and delivery required improvement, as actions for service development in line with current clinical practices were not always in place or proactive, as there was a lack of specialist lead roles.

The midwifery leadership model encouraged co-operative, supportive relationships among staff, and compassion towards people who use the service. An open, honest and transparent culture was evident, with staff confident in the support of their managers and the senior executive team.

## Services for children and young people

### Requires improvement



The children and younger people's service was caring and compassionate. We received positive feedback from the majority of children and parents that we spoke with. We were told that staff demonstrated a caring attitude. The service had a good incident reporting culture; however, more work was needed to embed and demonstrate a learning culture. Staff were clear in relation to their responsibilities with regards to safeguarding. We saw safe medicine practices being adhered to, and equipment was safety checked.

Improvement was needed with regards to the provision of a service for children with more complex needs. We found that although not commissioned to provide a high dependency care for extremely sick children, there was a local need for this service. This meant that the children's department was providing this type of care without sufficient numbers of trained staff. The critical care pathway for children was not well defined, and there was a lack of consistency in explanations with regards to roles and responsibilities. The critical care operational policy highlights 'paediatrics as a very small part of admissions, but as such represents significant risks'. Provision for critically ill children was primarily stabilisation prior to transfer.

Processes were in place to determine best practice guidance, which related to the children and



# Summary of findings

younger people's service. There was a lack of local initiatives and auditing to monitor and measure patient outcomes. Data provided by the trust showed that training in paediatric intermediate life support (PILS) had been completed by 90% of the staff who required it. Children and younger people's individual needs were taken into account, and there was a good approach to multidisciplinary working when delivering care and treatment.

There were many initiatives in place which demonstrated that this was a responsive and sustainable service. For example, we heard examples of how the service had been redeveloped, based on feedback from patients, and initiatives to grow and expand areas of the service. Every member of staff that we spoke with was passionate about providing the best care possible, and were keen to input into improvement. There was an open culture, and staff felt valued and well supported from the leaders within this department.

However, despite staff telling us that capacity was one of the biggest risks within the service, we were not provided with information which demonstrated that the department was safely managing increases in service demand.

Governance systems required developing which meant that the risk management system was not effective; we found risks on the register which had been present for nine years. There was a lack of evidence to support continuous monitoring and improvement over time, and a poorly developed audit programme. Senior members of staff within this unit however agreed, and had already identified that this was an area in which improvements were needed.

## End of life care

Good



Services for end of life care were good, with some improvements required in effectiveness. We found that whilst the new end of life care programme was in its infancy, patients were receiving safe care however improvements were required to embed this programme of care. Staffing levels for the palliative care service required review due to the number of referrals outweighing the number of staff available.

We found that the new end of life care tools that had been implemented trust-wide had been done

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so without formalised education of staff. The tools required improvements to ensure that all elements of care, including holistic, spiritual and emotional needs, were considered in line with NICE guidelines. We also found that these new tools required further information to ensure that they were individualised to the patient. We also found that staff required further training to ensure that they could identify patients at the end of their life who would benefit from the specialist service.

Staff at Ipswich Hospital provided very compassionate care to patients leading up to the time of their death. Locally, staff spoke highly of the care offered by the palliative care, mortuary, chaplaincy and bereavement teams.

The end of life care and palliative care team supported the provision of rapid discharge, and rates of discharge within 24 hours were in line with the England average. Relatives were being invited to share their experience, to learn and improve the delivery of end of life care. Locally, those providing end of life care within departments led the provision of this well.

## Outpatients and diagnostic imaging

Good



Outpatient and diagnostic imaging services required some improvement. Not all areas of the outpatient services were visibly clean. The outpatient ENT department decontamination room was not fully Hospital Technical Memorandum compliant. The equipment within the diagnostic centre was aged, and whilst it was noted on the vision for the service that equipment was aged, the plans for replacement had only recently been signed off by the trust board. Due to the age of the equipment, NICE guidelines were not being met due to out-of-date software and hardware. This meant that whilst they were safe they could not deliver treatment and diagnosis in line with current guidance. Seven day working did not take place in outpatients or in diagnostic imaging. The care provided by staff to patients in the outpatient and diagnostic imaging services was good. The service was responsive, and patients were able to access their outpatient and diagnostic appointments in a timely way, with the trust performing well on the outpatient and cancer pathways. The service was well-led locally, although the structure of the

## Summary of findings

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outpatients department meant that there was no overarching outpatients lead, and there was a disconnect between how each outpatient service was run, because it was run by each division. Staff were proud to work at Ipswich Hospital.

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**Good** 

# Ipswich Hospital

## Detailed findings

### Services we looked at

Urgent & emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and Gynaecology; Services for children and young people; End of life care; Outpatients & diagnostic imaging

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# Detailed findings

## Background to Ipswich Hospital

Ipswich Hospital has around 587 beds, although during our inspection a further 100 beds had been opened to cope with the Winter pressures. The hospital employees around 3,080 staff, and has over 500 volunteers who assist patients to locate departments and perform other supportive services.

The 2011 census shows that 10% of Ipswich's population was from an ethnic minority group, the largest of which

was Asian or Asian British accounting for 6.3% of residents. The Ipswich deprivation score was 83 out of 326. The health of the people of Ipswich is mixed when compared with the England average. Life expectancy for both men and women is similar to the England average.

We carried out a comprehensive inspection at Ipswich Hospital NHS Trust, as part of our comprehensive inspection programme between 6 and 8 January 2015.

## Our inspection team

Our inspection team was led by:

**Chair:** Sean O'Kelly, Medical Director, University Hospitals Bristol NHS Foundation Trust

**Head of Hospital Inspections:** Fiona Allinson, Head of Hospital Inspection, Care Quality Commission

The team included eight CQC inspectors and a variety of specialists, including six senior nurses, three ward level nurses, seven consultants and one junior doctor, a pharmacist and three 'experts by experience'. Experts by experience are people who use hospital services, or have relatives who have used hospital care, and have first-hand experience of using acute care services.

## How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection took place between 6 and 8 January 2015.

Before visiting, we reviewed a range of information we held, and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG); Trust Development Authority; NHS England; Health Education England (HEE); General Medical Council (GMC); Nursing and Midwifery Council (NMC); Royal College of Nursing; College of Emergency Medicine; Royal College of Anaesthetists; NHS Litigation Authority; Parliamentary and Health Service Ombudsman; Royal College of Radiologists and the local Healthwatch.

We held a listening event on 6 January 2015, when around 35 people shared their views and experiences of Ipswich Hospital. Some people who were unable to attend the listening event shared their experiences with us via email or by telephone.

We carried out an announced inspection visit on 7 and 8 January 2015. We spoke with a range of staff in the hospital, including nurses, junior doctors, consultants, administrative and clerical staff, radiologists, radiographers, pharmacy assistants, pharmacy technicians and pharmacists. We also spoke with staff individually as requested, and held 'drop in' sessions.

We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Ipswich Hospital.

# Detailed findings

## Facts and data about Ipswich Hospital

The trust provides services from one site at Ipswich Hospital, which is a medium acute hospital in Ipswich, Suffolk. The hospital serves a local population of around 400,000 people in and around Ipswich and East Suffolk. The main commissioners of acute services are the clinical commissioning groups (CCGs) for Ipswich and East Suffolk.

The trust has 541 general and acute beds, 34 maternity beds, and 12 critical care beds. The trust employs 3,080 staff (425 medical, 1,015 nursing, 1,640 other) and has a turnover of around £249m and is running a planned surplus of £749,000.

The workforce was supported by 6% bank and agency staff, which is the national average.

The trust had 45,787 inpatient attendances, 458,661 outpatients and 78,804 emergency attendances in 2013/2014.

The trust reported four 'never events' between February and November 2014; these concerned, in February 2014 in urology, wrong side of body exploration; in July 2014 in ophthalmology, wrong eye surgery; in October 2014 in trauma & orthopaedics, wrong side surgery; and in March

2014, a retained object in gynaecology. ('Never events' are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.)

Between April 2013 and May 2014, the trust reported 81 Serious Incidents (SIs). They consisted of 41 grade 3 pressure ulcers, 12 slips/trips/falls, six unexpected deaths of inpatients, four unexpected readmissions to the neonatal care unit (NICU), and 18 others.

There were a total of 5,617 incidents reported between April 2013 and May 2014. They included: eight deaths, 15 severe harm, 73 moderate harm, 1,507 low harm and 4,014 no harm.

There were 98% NRLS incidents reported with no or low harm. (The National Reporting and Learning System (NRLS) is a central database of patient safety incident reports.) The trust also reported fewer incidents than the England average. CQC analysis indicates that this is statistically lower than similar sized hospitals and there is therefore a risk that incidents may not be graded appropriately.

# Detailed findings

## Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Requires improvement	Good	Good
Services for children and young people	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
End of life care	Good	Requires improvement	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Good	Good	Good

### Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients.
2. We have deviated from the aggregation principle, as whilst two domains rated requires improvement

would usually mean that the trust was rated as requires improvement, seven out of eight services the trust were rated good with only one service rated as requires improvement overall therefore the overall trust rating has been determined as Good.

# Urgent and emergency services

Safe	Good	●
Effective	Good	●
Caring	Good	●
Responsive	Outstanding	☆
Well-led	Outstanding	☆
Overall	Outstanding	☆

## Information about the service

The emergency department (ED) at Ipswich Hospital is located within the newly developed Private Finance Initiative (PFI) wing of the hospital that was purpose built and opened in 2007. The ED at Ipswich Hospital provides a 24-hour, seven day a week service to the local area. The department saw around 77,700 adult patients and 15-20,000 children between April 2013 and August 2014.

Patients present to the department either by walking in via the reception or arriving by ambulance. The department had facilities for assessment, treatment of minor and major injuries, a resuscitation area, and a separate children's ED service. The emergency department is a member of a regional trauma network.

Our inspection included two days in the emergency department as part of an announced inspection. During our inspection, we spoke with clinical and nursing leads for the department. We spoke with five members of the medical team (at various levels of seniority), and eleven members of the nursing team (at various levels of seniority), including the lead nurses with responsibilities in specific areas, including safeguarding, infection prevention and control, and education.

We also spoke with eight patients, and undertook general observations within all areas of the department. We reviewed the medication administration and patient records for patients in the ED department. We also looked at quality indicators and audits within the ED around the patient care provided.

## Summary of findings

Urgent and emergency care services at Ipswich Hospital were good, with some outstanding practice in responsiveness and leadership. There was an open culture for quality improvement, and incidents were reported and learnings shared. Staffing levels and skill mix were planned, implemented and reviewed, and new staff well supported. Staff took the time to listen to patients, and gave explanations of care, to allow for patients informed involvement in decision-making.

The emergency department had an escalation policy and utilised a demand trigger tool, developed by the management team, which monitored and linked patient demand to whole trust demand. This enabled a pro-active response to clinical demands. The tool triggered when the department was experiencing high demand and set in motion a series of actions to reduce the pressure on the department. This was outstanding as it maintained flow through the department and ensured admission of patients in a timely manner.

The emergency department was led by operational and clinical managers, who were experienced, and strived to deliver and motivate staff to succeed.



# Urgent and emergency services

## Are urgent and emergency services safe?

Good



There were systems to protect patients and maintain their safety. These systems were consistently used within the patient pathways available. We saw that staffing levels were good in order to provide safe care to patients within the different treatment areas. Staff displayed awareness and practice of infection prevention and control, wearing gloves and aprons where required. We saw all grades of staff using hand sanitiser, which was available throughout the departments.

We observed and spoke with staff who demonstrated experience and an understanding of people's needs throughout the department. We observed staff providing emergency care which was appropriate, following national guidelines with care and compassion.

The department had a waiting area for patients that walked into the department requiring treatment. There was information displayed advising people what to do should their condition worsen. We observed that the reception staffing levels met the demand placed on the ED. We saw that reception staff were engaged and embedded in the whole ED team.

Risks were managed within the department and provided an environment that ensured people were safe when receiving care and treatment. We looked at the management and storage of medicines, which was safe, and staff handled medication in accordance with trust policy.

Training records identified that staff had received mandatory training, as well as further training to enhance individual skills across the whole multidisciplinary team. The requirements of people with complex need, such as those requiring dementia care and those with learning disabilities, were understood by staff. We looked at fourteen patient care records and found care plans completed, including nursing and medical notes.

### Incidents

- The trust had reported one Serious Incident (SI) relating specifically to the emergency department to the National Reporting and Learning System (NRLS) and to the Strategic Executive Information System (STEIS)

between March 2013 and October 2014. This related to an unexpected death of an inpatient. We saw that the department had learnt from this incident, and had introduced a new procedure when admitting patients and recording body mass index (BMI).

- We asked staff if they reported incidents and had knowledge of the reporting system. Staff told us that they reported incidents in a timely manner through the hospital's internal reporting system. We spoke with seven members of staff, who told us that they received feedback on the outcome of the incidents they reported, including closure.
- We spoke with senior nursing staff about evidence of learning from incidents. We were provided with an example of a change of practice. For example, the department had introduced a system called 'action after review' which asked three questions following an incident, which were 'What happened?' 'What do you expect to happen?' And 'What will happen now?' This ensured that open communication took place, and meant that everyone agreed the way forward to learn following any incident.
- During our inspection we asked to see four incidents that had been reported by staff, and we found that they had been investigated by an appropriate person, reported, and closed with accountable actions. We saw that where actions were required, these had been signed off as completed.

### Cleanliness, infection control and hygiene

- During our inspection we observed consistent use of personal protective equipment, such as gloves and aprons. We observed that staff used hand sanitiser between patient care, moving around the emergency department, and encouraging visitors to engage in the process, and also explaining the procedure to children in a manner which was understood.
- We noted during our inspection that there were hand cleaning stations within treatment areas. Hand sanitiser dispensers, which were full, were found at each door entrance and within corridors throughout the emergency department.
- We observed ambulance staff remove dirty linen and clean ambulance stretchers in a designated area away from patients and patient treatment cubicles.
- We looked at all areas of the department during our inspection and found them to be clean and bright. Clinical waste bins were available, and we looked at

# Urgent and emergency services

nine clinical waste bins and found all sections were completed by the person who assembled the clinical waste bin, such as the date when the bin was assembled and the name of the person who assembled the bin.

- Infection prevention and control audit data was available, which demonstrated compliance against trust policy. We looked at one audit, which reported that 100% of staff were observed to follow the required hand hygiene, and 98% of staff were 'bare below the elbow' in clinical areas. This told us that staff working in the ED followed the required practice, and understood safe infection prevention and control.

## Environment and equipment

- The emergency department had a designated children's department, which had a secure access and flow through the department.
- There was a separate entrance to the children's emergency department from the public waiting room, so that children and their parents, carers or relatives did not wait in the main waiting room or have to walk through the adult emergency department.
- The resuscitation area was clean and bright. Resuscitation equipment was available and clearly identified. Equipment trolleys followed a system that adopted the airway, breathing and circulation management approach within each resuscitation bay.
- We looked at emergency resuscitation trolleys throughout the department, and found that all the trolleys within the children's and adult emergency department and resuscitation areas had been consistently checked daily, with the signatures of the staff that checked them recorded. We looked at past records over the previous three months, and found no abnormalities within the audit of the checks.
- We looked at various pieces of equipment across all areas within the A&E department, which included electro-cardiogram monitors, defibrillators, suction units, oxygen administration equipment, and moving and handling equipment. We found consistency with regards to scheduled servicing. All equipment clearly displayed the trusts internal servicing and safety check stickers.
- The nurses and doctors station sat central with the department pathway, which allowed good visual access and appraisal of the demands on the department.

- The emergency department had designated ambulatory care bays in a separate area away from the major's treatment area. This was within an area that did not impede nor was impeded upon by either the adult or children's ED service. The ambulatory care team enhanced the patient pathway away from the ED and provided services that supported admission avoidance.
- We spoke with three people waiting in the main waiting room, and comments included "the new A&E waiting room is a great improvement and the chairs are very comfortable".

## Medicines

- During our inspection we checked the records and stock of medication, including controlled drugs, and found correct and concise records, with appropriate daily reconciliation checks carried out by qualified staff permitted to perform this task.
- We looked at patient prescription charts, which were completed fully and signed by the prescriber.
- We found, during our inspection, drug cupboards were secure and medicines were stored appropriately.
- Intravenous fluids were stored in a secure area, which was accessed via staff electronic ID cards.
- We spoke with ED managers, who told us about business plans to introduce a safe innovative way to manage medicines, using staff individual bio-metrics to access store rooms and administer medication; the ED planned to implement this management system within the next year.

## Records

- We looked at fourteen sets of accident and emergency clinical notes during our inspection, and all of the notes were consistent with completion in all sections. For example, nursing notes described a clear timeline of care provided in an organised manner that was quick and easy to find.
- We looked at three specific referrals, including safeguarding referrals, which were completed fully.
- We spoke with five nurses around the completion of records and referrals, and we were told that although the departments were busy, the importance of completing records and making timely referrals was paramount. We found this to be evident in both the adult and children's emergency departments.
- Accident and emergency notes were kept in specific trays on the nurse's station. Each tray had a

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confidentiality top sheet that sat on the top set of notes to ensure that patient details were protected and could not be read by passing people including members of the public.

- Emergency department notes were archived in a safe area, which was a secure room at the rear of the reception area with limited access to those staff authorised. The previous six months notes were available within the department. Emergency department notes above the six month period were then securely stored out of the department and were requested if required.
- We saw that records were clearly identified to differentiate between adult and children's notes, with a coloured strip down the side of the front sheet.

## Safeguarding

- Staff were clear on, and could describe, the procedure to be followed if there was a concern about a child or adult. If there were concerns regarding child or adult welfare, the emergency department would discuss it with the safeguarding lead.
- Staff we spoke to had knowledge of what constitutes a safeguarding referral for an adult, and we saw within one person's medical notes and previous safeguarding meeting minutes that adult safeguarding referrals were followed up.
- We saw that there was a specific trust lead on child safeguarding, and a separate lead on adult safeguarding. The emergency department had two band 7 nurses that lead on safeguarding.
- We looked at training records and saw that nursing staff had undergone mandatory safeguarding training to an appropriate level. Compliance of training for the current year, ending April 2015, for safeguarding adults and children level 1, was 100%. Level 3 children's safeguarding training was given where appropriate.
- We spoke with staff, including nurses, doctors, reception and housekeeping staff, who understood their responsibilities, and they were aware of the trusts safeguarding policies and procedures.
- The ED had completed a project, on their duties under section 136 place of safety, whereby they have worked with local agencies, involving them with training, which has enhanced patient discharges and care packages seven days a week. For example, the local Police Force

have attended the department and supported with mental health training, as there was previously a limited understanding of each agencies working practices in relation to section 136 at the weekend.

## Mandatory training

- We were provided with records of mandatory and supplementary training for staff for the current year ending in April 2015. Records demonstrated that there was 97% compliance across the multidisciplinary teams.
- Records demonstrated that the department provided training within many different areas, which included basic and advanced life support - adult, basic and advanced life support – paediatric, infection control (including hand hygiene), information governance, manual handling and risk management.
- Mandatory training was provided in different formats, including face-to-face classroom training and e-learning (e-learning was electronic learning via a computer system).
- Staff told us that the training offered was fantastic, and the availability to enhance individual skills to develop was encouraged and supported.
- We spoke with varied grades of doctors and were told that the induction provided was substantial. Two doctors told us that the lead consultant was very supportive and demonstrated a real drive towards their development.
- We saw that the department had increased the content of the immediate life support course (ILS) to include advanced airway management, which was above the national requirement.
- The emergency department provided refresher training for all staff, which included neutropenic sepsis, major incident training, orthopaedic support training, and mortuary training.
- The department had a permanent nurse educator who facilitated simulated announced and un-announced scenario training on a monthly basis. After each training session there was a hot de-brief.

## Management of deteriorating patients

- We observed that the department operated a triage system of patients presenting to the department either by themselves or via ambulance, and they are seen in priority dependent on their condition.
- There was a system in place whereby patients who walked into the department presented at the reception

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desk, and the receptionist would make contact with an emergency nurse practitioner, who would initially assess and triage the patient down the appropriate pathway. We observed that this system was quick and effective.

- Patients arriving as a priority (blue light) call were transferred immediately through to the resuscitation area. Such calls are phoned through in advance (pre-alert) so that an appropriate team are alerted and prepared for their arrival. The alert calls were recorded, which allows the ED team to replay any calls to confirm details if required. The alert calls can also be played back later if required.
- We looked at a pre-alert form with regards to a pre-alert that occurred during our inspection, and found that the forms had been completed fully, with any clinical observations recorded, together with the estimated time of arrival of the ambulance to the emergency department, and who took the details over the telephone from the ambulance service.
- We found that nursing handovers were always comprehensive and thorough; we observed five nurse handovers, and found general safety as well as patient-specific information was comprehensive within the handover.
- We noted during our inspection that patients were receiving the appropriate care or early intervention as recommended by national guidelines such as the National Institute for Health and Care Excellence (NICE) and the College of Emergency Medicine (CEM). These included patients suffering a stroke and cardiac problems.
- There was information displayed advising people what to do should their condition worsen, such as developing chest pain.
- Training for the care of the deteriorating patient was provided monthly in the trust simulation centre, and this was open to qualified and unqualified nurses, physiotherapists and all grades of doctors, including core trainees.

## Nursing staffing

- Information provided by the managers within the emergency department indicated that the establishment was operating at the required whole time equivalent (WTE), with a current 1 year secondment vacancy out to advert.

- Senior staff told us that the department supports newly qualified nurses to follow an emergency medicine route, and actively recruits one or two newly qualified nurses from student nurses each year.
- We looked at nursing rotas and saw that the emergency department was adequately staffed. The department used the 'Jones Dependency Tool' which uses patient dependency to calculate the staffing needs for the emergency department.
- The department currently had 20 emergency nurse practitioners (ENP's), including four advanced nurse practitioners (ANP's).
- The emergency department exceeded the Royal College of Nursing (RCN) 'BEST' staffing acuity tool, with regards to the whole time equivalent of nurses with specific paediatric qualifications working within the children's ED. The children's department also offered advanced paediatric nurse practitioners (APNP). The children's emergency department saw around 15-20,000 children per year.
- We saw that there was very little reliance on bank and agency staff. When bank and agency staff were used, they received local induction prior to working in the department, and their competency was checked.

## Medical staffing

- The department currently operates at the England average of 23%, with five whole time equivalents (WTE) of permanent consultants employed within a rota. The trust is currently recruiting consultants in emergency medicine. The department is using regular locum consultant, who received an induction to the hospital and unit, to fill the gap whilst recruiting.
- Consultant grade doctors are present in the department for twelve hours each day between the hours of 9am to 9pm. Emergency departments should have consultant cover for sixteen hours each day, and the current consultant rota did not support this, and was reliant on the goodwill of the current consultants in post, which was evident.
- There were middle grade doctors and junior doctors overnight with an on-call consultant system.
- There was 32% middle grade doctor cover compared to an England average of 39%. However, the department had a 33% junior doctor cover compared to an England average of 25%.

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- The department regularly employed locum middle grade doctors. When we reviewed the rota we noted that the same doctors were consistently in use. Doctors had received the trust induction programme, and were familiar with the department and protocols.
- We spoke with doctors at various levels of seniority, including two junior doctors, three middle grade doctors and two consultants. We were told that the support towards doctors was good at all levels; the induction was very comprehensive, and ensured that junior doctors were prepared to commence in the department.
- There was a specific paediatrician lead within the children's service provided in the emergency department, and we saw that the paediatrician was involved with local liaison in pathway tracking for children's services.

## Are urgent and emergency services effective? (for example, treatment is effective)

Good



The emergency department used a combination of the National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines, to determine the treatment they provided. Local policies were written in line with this, and were updated as national guidance changed.

The emergency department used evidence-based guidelines – for example, there were a number of care pathways in the department for patients with specific conditions to follow, such as the stroke and sepsis pathway.

The emergency department returned a number of CEM audits with measures found better than the England average for fractured neck of femur, consultant sign off and vital signs in majors and renal colic.

We spoke with doctors and nurses about the implementation of National Institute for Health and Care Excellence (NICE) guidelines. They told us that, as NICE

guidance was issued, they made sure that any relevant to the ED were implemented, and that staff were aware of the requirements through briefings and formal notices. We saw evidence of this in the records we reviewed.

We saw that nursing and medical staff were provided with the information and support they needed to deliver effective care and treatment to people who use the emergency department services. There was a learning disability nurse in the emergency department who delivered effective support.

People's nutrition and hydration were cared for on an hourly basis through effective rounding checking on people's needs. The emergency department had competent staff.

## Use of National Guidelines

- Departmental policies were easily accessible, which staff were aware of and reported they used. There were a range of emergency department protocols available which were specific to the ED.
- Further trust guidelines and policies were within the accident and emergency department, such as sepsis, head injury and needle stick injury procedure. We looked at three treatment plans which were based on the National Institute for Health and Care Excellence (NICE) guidelines. The emergency department followed the guidelines when we observed the care being provided.
- We found reference to the College of Emergency Medicine (CEM) standards, and spoke with four doctors and two emergency nurse practitioners who demonstrated knowledge of these standards.

## Care plans and pathway

- There was a clear protocol for staff to follow with regards to the management of stroke, fractured neck of femur and septicaemia. The department had introduced the 'Sepsis Six' interventions to treat patients. Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis.
- Nurses at the ED at Ipswich Hospital did obtain blood cultures from patients who were query septic, and were not reliant on doctors obtaining these blood samples. This meant that the process within the care pathway, to administer and treat with antibiotics, should be positive.



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- We spoke with eight members of staff that were knowledgeable about the care pathways available to patients and the appropriateness of each pathways benefit.
- We looked at fourteen patient care plans within the emergency department patient notes during our inspection. We found a consistency within both the care plans and notes. For example, care plans had prevention of pressure damage completed on admission. Care plans had an infection status assessment completed. We saw ED assessment notes with observations recorded on patients at the correct intervals.

## Nutrition and hydration

- The department undertook regular food and drink rounds 24 hours a day, seven days a week, and it was observed during our inspection that should patients require something to eat or drink, then they were offered this.
- We spoke to three patients in the emergency department who told us that they were offered drinks at regular times, and water was always available.
- We looked at the medical notes of a patient that had a urinary catheter, and fluid input and output charts were completed at regular intervals whilst in the emergency department.

## Outcomes for the department

- We looked at three internal audits which took place in 2014, and could see evidence that the results had been used to assess the effectiveness of the department, such as compliance of ambulance handover. We saw that compliance for October 2014 was 97.8%, November 97%, and December 97.3%.
- The department displayed information which demonstrated learning from previous CEM audits, and there were very clear guidelines and positive audits around education and awareness of septicemia management.
- We looked at recent audit data, which demonstrated that the emergency department was performing just short the required target levels. For example, 96% of septic patients had a full set of observations and a pain score within 15 minutes of arrival. The required CEM standard is 100%.

- The return of data within the CEM audit demonstrated that 97% of patients were administered antibiotics in the ED within one hour (CEM standard is 50%) and 91% of patients were administered antibiotics in the ED before leaving (CEM standard is 100%).

## Competent staff

- Nursing grades appraisals were undertaken at a rate of 85%, and staff spoke positively about the process and that it was of benefit. An appraisal is a personal development review of staff performance objectives, and a process for determining staff development needs. There was an appointment of new managers in August 2014, who introduced new practices to improve on the PDR process. We were told that 100% of staff appraisals will be completed by April 2015 through a monitored internal system.
- We were provided with details of the appraisals of medical grade staff which were undertaken, and were 100% compliant. Staff told us that they received a personal development review (PDR). Following the appointments of new managers in August 2014, there were new practices introduced to improve on the PDR process. The compliance at the time of our inspection was 85%, with a trajectory of 100% completion by April 2015.
- We spoke with nursing staff who told us that they felt the mandatory and supplementary training which was delivered was beneficial and of a high standard, which kept them up to date.
- We spoke with various qualified nurses and ED technicians, who told us that their professional development was encouraged and supported by management within the emergency department.
- We saw clinical supervision taking place during our inspection across all teams at an appropriate time.
- We saw records that demonstrated that all medical and nursing staff were revalidated in basic, intermediate and advanced life support.
- One doctor told us that they could access training to make sure that they were up to date with their current practice, and this was arranged around the pressures within the department.
- Non clinical staff told us that they received the mandatory training for their role, and felt they were included as part of the team and formed an important part of the patient experience, which was recognised by the ED managers.

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- The ED had enhanced the skillset of the porter service. Training was provided against competencies and porters were called technicians after receiving training in basic life support, patient transfer skills, assisting with plastering. Technicians were then able to further enhance their skillset by completing training modules. For example, obtaining electro cardiograms (ECG's), cannulation and taking blood. Upon completion, Technicians could then become clinical technicians. The ED managers then supported individuals further with access courses to nursing degrees if an individual wished to pursue this education and career pathway.

## Multidisciplinary team working and working with others

- We witnessed multidisciplinary team (MDT) working within the emergency department. During our inspection an alert happened with a patient attending the ED via the ambulance service. An alert was made to the ED and the correct teams were in place when the patient arrived.
- We observed that there was a medical and nursing team leader within the resuscitation area when required.
- During our inspection we witnessed within the major's treatment area that staff worked together as a cohesive team in a way that assessed and planned ongoing care and treatment in a timely way when people were due to move between teams or departments, including referral, discharge and transition.
- Staff we spoke with were aware of the protocols to follow, and who to contact, with regards to key contacts with external teams. We witnessed a patient experience, from transition from the care of the ambulance service over to the accident and emergency staff. This was carried out taking into consideration the patients respect and dignity when moving from the ambulance trolley to the ED's trolley.
- During our inspection we saw that the ambulance service had a hospital ambulance liaison officer (HALO) in the department, who was a senior paramedic or ambulance manager, to assist with the ambulance handover process. The HALO was integrated within the department team.
- The department held monthly clinical governance meetings, where mortality and morbidity are an item on a regular agenda; both clinical and nursing staff attend these meetings.

## Seven-day services

- There was a consultant out-of-hour's service provided via an on-call system.
- The emergency department offered all services seven days a week.
- We were told by senior staff within the A&E department and saw that there were external support services out of hours. However staff stated that it sometimes proved difficult at weekends to obtain external advice in relation to mental health assessments.

## Consent and Mental Capacity Act

- We spoke with eight staff who were aware of the need to assess whether a patient had a temporary or permanent loss of capacity in relation to decision making.
- We observed nursing and medical staff gaining consent from patients prior to any care or procedure being carried out.
- We spoke to four people who used the service, and one person told us "I have a son who has a learning disability and often injures himself. The staff here are fantastic with him and really understand his needs".
- Staff reported receiving training on the Mental Capacity Act 2005 within safeguarding training. Staff explained their systems for assessing people's mental capacity to give consent regarding treatment.
- We spoke with two staff working within the children's emergency department, who were able to explain and reference assessing children as 'Gillick competent'. (Gillick competence is a term originating in England, and is used in medical law to decide whether a child is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.)

## Are urgent and emergency services caring?

Good



Evidence collected and provided to our inspection team and from speaking to patients, provided us with assurance that the emergency department at Ipswich Hospital was providing a good caring service.

During our inspection we found Friends and Family Test questionnaires out in view within the treatment and

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reception areas, and we found posters in the waiting room displaying information to the public of Friends and Family Test results. These results were comparable to similar sized departments and were generally positive.

There were two systems available for people to use the Friends and Family tests. A paper questionnaire, and a system for people to use a small plastic disk provided by reception staff to drop into a corresponding box of their choice in order for the hospital to rate the service.

We saw episodes of nursing and medical interaction during our visit through observation and with feedback from individual patients and relatives.

## Compassionate care

- During our inspection we saw that staff responded in a timely manner to patients that requested help or required assistance. For example, we saw that call bells were answered in a timely manner.
- Staff we spoke with demonstrated an understanding of the need to recognise cultural, social and religious individual needs of patients.
- We found documentation available for people offering advice in different languages.
- We saw that staff respected the confidentiality required around patients and relatives when communicating, ensuring that people's personal information was protected.
- The trust was seen to be submitting data for the Friends and Family Test (FFT). FFT is an important feedback tool that supports the principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. The FFT highlights both good and poor patient experience. The Friends and Family Test score for the emergency department was displayed on posters throughout the department.
- The Friends and Family Test results were comparative to other trusts. We looked at two questions within the FFT, which were, 'While you were in the ED, how much information about your condition or treatment was given to you?' The trust scored 8.4 (max score = 10). And 'Were you given enough privacy when being examined or treated in the ED?' The trust scored 9.0 (max score = 10).

## Patient involvement in care

- We spoke with four people who were patients in the department, and one of the patients told us they felt informed about their patient journey and that staff were caring. Another patient informed us that the staff included them in decisions about their care.
- We saw an electronic noticeboard in the waiting area advising people that there was currently a wait to be seen. The information on the board was updated every hour by a demand management tool which was 'live'.
- We spoke with two patients about the services available and whether they were provided with further information or offered the opportunity to ask questions about their care and treatment. Patients felt informed, and we were told that there were leaflets available within the department for people to take.

## Emotional support

- We witnessed staff providing patients and relatives with emotional support, whereby staff demonstrated that they understood what the impact of treatment had on a person's wellbeing.
- Staff supported patients and their relatives as much as they could; however, staff were very busy during our inspection, and were therefore unable to spend a lot of time with people. Patients and relatives thought that the staff were very helpful all of the time.
- We saw that people's independence was respected, which enabled people to manage their own health, care and wellbeing where possible and able to.
- We saw a system in use within the ED called 'Blue Butterfly'. This was a blue butterfly sticker that was discreetly placed on the door of a cubicle, and also the ambulance entrance, which informed healthcare professionals that discretion and respect should be used due to emotional support being offered to people in difficult circumstances, such as when the bereavement room was in use.
- We saw that the chaplaincy responded to a pager alarm 20 minutes after activation by the ED staff when people had been admitted to the trauma area. The chaplaincy then provided emotional support for patients and relatives attending the department. This was outstanding and supportive to patients and relatives at a time of extreme distress.



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## Are urgent and emergency services responsive to people's needs? (for example, to feedback?)

Outstanding



The emergency department had surges of activity, which occur on a regular and potentially anticipatory basis. The department provided for people's individual needs, which were central to the planning and delivery of the care provided. The ED was flexible, provided choice, and the continuity of care in both the adult and children's ED was evident.

The ED's escalation protocol was efficient through innovation. The department used a trigger tool via an electronic tablet, which was carried by the ED shift co-ordinator and key managers within the trust, which was linked to demand management in the whole trust. This supported and allowed people to access the ED services in a way and at a time that suited them.

The ED took a pro-active approach in the involvement of other organisations, which were integrated in how services were planned. There were innovative approaches to providing person-centred care and pathways. Patients arriving by ambulance were seen in a timely manner, meeting the national Government target requirements of care being handed over from the ambulance service to the ED within 15 minutes. The ED has consistently met this during the Winter pressure period, with an 8% increase in ambulance arrivals.

The emergency department management team actively reviewed complaints, and how they were managed and responded to. We saw that improvements were made as a result across the services provided. People were involved in the review process, and we saw that people were invited back to an open discussion, to ask questions within six weeks if they had any concerns. It was easy for people to complain or raise a concern, and we saw that people were treated compassionately when they did.

We saw that at weekends and out of hours, an emergency nurse practitioner was based at the reception, working alongside the receptionist, providing an alternative

patient pathway service, and assisting patients who may require an alternative service within the community, such as treatment at a walk-in centre or from their GP, rather than within the emergency department.

## Meeting the needs of all people

- The emergency department had an escalation policy and demand trigger tool, which was outstanding and developed by the management team. We saw that the trigger tool was used via an electronic tablet, carried by the shift co-ordinator, operations manager, and bed management centre staff, which was linked to the whole trust demand. The system was updated hourly, via hourly rounding carried out by the shift co-ordinator, with the clinical input each patient required. The trigger tool would calculate the demand from each patient in the ED, and also advise the bed management centre of the predicted bed requirement from the ED.
- We saw the trigger tool change its colour code dependent on the ED demand. Each colour code had a pull down electronic action card for each management discipline to take, including the shift co-ordinator, operations manager and operations centre. The electronic tablet sent an hourly automated text message to a range of managers, including the executive on-call.
- During periods of demand the department managed by being pro-actively responsive in monitoring the ambulances inbound, reviewing patients regularly, and all staff having clear roles. There was co-ordination within teams, which supported the needs of people within the department, ensuring people were safe, and care maintained at all times. The implementation of the escalation protocol was used once during our inspection, whereby the colour code changed to black. We saw that through the response, interaction of the trigger tool, and communication, the ED downgraded from black within 30 minutes, with no patient care compromised.
- The department was co-ordinated, and delivered care which took account of people with complex needs. The emergency department had a permanent learning disability nurse, and we saw that individual nurses championed dementia care, and provided awareness and teaching to all staff.
- The ED had arranged for the chaplaincy service to carry a trauma bleep, and the chaplaincy service would

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attend the department 20 minutes after the bleep sounded, which facilitated a response to support relatives and friends if required, such as after a road traffic collision.

- The children's emergency department had a specific waiting room, which was appropriately decorated and equipped for children waiting to be seen.
- There was a designated ambulance handover area within the adult and children's ED, which took into consideration the privacy and dignity required to protect patients.
- We noted that the building was not a specifically designed emergency department. However, the trust and leadership within the department made use of areas that enhanced patient care and experience. All patients had an individual cubicle to be cared for in privacy and with dignity.

## Access and maintaining flow through the department

- The department operated a triage system for patients presenting to the department, either by themselves or via ambulance, and patients were seen in priority dependent on their condition.
- The trust was performing above, and maintaining performance against, the England average with regards to handover of patient care from the ambulance crew to the accident and emergency department. We looked at performance figures over the Winter period, which demonstrated that compliance for October 2014 was 97.8%, November 2014 was 97%, and December 2014 was 97.3%. The national Government target requirement is for 95% of patients to have had their care handed over within 15 minutes.
- The trust was seen to be performing better than the England average for the percentage of emergency admissions via the accident and emergency department waiting 4-12 hours from the decision to admit until being admitted. Between December 2013 and September 2014 the trust was achieving below the England average of 6% with an average of 2% or less of patients waiting to be admitted.
- NHS trusts in England are tasked by the government with admitting, transferring or discharging 95% of patients within four hours of their arrival in the emergency department. The trust struggled to

maintain the 95% target between August 2013 and December 2013. Performance had improved and the 95% standard had been achieved between January 2014 to September 2014.

- There was an internal 'live' electronic system, which was linked to the trigger tool. The system updated the information within the waiting room, providing waiting patients with 'live' data of the time they had to wait to be seen in triage, minors, majors and children's services.
- The department had two designated cubicles for rapid assessment of patients, which were permanently staffed to support the assessment of patients arriving by ambulance, to ensure that they were supported into the correct care pathway and not admitted directly into majors cubicles.
- This ED was supported by an emergency therapy team, made up of physiotherapists, occupational therapists and further specialists, dependent upon people's needs. This assisted and supported people to be discharged safely with the correct support, to avoid readmission into the ED.
- We saw that at weekends and out of hours, an emergency nurse practitioner was based at the reception, working alongside the receptionist, providing an alternative patient pathway service, and assisting patients who may require an alternative service within the health economy, rather than in the emergency department. This meant that patients were supported in getting the correct appropriate care, in the right place, at the right time.

## Complaints handling (for this service) and learning from feedback

- The emergency department advocates the Patient Advice and Liaison Service (PALS), which is available throughout the hospital.
- There was information available for patients, which was easy to understand, on how to make a complaint and how to access the Patient Advice and Liaison Service.
- All concerns raised were investigated, and there was a centralised recording tool in place to identify any trends emerging.
- We looked at a complaint, and saw that it was analysed at the root cause. There was a clear lessons learnt approach, and an openness of change of protocol and policy, to ensure that patient care improved.

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- There was an evident 'no blame culture' around complaints, and staff told us that they felt they could freely raise a concern which would be dealt with.
- We asked five members of staff whether they received information about complaints and concerns. They told us that if a complaint or concern was raised, they were informed about them. They told us that lessons were learnt and were discussed with two-way feedback.

## Are urgent and emergency services well-led?

Outstanding



The leadership within the accident and emergency department was inspiring, with a shared purpose. The emergency department was led by operational and clinical managers, who were experienced and strived to deliver and motivate staff to succeed. Turnover of staff was minimal, and sickness levels were low.

There were comprehensive and successful leadership plans in place to ensure delivery, and to develop the embedded culture of collaboration and support across all areas, and a common focus on improving quality of care and patient experience.

We saw that governance and performance management were pro-actively monitored and reviewed, and they reflected best practice. The department worked with other organisations to improve care, tackle problems that inhibited progression, and used innovative approaches to gather feedback from people who use the services, to gain new and sustainable ways to provide emergency care.

We saw that all managers welcomed rigorous and constructive challenge, and there were consistently high levels of constructive engagement with staff. Staff told us about an open door policy with managers, and were actively encouraged to raise any concerns or to speak with a manager.

The staff we spoke with demonstrated an attitude of commitment, and told us that they enjoyed working in the emergency department.

We spoke with nurses, technicians, and reception staff, and junior and senior doctors, to find out about the

culture of the department. We saw that all staff enjoyed the culture. We were told it was a happy place to work. Staff were clear about their roles, and accountability was evident.

The department managers were aware of the challenges to identify and provide good quality care, and delivered it consistently, even at times of increased intensity and demand on the department.

## Vision and strategy for this service

- We spoke with seven members of staff who were knowledgeable on the trust's vision and journey. They were aware of the challenges and the priorities for the department.
- We observed that operational and clinical managers worked cohesively to achieve a positive shared purpose for department outcomes, which enhanced patient care and experience, whilst achieving performance targets.
- Information was available to all staff in different formats about the trust's vision and strategy, including via the trust newsletter, and electronically on the trust intranet. There was information provided on noticeboards near staff rooms, with updates on any changes or amendments to the department's priorities, and performance against those priorities. The information was relevant and up to date.
- The trust had a clear vision in the promotion of best practice across the emergency department and encouraged innovation from all staff. The innovation we saw in place was manageable and achievable, such as the work of the permanent rapid assessment teams and emergency therapy teams, to support correct discharges and admissions.
- The future vision of the department was embedded within all the team and owned by all members of staff. One member of staff told us "it is great working here, it's my family". Another member of staff told us "I moved here eight years ago from another trust, I have quite a drive to work but, I would not work anywhere else".

## Public and staff involvement and engagement

- Staff in the emergency department felt engaged outside of the department, and demonstrated awareness of the various initiatives taking place across the trust.

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- Some staff felt that they were listened to, such as when they made suggestions to the trust about how to improve the department. The management team took it on board and fed back to staff the outcome of decisions. Success was celebrated.
- The emergency department made phone calls to patients that had been discharged, to gain feedback and enquire if any service provision could be improved. There were opportunities for members of the public to get involved in the ED, and posters were displayed in the waiting room telling people how to get involved.
- There was a patient user forum. This meant that people could get actively engaged, so that their views were reflected in the planning and delivery of services provided within the emergency department.

## Governance, risk management and quality measurement

- Monthly departmental meetings were held within the management teams. We were provided with minutes of the previous meetings. We were provided with assurance that risks were well managed within the ED. Managers were aware of the risks identified, and there was a robust timeline of actions to address each risk. This meant that quality in risk management could be measured against trust-wide risks.
- There was a set agenda for each of these meetings, with certain standing items, such as incidents, complaints, risk, staffing and training.
- A quality dashboard was displayed within the emergency department. This was displayed for patients and relatives to see within the entrance area. This meant that both people who used the ED service and staff were informed and aware of the department's performance around the care being received or delivered.
- We spoke with staff about quality indicators, and there was a clear knowledge displayed, whereby staff were able to provide an example of a quality clinical indicator or a performance indicator. This meant that staff were aware if the clinical care provided was of a good quality and measurable against national figures.
- Up-to-date audit data was displayed in staff rooms and corridors for staff to clearly review.

- Risk areas such as consultant cover and mental health issues were being mitigated through the recruitment of long term locum consultants or through working with partnership organisations to ensure that services met the needs of people using the service.

## Leadership of service

- There was an evident departmental team which was respected. The leadership of the team was led by the senior nurses, and we saw that nursing teams were led by a band 7 sister/charge nurse, who had responsibility for shift management of staff, mentoring and development.
- Staff told us that they felt supported by the senior executive trust management team, and in particular, the chief executive officer, who was highly respected and often seen in the department supporting where required, and moving patients to wards. They told us that the nursing leadership in the department was excellent, and encouraged learning in an open environment, with no limitations of where an individual's pathway could develop, such as in management, clinical or both.
- When the ED was under pressure, the department received the support and leadership it needed from an ED and trust-wide perspective.
- During our inspection we saw that the departmental leadership was matured, and had the capability and experience to lead effectively.
- We were told, and we saw, that the capacity of the leadership was embedded, accepted and open to change. Staff told us that they trusted the ED and trust leadership.
- The lead nurse provided six hours out of each day, whereby they had an open door policy for staff to 'call in'. We saw this in practice, which facilitated issues to be dealt with in a timely manner, supporting staff with decisions, and did not allow problems to escalate.

## Innovation, learning and improvement

- We saw evidence of staff innovation on an individual and team basis that was put into practice and owned by the department, including the business plan around using bio-metrics to improve medicine management, and the IT integrated trigger tool via electronic tablets.
- We spoke with a senior manager within the trust about how lessons learned from incidents were disseminated across the trust. They told us that they would expect senior staff to pass this information to the rest of the

# Urgent and emergency services

team. There was a mechanism in place to check that this was happening. This meant that the culture centred on the needs and experience of people who use the services.

- Clinical leadership was evident by an experienced ED consultant and lead nurse, who both demonstrated to all staff an ethos of leading by example. We saw that the consultants and nurses were passionate about the department, and there was very much an open door policy in place throughout all disciplines.
- Junior doctors told us that they felt very much supported with their learning, and were given teaching time, with sessions taking place weekly in protected time. We looked at rotas that supported this.
- We saw that there were three bays within the resuscitation area that were not commissioned. However, the ED management team demonstrated some innovative ideas and plans to offer specific care bays within this area, with, for example, stroke services in a designated bay.







## Culture within the department

- All staff we spoke to told us that within the department, there was a sense of team working. They thought that

the team pulled together in difficult times and supported each other. Staff told us that they did not feel under pressure to meet targets and were made to feel that correct safe patient care was the priority.

- There were mechanisms in place to support staff other than formal routes with regards to stress management, such as informal approaches with the support of occupational health on health style and mentoring on a one-to-one basis. This meant that there was a strong emphasis on promoting the safety and wellbeing of staff.
- We spoke with staff of various grades within the departments in clinical and non-clinical roles, and they told us that the culture within the trust did encourage openness and honesty, and there was very much a 'no blame' culture.
- The culture within the department encouraged candour, openness and honesty. Complaints and concerns were not hidden, and were very much displayed for all to learn.

# Medical care (including older people's care)

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

## Information about the service

We visited medical wards and departments, including the cardiac centre, emergency admission units, and haematology unit. Specialties included general medicine, elderly care, cardiology, clinical haematology, oncology, and stroke care.

Wards visited were Claydon, Debenham, Grundisburgh, Haughley, Kirton, Shotley, Sproughton and Stradbroke. We also visited Bramford and Woodbridge Wards, which were allocated as escalation areas to manage seasonal pressures. Waveney Ward was the nurse-led reablement unit. We visited the acute admission area and assessment units, where admissions directly from GPs arrived in the hospital.

The number of admissions to the medical wards in 2013-14 was 40,190 patients.

During our inspection, we spoke with 53 staff in clinical areas, and another 102 staff in focus groups. We spoke with 20 patients, and 10 relatives or carers. We looked at 25 records of care and treatment.

## Summary of findings

Medical services protected patients from avoidable harm, and were effective, caring, responsive and well-led. There were systems in place to report and review incidents, and share learning across teams. Staffing levels had been reviewed, and nurse staffing had increased in some wards to support the complex needs of frail, elderly patients.

Clinical outcomes for patients were good, with better than national performance on length of stay and readmissions. Services were consultant-led with daily reviews undertaken by the multidisciplinary team to maintain patient progress and facilitate discharge. Written records were, on the whole, good. Patients were treated with dignity, compassion and respect, and were involved in planning their treatment.

There was continual pressure on the availability of beds; however, the hospital responded well to seasonal increases in activity. The trust had created flexibility through the provision of consultant-led escalation wards and appropriate staffing changes.

The trust were aware of areas that required improvement (Sproughton Ward), and managers and staff acted quickly to ensure patient were protected from avoidable harm where we identified issues that were at risk of affecting patient safety or dignity. This included a medical, nursing and pharmacy review of each patient on the ward and a review of the multidisciplinary team workforce on the ward.



# Medical care (including older people's care)

There were clear governance arrangements in place for all levels of staff. Staff felt supported and valued.

## Are medical care services safe?

Good



Medical services protected patients from avoidable harm. There was a system in place for staff to report incidents, and action was taken to improve practice and patient experience. We saw in ward meeting minutes that feedback was provided and guidance given to staff to improve safety. There were effective systems and processes to promote safe care. These included infection prevention and control, maintenance of equipment, and safe management of medicines.

There were systems to recognise and respond to any deterioration in a patient's health. Patient observations were monitored using an early warning score, with designated steps to follow, which ensured early intervention if the patient's condition changed. Safeguarding procedures were in place.

Staffing levels were set to meet expected patient needs on wards. This was supported by inducted bank and agency staff, in particular to enable the trust to provide care to patients in additional beds opened to manage seasonal pressures. Patient dependency had been reviewed, and the trust board were supporting phased increases in staff levels in medical wards. There was close working of operational managers and lead nurses with clinical teams to continually monitor workload. Major incident plans were in place.

### Incidents

- We saw that incident reports were completed appropriately as required. There was an online computer system used to report incidents, such as falls, pressure ulcers or accidents, and staff were able to demonstrate the process. We saw data showing that there had been 65 falls on medical wards from October to December 2014, where patients had some level of harm as a result. Only two of these were medium or high harm level where the patients' admission was extended by a week or more. This showed that incidents, even with low impact, were being reported and learnt from to improve outcomes and reduce harm. We saw that

# Medical care (including older people's care)

detailed Serious Incident reports and lessons learnt had been shared across ward areas, as staff in different wards were aware of high impact cases. We found that incidents were being graded appropriately.

- There were 23 falls reported on the Grundisburgh and Haughley Wards (the Constable Suite) for patients with complex care needs including people living with dementia; all these falls were low impact. We examined the audit records showing that the falls were judged to have no lasting effect on patient welfare.
- Senior nurses and staff in ward areas told us that governance meetings were held in ward areas each month to discuss incidents and risks across departments and directorates. Staff in ward areas told us that they were informed at ward meetings, and through newsletters and displays about incidents and any relevant learning points.
- Mortality and morbidity meetings were undertaken monthly for medical specialties. There were also multidisciplinary meetings held weekly, where any complications were discussed with all consultants and registrars. In cardiology, a visiting regional specialist was also in attendance at these meetings. We examined minutes of the meetings showing investigation into cases, and we saw that there had been clear communication to attendees of the lessons learnt. Reminders were provided to medical and nursing teams to improve the adherence to clinical guidelines and the following of policies.

## Safety Thermometer

- Safety Thermometer information was recorded continually for inpatients. This showed information about incidents such as falls, pressure ulcers, infections as a result of catheters, and venous thromboembolism (VTE) risk. VTE assessment and prophylaxis details were recorded in medication charts. We reviewed eight medication charts and saw that this had been completed. We saw ward minutes that recorded the performance on completing the checks and prophylaxis to remind staff of the importance. Minutes also included feedback to staff on the completeness of the assessments.
- There were clearly visible displays of performance information relating to safety (such as the number of falls or infections) and incidents in all medical wards. They were displayed for patients and visitors to view at the entrance to ward areas. Safety information was

displayed graphically in ward offices, so that staff could see at a glance the performance from Safety Thermometer information. We saw that this information was discussed at ward meetings with all staff and changes to practice implemented.

- We examined the safety reports for Debenham, Sproughton, Shotley, Somersham and Kirton Wards for November and December. Data showed very low numbers of pressure ulcers, and urine infections with catheters, across the two months. Only one fall resulted in moderate harm. This showed that the medical wards were maintaining a high level of safety monitoring, and harm to patients was being kept to a minimum.

## Cleanliness, infection control and hygiene

- The wards were clean, and adequate hand-washing facilities and alcohol gel were available throughout the areas visited.
- We saw that staff followed hand hygiene, 'bare below the elbow' guidance, and used protective equipment, such as gloves and aprons, when providing care.
- Ward areas undertook audits of compliance with hand-washing procedures to prevent and control infection. Senior staff from each area carried out the audits in each other's clinical areas. Hand-washing audits for medical division wards showed 100% compliance with procedures over the month of August and September 2014, except for Kirton Ward with 97% in September. Environmental audits identified minor cleaning omissions that were dealt with by reminding all staff or providing more regular housekeeping support where sickness had affected consistency.
- Reports were made on hospital infections and preventive measures for the medical areas, cardiology, respiratory, stroke care, diabetes, renal, neurology and the general care of elderly wards. There was a high level of screening of patients for MRSA, with all elective patients and over 97% of non-elective admissions screened in August and September 2014.
- There were few serious infections recorded. Only two *C. difficile* infections were found in patients in August and September 2014 in different cardiology wards.
- We checked the cleanliness of equipment in ward areas. Equipment was kept clean and ready for use. We observed ward staff cleaning dressing trolleys appropriately. Commodes looked visibly clean; As per



# Medical care (including older people's care)

the Trust decontamination policy and guidelines, commodes are upturned to indicate cleanliness and readiness for use. The Trust do not use stickers to demonstrate cleanliness.

## Environment and equipment

- There were adequate supplies of suitable equipment. We saw that profile beds, pressure relieving mattresses, or falls alarm equipment were available where required.
- The cardiac unit had ten beds with monitoring facilities, and it was possible, but not routine due to availability of equipment, for patients in other ward areas to have telemetry monitoring, so that cardiac specialist staff could provide support and advice.
- We saw that there was resuscitation equipment, available and accessible within the medical wards. We checked resuscitation equipment and trolleys. Equipment had been checked daily and tested, and we saw that checklists were up to date showing these regular checks.
- There had been risk assessments made by the resuscitation team about the need for emergency equipment in all areas. This had included the newly opened nurse-led reablement ward, where there was no resuscitation trolley, but this had been judged safe due to the medical fitness criteria for admission to the ward. In an emergency, staff had been instructed to collect emergency equipment from a ward on a floor below. We examined that equipment and saw that appropriate daily checks were made. In view of the condition of patients in this ward the risk was assessed as low, because these patients were medically fit to be discharged and only required additional arrangements or support before leaving the site. We saw that one patient had a chest infection and discussed this case with staff. There were clear protocols in place for assessment by medical teams and readmission through the emergency admission ward.

## Medicines

- Policies and procedures were accessible to staff on the trust's intranet, and staff were aware of the procedures to follow.
- We saw that medicines, including controlled drugs, were stored securely, and administered and recorded safely and appropriately in medical ward areas. All medication

cupboards and fluid stores were behind locked doors. We saw that nursing and medical staff accessed the areas using their security badge. Medication fridges were monitored for appropriate temperatures.

- We saw that medication rounds by staff were efficient and supportive of patients. We spoke with two patients with diabetes. Both patients told us that they had been in the hospital for several days and their insulin had been provided at the right time given their condition.
- Medicine charts we reviewed had no omissions without clear reason for non-administration. Ward managers told us of checks at each medication round. Incident reports were made if omissions occurred without explanation on the chart.
- Medication omissions were reviewed by the pharmacy team, including the medication safety officer and senior nursing staff. A display reminded staff in each ward area how well they were performing on this issue. Data provided by the trust showed 13 missed doses on medical wards in November 2014. We saw records that each case had been investigated and followed up to ensure learning for individual staff and teams.

## Records

- We examined 25 records of patient care. We found initial general risk assessment had been completed in all these records on admission. Specific risk assessments were completed for pressure ulcers, falls risk, bed rails risk, and nutrition. We saw that risk assessments were reviewed if the patient had a change of condition, or had been in hospital for more than a week. An example of review included that in records for one patient on Kirton Ward we saw that the pressure ulcer risk had been reviewed on 30 December, 7 January and 10 January, with relevant notes about discussions by the multidisciplinary team and actions to protect the patient. We spoke with relatives of this patient, who said that they were happy with the care and felt there had been good communication with them.
- We saw that regular observations and early warning scores were completed as needed, to monitor a patient's condition. We also found that intentional rounding checks were well recorded. These charts show that patients received regular scheduled checks, such as two hourly, by staff to ensure the patient was safe and comfortable. Staff told us, and we saw, that they also checked on patients between these times to promote a safe environment.

# Medical care (including older people's care)

- In Sproughton Ward we saw that some documentation was not fully completed. One patient, who was at high risk of pressure ulcers, had had an assessment of the risk but no clear plan of care was initially available to show the inspectors. It was made available during the inspection. We saw that staff had changed the patient's position, and were using barrier cream to protect the skin. We were concerned that this meant that care was being provided, but there was a risk that unfamiliar staff, such as an agency staff member, may not be clear of the care required. However staff told us that information on patients with high risks was also provided to the team at handover, which was undertaken on commencement of each shift. We attended a handover and saw that this was the case. Tissue viability specialist staff were available to support ward teams and we saw these were present in ward areas checking patients assessed at risk of pressure ulcer development.
- There were also gaps in documentation in Sproughton Ward noted by the end of life core service inspection team in respect of medication prescribed, whilst this did not affect the care given to the patient we notified this issue to senior managers. Trust managers acted immediately to review the care records, plans, and the care being implemented in the ward. When we revisited the ward, we found appropriate documentation was in place. We examined records for a patient with a high risk of falls, and found detailed assessment, plan of care and appropriate reassessment of risk after a minor fall. The patient was nursed in a high observation area, and bed rails were being used after appropriate risk assessment.

## Safeguarding

- We asked staff in medical departments about safeguarding procedures. Staff knew how to raise any concerns regarding vulnerable adults, and they told us that they had received feedback from concerns they had raised in discussion at ward meetings.
- Staff followed reporting procedures for the safeguarding of patients. Staff showed us safeguarding policies and procedures available on the computers in medical ward areas. The safeguarding lead for the trust advised that there had been two referrals between October and December on different medical wards. Staff also raised concerns about care in the community for six patients in this period.
- We saw that most staff had received safeguarding training with 89% of staff attending safeguarding adults

training and 95% receiving level 1 children's safeguarding training. Level two and level three safeguarding training had 90% and 97% compliance rates.

## Mandatory training

- Staff in medical wards told us that they had good access to mandatory training, and this was monitored by the ward managers.
- The medical division had a mandatory training rate in June to October 2014 of 89%, against a target of 95%. Although this was a high performance, the issue was noted on the risk register to continue monitoring related to staff competence in their roles.

## Assessing and responding to patient risk

- There was a clear policy for staff to follow in monitoring patients conditions, and to use an early warning scoring tool to identify any deterioration of condition. The policy included clear instruction as to the communication and escalation. We saw that early warning scores were completed comprehensively in all medical ward areas. Staff told us that there were clear structures to follow so that communication about patients was effective and accurate, and action was taken where needed.
- The critical care outreach team were easily accessed by ward staff to gain help for deteriorating patients. Staff also told us that consultant advice or review was also easily accessed when needed.
- For technical procedures in the cardiac unit, a safety checklist was undertaken with all staff in the team before commencing to reduce patient risk. This followed the format of the nationally-recognised WHO (World Health Organization) checklist, and included equipment, procedure and patient medical history.
- We examined 25 clinical notes in ward areas. There were standard broad risk assessment tools completed on admission. This was followed by use of specific tools for pressure ulcer risk, moving and handling, and bed rails risk, nutrition, falls, and dementia screening. The risk of blood clotting was noted on medication charts. These were included in an assessment booklet which different professional and care staff could use.

## Nursing staffing

- Nurse staffing levels in all ward areas were reviewed in April 2014, and progress against the agreed plan was reviewed by the trust board in December 2014.

# Medical care (including older people's care)

- The trust had reviewed detailed staffing levels in all areas using safer staffing tools, and a phased plan for increases was being implemented. The trust board had, for example, approved night staff increases in complex needs wards in 2014. Four additional nursing staff had been allocated from January to July 2014 to the Constable Suite for patients with complex needs, given the assessment of workload and safe staffing levels in that ward.
- The plan included recruitment of registered nursing staff from non acute sectors and from overseas by December 2014.
- Bank and agency staff were block-booked to support the opening of additional beds and to support staffing generally whilst recruitment was on going. Staffing levels were reviewed each day by senior nursing staff as part of the operational team reviewing workload continually throughout the day, as requests for help were received into the operations centre.
- Additional nurses had been added to the team in cardiology to ensure safe support for the technical work and procedures in that unit. These additional staff had been introduced as a result of a business case made in 2014.

## Medical staffing

- In the cardiac unit there was consultant cover 24 hours for seven days a week, provided by seven consultants. This meant that all patients were seen every day by a consultant, to review their progress.
- There were two junior doctors on at night to cover medical wards. With the support of a medical registrar, two junior doctors provide medical cover for approximately 350 medical beds at the peak of escalation. Doctors told us that they usually got off work on time at the end of the day, as systems of handover and cover were well established and effective.
- Clinical decisions in medical ward areas were led by a consultant allocated for that area. This meant that patients did not have to wait for different ward rounds. There was a daily review of care, with a consultant leading the multidisciplinary team.
- All GP telephone referrals were assessed by a consultant as appropriate for admission given the information provided. There was consultant attendance in the emergency admission areas through the day (9am to 9.30pm), with a dedicated registrar and two junior

doctors overnight. This meant that all patients were seen on admission by a senior doctor, who could judge the need for admission, and make an immediate plan of the care and treatment.

## Major incident awareness and training

- Staff were aware that the trust had a major incident procedure in place, which was accessed via the intranet. We reviewed these plans and saw that there were general action cards for ward areas giving broad guidance on how to prepare the wards and what communication lines would be set up.
- Staff were able to show us the up-to-date list of ward staff contact numbers that each would use to request urgent attendance from staff off-duty.
- All major incident procedures and action cards were dated 2009 and for review in 2010. However, the guidance was sufficiently broad that it remained a useful guide to all staff.

## Are medical care services effective?

Good



Patients received care and treatment based on best available national evidence-based standards and guidelines. Staff received regular relevant training and appraisal.

There was a good multidisciplinary approach to care and treatment in the medical directorate, to assess, co-ordinate and plan care. Patients were involved and supported to make decisions about their care and treatment.

Effective and consistent levels of care and treatment were available 24 hours a day, seven days a week.

## Evidence-based care and treatment

- Cardiology teams used integrated care pathways for care of patients having angiograms, percutaneous coronary intervention, angioplasty, and permanent pacemaker insertion, to provide continuity of care.
- Policies were based on NICE guidelines where relevant. We saw that the guidelines were available on the intranet for cardiac conditions such as heart failure, myocardial infarction, fibrillations and arrhythmias, for staff to refer to.

# Medical care (including older people's care)

- We found that clinical guidelines on the intranet were organised inconsistently. Some junior doctors, when asked, were unable to find specific guidelines.
- Specialist heart failure (HF) treatment pathways were written for patients assessed by specialist staff using a recognised trigger of the B-Type Natriuretic Peptide (BNP) blood test result. This meant that modern diagnostic tests were being used to plan appropriate treatment. All new referrals to the HF service were seen by a specialist consultant.
- There was a cardiology heart failure clinic and rehabilitation service. Rehabilitation was offered to patients with heart failure, along with those recovering from other cardiac conditions.
- We saw that patients with diabetes had specific additional documentation to guide staff in appropriate care and assessment. Diabetes pathways, which included peripheral sensitivity tests, had meant a reduction in heel ulceration. Trust data showed a 68% reduction in hospital-acquired heel pressure ulcers.
- Wireless connection of point of care blood sugar testing enabled specialists to identify patients at risk of hypoglycaemia. There was a diabetes specialist nurse supporting ward areas seven days a week. Trust data showed 98% of such patients were seen by a specialist on the same day that the risk was identified. In addition, the monitoring has shown a key risk overnight, and the trust had implemented evening snacks for diabetic patients to further protect against the risk.
- We found that audits of ventilation support for patients in acute respiratory failure had been undertaken in line with British Thoracic Society's Non-Invasive Ventilation audit in 2013. Comparison of care showed that, whilst the results were generally positive, improvements would be possible through improved prescribing of the ventilation, and better correlation with blood gas results. This meant that services were reviewed and improvements made to patient care. We did not review current outcomes, but saw that improved documents had been implemented following the audit.

## Pain relief

- We saw that staff asked patients about levels of pain, and recorded this regularly in observation charts. We examined 25 patient case notes, and saw that there was attention to detail in assessment of patients pain, and recording of the patients perception during intentional rounding or checks on patients comfort.

- Patients told us that they were always asked about pain during medication administration rounds. We examined prescription charts, and saw that as required, medication was prescribed for pain where appropriate.

## Nutrition and hydration

- We saw that patients were offered meals appropriate to their needs. Relevant diet information was coded on boards behind the patient's bed. This meant that clinical and non clinical staff could see at a glance any specific patient requirements, such as if a patient was diabetic, or on a fluids-only regime.
- We saw in patient care records that MUST nutritional risk assessments (using the Malnutrition Universal Screening Tool) had been completed; however, this was inconsistent. In the trust's audit of completion and effectiveness of MUST screening in November 2014, 8% of patients were not screened. The rescreening for patients who were initially found to be at risk was not always completed, and the patient's weight and height were not always measured or recorded accurately. Recommendations were made following the audit; however, staff in ward areas were unaware and did not mention that they were trying to improve this performance.
- Where patients were on fluid record charts, we saw that these were kept up to date by staff.
- Patients had access to drinks at meal time and other periods in the day. We saw that patients in all areas had access to water in jugs at the bedside. We noted that staff ensured that they left drinks within reach after talking with the patient or providing care. We observed ward hostess staff providing drinks and additional food as requested by patients in medical wards, the complex care suite, and the nurse-led enablement ward.
- Where appropriate, patients in the stroke care ward were supported to take fluids through a nasogastric (NG) tube. When medical staff or speech therapy staff were not available, a swallowing test and placement of the NG tube was performed by the experienced nursing staff, who were tested competent for these skills. This meant that once the position of the NG tube was confirmed, the patient could be hydrated effectively without intravenous fluids, thus promoting recovery by maintaining good hydration.

# Medical care (including older people's care)

- In Waveney Ward we observed a patient being supported to eat their meal. The staff member allowed time for the meal, there was good interaction and eye contact with the patient, and drink was also offered appropriately.

## Patient outcomes

- Readmission rates were better than the England average. The hospital episode statistics for 2013-14 on Standardised Relative Risk of Readmission indicates how services compare nationally in providing care that is effective, such that patients recover and do not require a return visit to hospital. The rate was less than the England average for all medical service specialties at Ipswich Hospital, indicating effective care. The statistics showed that 91% of patients who were expected to be readmitted, as compared nationally, actually had emergency readmissions in general medical service. This was a positive result showing effective care and discharge.
- Stroke national audit information, the SSNAP survey, showed that the trust improved performance from December 2013 to June 2014 on most indicators, including timely thrombolysis, scanning, and provision of therapy. The overall trust grade for April to June 2014 was B, on a scale of A to E, with A being the best.
- In SSNAP data, the provision of speech and language therapy (SLT) was showing red on the national report, which reflected the performance nationally. Most trusts were graded E (the worst of five grades), from October 2013 to March 2014 for the SLT aspect of stroke care. We asked staff on the stroke unit about provision of SLT for patients. This service was provided from the community service provider, and staffing difficulties have led to reduced performance. Staff informed us that the trust was considering employing therapy staff internally, to secure early assessment and support for patients particularly recovering from stroke. We saw that this risk and plans had been discussed in stroke service monthly meetings as an ongoing issue.
- We reviewed three care plans of patients in the stroke ward, and saw that SLT assessment had been made within 24 hours of admission, and regular visits had been made to provide speech therapy. Two patients told us that they were having good support from therapists, and knew what exercises they could take to

aid recovery. One patient in the stroke ward told us that staff in all departments following his emergency admission had worked quickly and effectively, and this had saved his life.

- Information from MINAP, the Myocardial Ischaemia National Audit Project, March 2013, showed that the trust scored about the same or better than the national average on two of the three measures it participated in. Percutaneous coronary intervention, to treat patients with blockage of blood vessels in the heart, had been a service provided in Ipswich for ten months prior to our inspection. The performance was likely to be improved since data in March 2013, due to the setting up of the cardiac centre and this angioplasty service, but we did not have performance data to evidence this.
- National lung cancer audit data from 2012 showed that the hospital performed better than the England and Wales average for patients being discussed at MDT meetings; and slightly worse than the England and Wales average for patients having a CT prior to bronchoscopy.

## Competent staff

- Staff told us that they had appraisal meetings with managers to review training needs and performance. We spoke with ward managers who were able to identify the appraisals that were due for the month.
- Specialist clinical staff provided support to medical wards and departments. Staff were, for example, provided with advice and training on diabetes and diabetic ketoacidosis, management of pressure ulcers, and the support of patients with learning disability or living with dementia.
- Nurse recruitment had taken place, with staff appointed from abroad, and registered nurses also recruited from nursing homes. These staff required additional support to integrate into the teams and work safely within the policies and procedures expected. The staff had training and induction, and then a four week supernumerary period attached to one ward area.
- We saw that there was an induction checklist used when agency staff joined ward teams. This included emergency equipment location, reporting of incidents, and infection control procedures. We spoke with agency staff who stated that they had been given an induction to the ward area and equipment, the arrangements for fire or clinical emergency, and clear handover of the patients they were caring for.



# Medical care (including older people's care)

- In the Constable Suite wards, for care of patients with complex needs, 80% of staff had additional training in supporting patients with dementia.
- All nurses in cardiology were trained in advanced life support procedures. Nurses in other areas told us that they had life support training, and access to advanced training.
- Junior medical staff working in the medical directorate said they had time to attend different aspects of the service to broaden their experience and learning. A doctor based in the cardiac ward told us that they were able to find time to observe cardioversion or angioplasty. At a focus group of 26 medical staff, we were told that doctors had good learning experience in the hospital, with approachable supportive consultants, leave to attend training, and opportunities to experience a broad range of clinical work due to the busy workload of the hospital.

## Multidisciplinary working

- We saw regular consultant-led multidisciplinary meetings or rounds in clinical areas. Patients were reviewed daily in ward areas, with action being taken to progress care. In most areas, there was an identified consultant responsible for the care of patients. In ward areas with more than one specialty, we saw that patients were still reviewed each day.
- Multidisciplinary rounds in ward areas included nursing and medical staff, with therapy staff in attendance when available. We saw that each ward manager had systems for recording decisions made, such as communication books and patient flow sheets. In case notes we examined there were records made of decisions at ward rounds and the current plan of care for the patient.
- We observed a ward round, which the team attended promptly at 9am. This was led by a consultant and a ward sister. Each patient's treatment was discussed, including medical, nursing and therapy support. There was identification of patients ready for discharge and the arrangements required. Patients were then spoken to in turn, commencing with those ready for discharge so that preparations could be made.
- There were weekly MDT meetings in cardiology and for the heart failure service, which were attended by a visiting regional specialist to facilitate referrals and transfers. We examined documents which showed

discussions about specific cases and agreed plans of care. Cardiac consultants told us that there was effective collaboration to support patients by cardiology, neurology and renal clinical specialists.

## Seven-day services

- Consultant medical staff provided a seven day service across the medical directorate. This meant that patients were reviewed each day, and admission reviews and discharges could be facilitated through weekends. In the GP admission area and short stay wards there were two consultants each day to make early review and plan admission where needed. A third consultant accepted calls about patients for admission to reduce admission levels if possible. This senior level overview allowed for admission prevention where possible, and early planning of care to reduce the length of hospital stay. In addition, there were dementia specialist staff each day to assess patients with complex needs, in order to support arrangements for discharge where possible.
- There were two junior doctors on at night to cover medical wards. With the support of a medical registrar, they provided medical cover for 400 patients and admission areas. Junior doctors told us that there was support at night from outreach specialist staff from intensive care, and a hospital at night team, which included clinical technicians, but not nurse practitioners. Clinical support technicians undertook tasks such as cannulation and ECG cardiac tests to relieve pressure on other clinical staff. We examined rotas showing that there were two technicians on shifts, including through the night.
- There was a seven day a week cardiology service, which meets the national requirements of a cardiac unit. The seven day service meant prompt review of patients attending any day of the week, and it had reduced length of stay for such patients.
- Routine CT (computerised tomography) scanning and ultrasound services were provided at weekends. This enabled diagnosis when patients required these imaging diagnostic tests, and so maintained the progress of care towards discharge.

## Access to information

- The trust operated a computer-based information system, which had been introduced approximately eighteen months ago. Staff in medical wards told us that the computer system was slow at times, and there were many passwords to access the various applications.

# Medical care (including older people's care)

Junior medical staff told us that there may be delays in ordering blood tests or preparing discharge letters as administration details for patients had to be entered onto a patient record system before the other systems could be used. Doctors said that it may take them up to 20 minutes to complete discharge information on the computer, and they may be doing this up to ten times a day.

- Staff knowledge of the computer system was not embedded in all areas. There were two systems in place, one specifically for discharge, and not all staff were aware of how to track a patient through the hospital. A relative told us about a problem of not knowing where a patient had been moved to. When we asked on one ward, nursing staff present at the time did not know how to access the tracking system, as they were new in post or were agency staff. Therapy staff visiting the ward did know how to use the system.
- Junior medical staff in a focus group said that the system did not always have up-to-date tracking, and so this sometimes led to difficulties finding their patients. This could occur because, when a patient is transferred between wards, there can be a delay in the IT system logging the change. Managers told us that staff were able to contact the operations centre for an update on the live tracking of patients as this was also recorded manually and therefore the risk of losing a patient within the hospital was mitigated. During the summer months there had only been at most 12 outliers however during the winter this number had increased.
- We saw that in the clinical areas, there was good access to computer terminals, and this enabled the different members of the multidisciplinary team to search for or enter data when needed. This included clinical guidelines and protocols, along with the operational systems, such as ordering tests or referrals to other professionals.
- Clinical leads and managers for clinical areas had portable tablet computers enabling access to information as they provided support across the hospital site. Consultant medical staff told us that this was a significant improvement, enabling more rapid access to patient and management information.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

- We observed staff providing care for patients. Staff sought consent before commencing care or treatment.

Patients confirmed that staff were polite, and always asked before providing care. We examined care records for 25 patients in medical wards. Consent was noted by therapy staff when recording episodes of therapy in ward or gym areas. We saw that nursing records about the care provided on shift did not state that consent was requested

- We saw that documents were in place for consent to diagnostic scans and interventions. These were completed appropriately to show that patients understood the procedure and relevant risks.
- We asked in wards about Deprivation of Liberty Safeguards (DoLS). Staff understood the safeguards and were able to identify if any patients in their ward had DoLS in place or were living with dementia. Staff were also aware of patients who may have a temporary or permanent lack of capacity and what to do in these situations.

## Are medical care services caring?

Good



Patients and their relatives or carers gave positive reports about the care and support they had received. Staff involved patients and their relatives in decisions about their care. We saw that staff responded to anxiety or distress with compassion, and offered emotional support. The friends and family tests results were generally positive for the medical service.

## Compassionate care

- Friends and Family Test survey results showed that in September 2014, over 80% of patients would recommend the care on medical wards to friends and family. There had been poor results from the Friends and Family Test survey of patients on Debenham and Sproughton Wards, the results were 45% and 62% respectively, although the return rate was only 15% on Sproughton Ward. The trust had recognised this reduction in patient satisfaction, and had implemented additional ward manager rounds to improve communication with patients and visitors.
- Staff consistently provided care in a kind, respectful and considerate way. We observed staff providing

# Medical care (including older people's care)

compassionate care in all medical ward areas. One relative told us that staff treated the patients with “respect and dignity”. A patient in the stroke ward told us that staff provided “brilliant care”.

- In other wards we saw that patients were cared for in ways appropriate to their needs. Patients with dementia were cared for with compassion and understanding. We saw patients being guided to ensure safety, but allowing the patients choice and support in their activity.
- In all ward areas we saw staff pulling curtains around each patient's bay and closing doors to rooms to maintain patient's privacy and dignity.
- On Sproughton Ward we spoke with two relatives, who said that some nurses had not been as caring as they would expect. One relative felt that they had been curtly addressed, and had been told that the staff were busy when they rang the call bell for assistance in changing the bed. The ward manager and trust management were aware of problems on the ward, and provided an action plan that was in place to improve care. Staff had been provided with training and guidance from specialist nurses, and supervision by the ward managers, to ensure basic care, such as position changes and mouth care.

## Understanding and involvement of patients and those close to them.

- We heard medical and nursing staff in all clinical areas explaining care and treatment options to patients and relatives or carers. Patients were asked routinely if they agreed to being cared for, or to specific treatment being undertaken. We observed a consultant provide reassurance about test results, and explanation of potential procedure to an anxious patient after a ward round.
- We observed a consultant ward round; staff had an excellent manner with patients, giving good reassurance and information. There was a good response to any concerns from the patients. We saw that privacy and dignity was maintained throughout, and that language used was appropriate to the patients understanding. We saw that a nurse stayed with the patient to ensure understanding and answer any further questions.
- We saw that staff recorded consent to treatment in clinical notes. This was more rigorously recorded by therapy staff than by nursing and medical staff; however, nursing care was provided at many points after the nurses introduced themselves for the shift.

- A patient in the cardiac unit said that they were anxious, but felt well cared for, and everything had been explained by the consultant.
- A patient had commented, in a returned questionnaire about the heart centre that the pre-assessment enabled them to cope better with treatment. Two patients said that there was “excellent attention to detail” by staff in the heart centre. Other patients commented about good information and reassurance by staff.
- A relative in the Constable Suite, where patients with complex conditions, including dementia, were cared for, said that staff helped patients to maintain independence and that the care was “marvellous”.
- One patient in the stroke ward told us that they understood the nature of the bleed that had caused the stroke; they had been given clear guidance about how to practice to improve speech after the stroke.

## Emotional support

- We observed staff in the Constable Suite supporting patients who were confused to return to the area they wished to with compassion and understanding. Language used was appropriate for the age and the level of confusion of the patient, and further promoted the independence of the patient.
- Patients had commented in returned questionnaires about the heart centre that “care, patience and reassurance provided by staff was fantastic”.
- In all ward areas we saw that staff spent time in the bed bays, and spoke with patients freely. Staff made eye contact with patients, and went to the bedside to allow patients the chance to communicate their needs. Patients were informed of which member of staff was their main carer for the shift. For some patients, there was a reminder note left on the bedside table, of the relevant staff name.
- We saw that patients with a learning disability, or complex care needs, including dementia, were given extra support to promote communication, such as flash cards.
- We visited the oncology unit, which had at the entrance, a prominent cancer information centre. This meant that patient's relatives or carers could ask for information or support, and talk with staff about the effects of their illness.



# Medical care (including older people's care)

- Staff in wards for patients with complex needs were aware of the negative effects of overstimulation for people with confusion due to dementia. We observed that voices were kept low to minimise noise levels.

## Are medical care services responsive?

Good



The medical service was responsive to the individual needs of patients using the service. The trust had effectively planned and reorganised facilities and staffing arrangements to respond to a daily increase of up to 16% more admissions than usual in the winter period. Systems to manage admissions, discharges and peaks of workload were effective. Patient safety and satisfaction were also considered, as patients were placed in wards with appropriately skilled staff. Systems and processes were in place to receive, review and learn from complaints and compliments.

## Service planning and delivery to meet the needs of local people

- Trust managers and staff had made significant changes to ways of working, and the use of wards and departments, to prepare for seasonal pressures. Additional beds for medical and elderly patients had been allocated in escalation wards. There were clear protocols for the admission to these beds. This was to ensure efficient and safe use, and to maintain a flow through the hospital, and continue to discharge as early as was safe for patients. There was effective clinical management of admissions through assessment units and short stay areas, and discharge was promoted in all medical ward areas through daily reviews of the progress of care.
- Seasonal pressure or escalation beds had also been created in other wards areas. For example, a clinical treatment unit had been moved to open 28 beds on Woodbridge Ward. We found that medical cover was well organised in the escalation wards, with a consultant visiting each day to assess and plan care with the multidisciplinary team. This daily review meant that patients' progress towards discharge was facilitated by timely treatment and support.
- Experienced ward managers had been allocated to the escalation wards. Medical staff had been transferred to

different specialities, where this was required to support additional seasonal pressure of work. Surgical junior doctors had been moved temporarily to support the respiratory medicine team. Therapy staff told us that they prioritised the assessment of people admitted, to plan rehabilitation support early in the admission. We saw in the morning, on Bramford Ward that therapy staff were assessing patients who had been admitted with a risk of falls the previous night. We saw that support services, such as catering and cleaning, were arranged to ensure patient care was efficient and safe.

- Staff in medical wards and departments told us that they were confident in the efficient working of other professional staff and services. They said, for example, that pharmacy, dietetics, diagnostic and radiology services promoted efficient and effective care for patients by providing a responsive service. We saw that therapy staff, such as physiotherapists and occupational therapists, were considered a key part of the ward teams, being present for rounds to review patient care, and recording informative notes about the therapy support for patients.
- Angioplasty procedures were available to treat heart attacks, which meant that patients received treatment faster and closer to home than if they had to transfer out of the county.
- During the inspection, we advised trust managers of continued issues on Sproughton Ward, such as the perception by patients and relatives of problems with staff attitude; the arrangements in the ward were reviewed, and action was taken directly to support staff in providing a caring service.

## Access and flow

- We reviewed national statistics for length of stay, and saw that it was better than the England average for all medical specialities, except clinical haematology. This meant that the medical service was timely and efficient in treating patients and enabling discharge. The length of stay (LOS) in 2013-14 for general medical patients was 6 days compared to national average of 6.4 days. In elderly medicine, the LOS was 4.9 days compared to 9.8 nationally.
- The medical service was achieving the target of treating patients within 18 weeks of referral for all medical specialties. The rate was over 96% for all specialties.

# Medical care (including older people's care)

- There were high numbers of admissions in the week prior to our visit, with admissions increased by approximately 16%. The trust had forward planned for such seasonal pressures.
  - The trust had systems in place to promote discharge, and there was a focus on reducing the length of stay. There were discharge co-ordinator staff in clinical specialty areas who, alongside the post-acute care team, supported the timely effective discharge of patients, especially for patients with complex needs.
  - In most medical ward areas, there was a daily consultant ward round, reviewing patient care and plans, and working with the multidisciplinary team, including discharge co-ordinators. We saw that operational management staff worked closely with clinical team leads. Meetings were held regularly throughout the day to monitor the flow of patients and allocate staff resources as required.
  - The medical service aimed to keep the number of medical outliers to a minimum, but to ensure that such patients were reviewed by consultants regularly. In the assessment unit and short stay wards, consultant physicians decided on the appropriate medical team and ward for admission. This was dependent on bed availability, and we were told that for example, on Stradbroke Ward, for longer stay surgical and gastroenterology patients, there were 20 medical beds.
  - Clinicians and operational managers decided on admission as a preference to either the consultant's base ward or a suitable escalation ward. This reduced the number of bed moves during patient stay.
  - The trust had worked with local commissioners of service to open Waveney Ward, where patients were cared for by a nursing team. This was with support twice a week, or as required, from medical staff. This ward was for patients ready for discharge, but requiring reablement support, and to make social arrangements or provide therapy support prior to discharge. This meant that such patients were not blocking beds while final arrangements were made to facilitate discharge.
- Meeting people's individual needs**
- The trust had developed an excellent environment in the Constable Suite to support patients living with dementia and with complex needs. The layout and décor of the suite was visually striking. There were visual prompts for direction, and colours were used to promote independence. We saw that staff in the suite provided support which recognised any confusion or anxiety of the patient, but also enabled independence through offering choice with guidance. There were clear displays of the team and staff on duty to inform patients and visitors as to who was providing care.
  - The trust patient record system had an alert facility that informed staff on admission, of the patients' additional needs due to dementia or to patients with a learning disability.
  - Staff in ward areas were able to show us their contacts for arranging language translators for when this might be required to support patient care.
  - One relative noted that the hospital television system was not easy to use for patients with dementia. They also stated that the daily charge meant that some patients and families decided not to use the system, although they considered that television could provide some familiarity and stimulation for patients living with dementia.
  - We found that a patient with a learning disability, who was being nursed in bed, was cared for appropriately, with dignity and respect. The patient showed that they were happy with a 'thumbs up' to the nurse and the inspector, after being helped with a wash and change of position. Visual aids were close at hand for the patient to use in order to communicate their needs. Staff knew about the learning disability specialist nurse, and that all patients with learning disability were notified to the specialist. This meant that patients' needs were assessed, and any adaptations or support put in place.
  - In the nurse-led reablement ward, although patients had been discharged administratively to the care of the nursing team, patients were also able to access care from other nurse specialists, as on the other inpatient areas. We saw that a palliative care specialist nurse had responded to provide advice and support to a patient.
  - The trust had improved the nephrology and diabetes service, so that reviews and care could be provided when people need the service. The renal unit and diabetes specialist nurses provide care and support respectively, seven days a week.
  - We saw that equipment, such as beds and chairs for patients who were overweight, was available to ensure safety for the patient and staff.
  - There were displays of information about uniform colours in all ward areas to enable patients to

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understand the roles of staff according to the colour of their uniform. We saw that identification badge lanyards also clearly indicated to patients and visitors each staff member's role.

## Learning from complaints and concerns

- There were clear leaflets available in all areas so that patients and visitors could make comments or complaints to the Patient Advice and Liaison Service, or the hospital complaints service.
- Staff in ward areas showed us the reports from Friends and Family Tests. The results were shared with staff and displayed in office areas. This meant that staff were aware of the feedback from the survey. One nurse told us that their ward had feedback from patients about slow response to call bells and other waits in hospital. As a result, the ward manager was making additional checks with patients to assess satisfaction with the service.
- We saw that senior managers responded quickly to complaints, and acted, where required, to improve the care and treatment provided. This also included talking with other patients in that part of the service, to identify any wider problems and assess overall service quality.

## Are medical care services well-led?

Good



Leadership and management of the medical directorate focused on the delivery of efficient, high-quality, person-centred care. There was a positive culture, with a strong team ethos, and good relationships between professional staff and managers. All staff groups worked together to ensure effective working. This meant that significant service changes were possible to meet seasonal activity pressures or implement service developments and improvements. The service was aware of the issues on Sproughton ward and during our inspection the trust managers reviewed the care provided and the multidisciplinary team workforce on the ward. Staff from other areas of the medical service volunteered to work on the ward to ensure that services met the needs of patients on the ward.

## Vision and strategy for this service

- Many staff told us that they felt able to approach the chief executive and other managers leading the services. They said that there was good personal support from management in the clinical areas.
- All staff in medical wards told us that it was a busy working environment, but acknowledged the focus on patient safety and high quality of care. This matched the stated vision and values for the trust.
- We saw that professional clinical staff at all levels, and managers, worked flexibly together to ensure safe patient care was provided, and a flow maintained of patients through the service to manage the seasonal increase in activity.

## Governance, risk management and quality measurement

- Operational managers and senior clinical staff held meetings throughout each day to monitor the safe provision of the service. Meetings to manage the bed availability, and place patients requiring admission, also included consideration of risk for individual patients, and the staff resource available to provide care. Staff vacancies and sickness were managed at ward level, but information and requests for support were passed to lead nurses for discussion at the operations meetings through the day. This enabled bank and agency requests to be allocated according to live assessment of risk on the day.
- All staff were involved in the governance framework. There were governance meetings at different levels in the trust. Ward teams discussed risk and incident information, and were informed of learnings from across the trust. We saw newsletters and performance displays in each ward area, so that staff knew the quality indicators for their area of work. Ward meeting minutes showed the discussions with teams about incidents, quality of care and patient feedback. We heard from staff in different wards that they had increased the focus on checking patients, following a fall that had occurred between scheduled checks.
- Senior nurses and nurse specialists met at monthly governance meetings to discuss risk, incident and audit findings, and to share learning between wards and directorates. Senior nurses discussed trends in incidents and learning at the monthly nursing and midwifery board, such as clusters of falls and any resulting harm to patients.

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- Complaints were all seen by the chief executive, and also discussed at the nursing and midwifery board meeting to share learning across the nursing teams.
- Following the raising of our concerns on Sproughton ward the trust acted immediately to mitigate any perceived risk to patient care. A full review of medical and nursing care was undertaken for every patient and any gaps in care addressed immediately.

## Leadership of service

- Consultant staff reported that they were supportive of senior hospital management, including the medical lead for the trust. In a focus group with 64 consultants, there was agreement that the management were very well engaged with clinicians. This had meant key initiatives, such as seasonal pressure service changes, were developed with the involvement of all staff.
- In a focus group of 26 medical staff, we were told that the consultant body in the hospital listens to the views of more junior doctors, and that they were approachable and supportive.
- Senior clinicians told us that the community diabetes and respiratory services were implemented effectively, due to close effective working with trust executive and operational managers. In a large group of consultants, they said that in the past, such proposals had not been successful due to lack of engagement.
- In clinical areas we saw that ward managers and consultant staff were visible, and closely involved in day-to-day management of care and services. There was support from senior clinicians seven days a week to the teams in the medical directorate, and close working with operational leads for the hospital.
- In one ward, a nurse who had joined the service recently from abroad, explained that they had felt they had been welcomed to the trust, including personally by the chief executive. They considered that there was much better teamwork evident, when compared with working in their home country.

## Culture within the service

- Staff in ward areas told us that they were confident that they could raise any issues about welfare of patients or staff, and that managers would be positive about trying to improve the service.
- We spoke with staff about moving patients between ward areas to gain a view on team working. Staff at all levels recognised the importance of placing patients in appropriate wards, but also that the hospital was working as a whole to manage the increase in patient demand, and that this meant some transfers to make best use of the beds and staff available.
- Staff felt valued in their role, and told us they recognised their responsibilities in the team. Nursing staff, speaking with us about discharge arrangements, recognised the role played by medical staff, therapy staff, pharmacy services, and the importance of effective records and communication.
- Following the management review of the multidisciplinary team workforce on Sproughton ward staff from other areas of the service volunteered to work on this ward to ensure that patients received the best possible care through the use of experienced and skilled nursing staff.







## Public and staff engagement

- We saw that the trust board monitored the support and inclusion of carers in the service to patients. In a survey of carers in July 2014, 90% of carers of patients with dementia responded that they felt involved in their care, and 100% were happy to leave their relative in the care of the hospital.

## Innovation, improvement and sustainability

- The refurbishment of the Constable Suite, to provide an excellent environment for patients with complex needs, including dementia, was an exemplar for such care in acute hospitals. The environment and commitment of staff enabled very responsive, compassionate and effective care. Staff, managers and senior clinicians told us that they were proud of the suite, and they recognised the benefits for patients, relatives and carers.

# Surgery

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

## Information about the service

Ipswich Hospital surgical division provides surgical services to Ipswich and East Suffolk patients for trauma and orthopaedics, general surgery, colorectal, upper gastrointestinal (GI) and urology, amongst others. It provides a spinal service to patients from further afield. Patients requiring complex vascular surgery are treated at Colchester Hospital. There were 31,689 spells of care for surgery at Ipswich in 2013/14. Services were provided through 18 theatres, which were located in five different areas of the hospital.

We visited four theatre suites, recovery areas, the surgical assessment unit, five ward areas, and the pre-admissions clinics. We spoke with patients and relatives, and junior and senior staff from a range of backgrounds; we observed care being given, and reviewed records and information provided by the trust, stakeholders and individuals.

## Summary of findings

Surgery services at Ipswich Hospital were good; however, staff in East Theatre felt unable to report incidents due to time constraints, and believed the process to be too time consuming. Therefore, an open culture for raising safety concerns was not embedded throughout the division. This area require improvement.

Patients were monitored and reviewed promptly. Care and treatment given was evidence-based, and followed NICE guidelines. The surgical division had taken a robust approach to audit, and was benchmarking patient outcomes internationally by participating in the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP). Best practice learnings was shared across the trust.

Surgical services were planned, and surgery cancellation rates were low. The service was responsive to the needs of patients; patients were treated with compassion, kindness, dignity and respect.

The arrangement of surgical services across the site made for logistical problems and management challenges, resulting in varying leadership across the division.



# Surgery

## Are surgery services safe?

Requires improvement



Surgical services required improvement as some staff felt that they did not have the time to report incidents, particularly in the East theatres; some equipment had not been serviced at the correct time; and a mixture of monitoring equipment was provided in day surgery. Potentially harmful solutions were stored incorrectly in theatres, and we were concerned that medicines were not always stored safely. There were significant vacancies in some ward and theatre areas that were being filled by bank and agency staff at the time of our inspection.

We saw that 'never events' which had occurred were actively and imaginatively investigated, including using human factors analysis, and that lessons were learnt. Patients were appropriately monitored, and escalated for further care and assessment in a timely way. Most staff were up to date with mandatory training, and there was appropriate surgical staffing support within the division out of hours.

### Incidents

- Data from 2013/14 showed that there had been 26 Serious Incidents reported for surgery, with half of these being grade 3 pressure ulcers, though not all of those pressure ulcers may have occurred in the hospital.
- Data to July 2014 showed a low incidence of pressure ulcers, catheter-associated urinary tract infections, and falls.
- There had been four 'never events' in the surgery division in the last twelve months. We saw that all had been investigated fully, with changes made to reduce the risk of reoccurrence, and a full implementation plan established and changes made. Human factors had been actively considered as part of the investigation, human factors training for clinical staff in the future, as well as discussion of human factors influence on 'never events'. This was seen as a positive and holistic approach to change management.
- We saw from information provided that Serious Incidents were properly investigated and lessons learnt.

- Most staff told us that they were able to report incidents in line with trust policy. However, some staff in theatres told us that due to work pressures and shortages of staff, they were unable to report all incidents, as the process took too long.
- Most staff we spoke with told us that they received feedback, following incidents they had reported or which had happened in their area. We saw from meeting minutes and information available to staff in ward areas that feedback relating to incidents was available. However, staff in main theatres and day surgery theatres told us that they had not always received feedback regarding incidents reported in their area.
- We saw that mortality and morbidity meetings were held within the surgical division to discuss individual cases. Letters and minutes reviewed showed that learning was identified and actions taken, that themes were identified, and moving forward, further outcomes were benchmarked.

### Safety Thermometer

- We saw that all wards displayed the Safety Thermometer at the entrance to the area, so that it was clearly visible to patients, visitors and staff.
- On Needham Ward, the information showed hand hygiene compliance at 100%, cleaning audit at 99%, four falls in December 2014, and no pressure ulcers.
- Lavenham Ward results showed that there had been 12 falls in December 2014 and no pressure ulcers. It also showed the results of a records audit that demonstrated that not all nutritional assessments had been completed for a number of months in 2014, though there was a ward-based action plan to address this.

### Cleanliness, infection control and hygiene

- Staff used appropriate personal protective equipment when caring for patients.
- Staff washed their hands, and used decontamination gels between patient interactions. Staff were 'bare below the elbows' in clinical areas, in line with trust policy.
- The surgical division took part in the national surgical site surveillance audit run by Public Health England for some orthopaedic surgery. Audit results for 2013-14 showed that there were lower levels of surgical site infection than the England average in these categories.
- The hospital undertook 1,592 spinal procedures in the ten months prior to our inspection, with three surgical

# Surgery

site infections identified at a rate of 0.2% for all spinal cases, or 0.5% of major spinal cases. This was a positive sign that staff undertook effective infection control practices.

- Cleanliness audits regularly showed results greater than 95% across surgical areas. Staff in East Theatres told us that due to insufficient staff, damp dusting was not completed as thoroughly as before and that in consequence, cleanliness audits had dropped to 98%.

## Environment and equipment

- Most equipment was maintained and serviced in line with manufacturers and national guidance. However, in South Theatres we found two fluid warming cabinets that according to the affixed stickers, were due for service in September 2014. We brought this to the attention of a manager in the area for them to investigate.
- Resuscitation equipment was in place and was checked daily. We found this to be correct. We saw that defibrillators in ward areas were commonly shared between two wards, meaning that there was one defibrillator for up to 60 acute patients. Whilst this had been risk assessed, we were concerned that this was not sufficient emergency equipment to care for acutely unwell patients. The day surgery unit did not use a standard resuscitation trolley, though all equipment was available and checked daily. Staff were familiar with the trolley.
- In theatres, the difficult airway management equipment was readily available in an emergency, with clear guidance for staff, which was in line with Royal College of Anaesthetists guidance.
- Due to a lack of storage space, some equipment, such as trolleys and hoists, were stored in corridors, leading to a cluttered environment in theatres and the ward area. However, the day surgery unit was spacious and well organised.
- We found that the day surgery unit recovery area had a mixture of different monitors. We were told that when monitors went for servicing the original monitor was not always returned. We saw one monitor labelled as belonging to the eye suite. This meant that at the time of our inspection, two monitors were not compatible with the monitors in theatre, and one could not utilise arterial lines, though these are seldom required in day surgery therefore the risk had been mitigated.

- Staff had received training on specific medical devices within theatres and the ward areas. Staff on one ward told us that there were insufficient observation machines. However we saw that patients observations were recorded. Minutes from ward meetings showed that this was recognised.
- Some equipment appeared dated, such as the patient-controlled analgesia pumps. Staff told us that they were in the process of being replaced, with ten new pumps due in March 2015, and a further ten the following year.

## Medicines

- Medicines in ward areas were kept locked, and were accessible only with a staff identification card.
- Medicines, including those requiring cool storage, were stored appropriately, and records showed that they were kept at the correct temperature, and so would be fit for use. We saw that controlled drugs were stored and managed appropriately. Emergency medicines were available for use, and there was evidence that these were regularly checked.
- A pharmacist visited all wards each week day. We saw that pharmacy staff checked that the medicines that patients were taking when they were admitted were correct, and that records were up to date.
- In South Theatres we found the main medicines cupboard to be unlocked and freely accessible to visitors within theatres. We were told that as it was in frequent use and it was not always easy to get the key, it had been left unlocked. A risk assessment had been completed and all high risk drugs were stored in a locked metal cabinet within the main South Theatres cupboard. As no patients accessed this area it was considered safe. The cupboard was, however, accessible to visitors to the area, and the trust policy indicated that medicines cupboards should be kept locked.
- The medicines policy gave information on who was able to access the cupboard. It noted that all other access was at the discretion of the area manager, but as the door was unlocked and allowed entry to anybody in the department, they effectively could not manage this discretion.
- We saw a risk assessment that indicated the above arrangements were suitable, as medicines were required in an emergency; however, ward areas managed this by having immediate swipe access via ID badges, and kept cupboards locked in line with policy.



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- We saw that medicines cupboards within anaesthetic rooms were routinely left unlocked and unattended. In each cupboard there was a scheme of how the medicines should be stored and located, but we saw that this was not always adhered to. This meant that it was not clear which medicines were available, where they were located, and the quantity of the medicines.
- In South Theatres we found an open shelf, with bottles of liquid stored on it. We saw formalin solution (a low formaldehyde solution used for tissue fixation) stocked next to saline irrigation. We brought this to the attention of the manager in the area and asked for it to be moved.
- We saw that drug chart errors had been identified in one ward area. An action plan had been developed and put in place to address the concerns identified.

## Records

- Records were stored securely and were easily available for staff.
- We saw that records contained appropriate risk assessments, including pressure area care, and nutritional and pain assessments, and that most were completed accurately and acted upon. We found a number of incidences where falls risk assessments were not fully completed, although the tool being used indicated that the patient was at risk of falls. This included one ward (Lavenham) where there had been 12 falls in the previous month. Four of the six falls risks assessments we looked at on Lavenham Ward had not been completed fully.
- We saw that risk assessments were regularly reviewed and updated to reflect changes in a patient's condition.
- There were comprehensive pre-operative assessments completed, which were commenced in the pre-op clinic, and were continued on admission to the ward.
- We saw that theatre care plans were fully completed, and included sterile tray labels to allow audit, and the theatre register was completed.
- In day surgery and ward areas we saw that VTE (venous thromboembolism) assessments were completed and acted upon, commencing prophylactic treatment as required.

## Safeguarding

- Staff had received safeguarding training as part of their mandatory training. Adult safeguarding training compliance in surgery Oct-Dec 2014 was 88%. Children's safeguarding training at levels 1, 2 and 3 were 95%, 85% and 96% compliant respectively.

- Safeguarding information was clearly visible in a number of ward areas.
- Seven staff we spoke with were able to clearly describe how they would escalate and report any safeguarding concerns.

## Mandatory training

- Mandatory training included infection control, basic life support, and moving and handling, amongst others. Training was tailored to specific areas, so that staff in theatres received updates relating to their specific area of work.
- Staff we spoke with told us that they were up to date with mandatory training, which they received as a mixture of face-to-face teaching and e-learning.
- Information reviewed showed that most staff across the division were up to date with mandatory training, which was commonly above 85% completion.

## Assessing and responding to patient risk

- The hospital used national guidance, Five steps to safer surgery, in the operating theatres.
- We saw that pre-operative assessment checklists were carried out prior to surgery.
- We saw that the WHO checklist was used appropriately, with good communication and briefings being held and all staff taking part. In day surgery we saw an excellent debrief at the end of the operating list that considered what went well and any areas for improvement. The adapted WHO checklist being used did not have each section signed, or space to indicate what the allergies were. We noted that the World Health organization checklist was completed and that the hospital was currently achieving 100% completion of this.
- A safer surgery policy was in place, and senior staff were driving a culture to change, so that any member of the theatre team could call a surgical stop.
- The wards used the modified early warning system (MEWS) to identify patients who were, or were at risk of, deteriorating. Records we reviewed in all ward areas showed that the MEWS score was consistently and appropriately used to manage patients condition.
- Where patient's scores met a threshold, or if there was clinical concern for a patient, the outreach team assessed and reviewed the patient on the ward. The outreach service operated on a 24 hour basis. Staff we spoke with told us that they felt well supported by the outreach team, particularly out of hours.

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- MEWS scores were audited by ward staff to ensure that they were completed and the correct action taken in response to the score.
- There were clear arrangements to access medical teams, including anaesthetists to manage patients who were unwell. Staff told us that they were always able to access medical support.
- The surgical assessment unit admitted patients directly from the emergency department. On our unannounced inspection on 15 January 2015, we saw a patient, who had been admitted to the unit, waiting in the day room. The day room for the surgical assessment unit had approximately 10 chairs in a side room. The patient had intravenous fluids running, and we were told they were stable. We asked if the unit had any admission criteria for patients admitted from the emergency department, who would be considered safe to be cared for in the waiting room, but we were told that it was a clinical judgement. We were concerned that patients not suited to be cared for in that environment may be admitted to it, especially given the use of temporary staff on the unit.
- Most major vascular surgery was carried out by another provider at Colchester Hospital. Staff told us that patients who were unsafe to be transferred, were operated on at Ipswich Hospital. Theatre staff told us it was a challenge to ensure that staff remained skilled. The division were aware of this, and were formulating guidelines for suspected vascular emergencies. We saw a report from a CCG, with improvements to be made which included improved collaboration and communication between Colchester and Ipswich ; patient transport between the two organisations needing to be reviewed and updated; and record-keeping standards needing to be reviewed by both organisations. The service had begun to make improvements based on this report.
- Lavenham Ward had a large number of side rooms. We saw that nurse staffing had been increased to one registered nurse to five patients during the day, with support from health care assistants (HCA) to compensate for the lack of visibility of patients and their acuity. At night, there were five registered nurses and two HCA. Staff told us that they felt there were not enough staff at night because of the acuity of the patients. Managers told us that following the safer nursing tool, this would be increased to six registered nurses at night, with two HCA in the near future. Other ward areas we visited planned for a minimum of one registered nurse to eight patients at night, but we saw that on occasions (due to staff absence), this was not always met. Rotas indicated that staffing numbers were broadly maintained.
- There had been a division-wide dependency/staffing tool completed in the summer of 2014, which had resulted in the uplift of nursing posts across the division. Managers told us that they were continuing to recruit to the new posts, but recruiting high calibre staff was proving a challenge.
- There was a low vacancy rate in South Theatres, but we were aware that there was a high and persistent vacancy rate in East Theatres. We saw that three incidents had been recorded between September and November due to staff shortages in East Theatres. We saw that an action plan was in place to recruit theatre staff, and some progress was being made against this. RCN guidance in 2012 stated that there should be a minimum of three staff per theatre, depending on the case, and the Association for Perioperative Practice suggest this should be five, depending on the acuity of the case. Rotas we examined showed East Theatres had four per theatre, but this included the theatre assistant who was not always within the theatre suite, as they were collecting patients. We could not see how the nature of this role (to be regularly outside of theatre suite) was considered in determining the establishment for each theatre.

## Nursing staffing

- We saw that staffing levels for each shift were displayed on the wards, with the planned and actual staffing clearly shown (safer staffing).
- Rotas indicated that staffing levels were usually maintained, but the pressures on the hospital meant that on some occasions, staff were moved to work elsewhere. Where possible, staff were back-filled with agency or bank staff.

## Surgical staffing

- Information showed that the hospital had more consultants and junior surgeons than the England average, but less than the average for middle career and registrar surgeons.
- We saw that trauma and orthopaedics had a ward-based junior doctor. The surgical wards were

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covered by a junior doctor out of hours, with support from a more senior doctor, who also covered the emergency department. There was further cover for surgical wards by a 'late cover' doctor, who worked until midnight.

- At weekends, there was a junior doctor covering the surgical assessment unit, with support from senior doctors. There were on-call senior doctors, including consultant cover for trauma and orthopaedics, and general surgery.
- Three junior doctors we spoke with told us that they were busy, but felt well supported by senior staff who would attend and review patients promptly if requested. They told us that handovers were done at each shift, and were detailed and comprehensive.

## Major incident awareness and training

- We saw that there were clear major incident plans and business continuity arrangements in place for the trust, and for the surgical division.
- Senior staff we spoke with in theatres were not aware of the major incident plan, or the business continuity plan for their area. We were concerned that in the event of these happening, staff may not be fully prepared or make timely arrangements.

## Are surgery services effective?

Good



We saw that treatment given was evidence-based and, where appropriate, was underpinned and guided by NICE guidance. Staff followed local policy and procedure, and we saw the use of care bundles including sepsis. Patients were given adequate pain relief in a timely way. Patient outcomes were measured, and the division had actively participated in internationally benchmarking patient outcomes.

Staff were competent to carry out their duties, as they had induction and supernumerary periods, and had access to further education and training; however, we had some concerns about appropriate competency assessments for some staff including those in vascular surgery. We saw that there was effective multidisciplinary working within the hospital, and with other stakeholders, and we were aware that further work continued with the transfer and treatment of vascular patients at Colchester Hospital. Patients gave

their consent before any care and treatment. We saw appropriately completed DoLS assessments, and whilst staff were aware of their responsibilities under the Mental Capacity Act, records did not always indicate when it had been considered.

## Evidence-based care and treatment

- We saw that guidance from Royal Colleges was in place, including Royal College of Anaesthetists guidance on difficult airway management.
- NICE guidance was routinely followed, including CG124 for fractured neck of femur patients, CG177 for care and treatment of patients with osteoarthritis, and CG92 for reducing the risk of blood clots in surgery, amongst others.
- There were pathways in place for patients undergoing some procedures, such as elective joint replacements and some general surgery, which were underpinned by NICE guidance. There was a surgical pathway in place for patients undergoing elective surgery and day case surgery.
- Though the hospital performed well on many standards on the national hip fracture audit data, we were told that there was no pathway in place for patients with a fractured neck of femur.
- The sepsis bundle was fully utilised across the division. A sticker was placed in patient notes showing the assessment, investigations carried out, and any treatment given.
- We saw care and treatment being carried out in line with local policy and procedure.
- There was an enhanced recovery pathway in use for colorectal patients, which mirrored NICE guidance, and was completed by all members of the MDT.

## Pain relief

- We saw that patients initial pain assessment and pain relief plans were discussed at pre-operative assessment clinics.
- Four of the six records we reviewed showed that regular pain assessments had not been completed for patients on the ward post-surgery, and for other patients who required analgesia.
- Acute pain following surgery was managed by the acute pain team, who were available between 9am and 5pm, Monday to Friday. Outside of these hours, support was

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provided by on-call medical and anaesthetic staff, as well as the critical care outreach team. Staff in the clinical areas felt well supported in managing patient's pain.

- We saw that pain relief was administered in a number of ways, including patient-controlled analgesia, epidural, and oral pain relief. Patients we spoke with told us that they received pain relief in a timely way, and that their pain had been controlled.
- Medicines charts we reviewed showed that pain relief was given as prescribed.
- The pain team told us that they were investigating new ways of surgical pain management, and were due to start trialling a new device to improve post-operative surgical pain management.
- Pain relief was initially discussed with patients at pre-admission clinic, where advice was given and post-operative pain relief planned.

## Nutrition and hydration

- Patient's hydration requirements were supported by intravenous fluids if required pre, peri and post operatively.
- Documentation reviewed showed that fluid charts were accurately completed and totalled, so that patient's hydration status could be accurately monitored.
- We saw that patients, who were unable to eat, were supported with nutritional needs via the use of percutaneous endoscopic gastrostomy feeds and total parenteral nutrition.
- Patients were routinely assessed as to whether they were at risk of malnutrition. Patients who were deemed at risk had their intake monitored and were referred to the dietician if required.

## Patient outcomes

- We saw that there was frequent local audit activity, such as notes and records audit, and that audit results were visible in clinical areas.
- The hospital took part in the national hip fracture audit. Most recent available data indicated that Ipswich Hospital was performing better than the England average on eight measures, including patients being admitted to orthopaedic care in four hours; pre-operative assessment by an ortho-geriatrician; and falls assessment. The 2014 Hip Fracture Audit report found that length of stay was 16.4 versus the national average of 19.

- The surgical division also took part in the national bowel cancer audit. The last available data for 2013 showed that the hospital was performing better than the England average for case ascertainment rate; and for the number of patients seen by a clinical nurse specialist. The hospital performed worse than the England average for patients being discussed at MDT meetings; and time to report CT scans.
- Large parts of the data for the national laparotomy audit 2014 were unavailable. The available data indicated that emergency theatres were appropriately staffed, and that formal handover between surgeons and anaesthetists took place. We saw an action plan was put in place in October 2014 to address the laparotomy audit.
- Readmission rates for elective patients were lower than the England average for all specialties, with the exception of urology, which was higher than the England average.
- Readmission rates for non-elective patients were lower than the England average for all specialties.
- Patient-reported outcome measures (PROMS) showed that the hospital performed broadly in line with the England average, and better than the England average for varicose vein surgery and hip replacement.
- Ipswich Hospital was one of only two trusts in the UK to participate in the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP). The trust had specifically requested to be included in this audit and to benchmark patient outcomes internationally. Where data indicated that the trust was not performing as well as hospitals in the United States, we saw that the trust had identified actions to address this. Specifically, for a higher rate of surgical site infection, Ipswich Hospital was 'buddied' with a high performing hospital in the US, to manage and improve quality and performance. We saw these changes in practice, and the sharing of best practice in surgical site infection between pre-assessment staff, nurse specialists, medical and surgical and ward staff.

## Competent staff

- Data reviewed showed that most staff had received appraisal and supervisions. On wards with a lower level of completed appraisals, we saw that these were booked to be completed in the near future. Two wards we visited had 100% appraisal rates.
- We saw induction programmes for new members of staff, with competency assessments throughout the

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induction period. Three new members of staff told us that they had felt supported when starting work at the hospital, and had completed an induction programme. However, two agency nurses we spoke with told us that they had had a limited induction, with a short tour of the ward.

- We saw that staff were supported to undertake additional training and education to enhance their skills. Two members of staff we spoke with had been sponsored to undertake further qualifications.
- Medical staff told us that they received adequate support to maintain their registration/revalidation.
- In the pre-admission clinic we saw that some nursing staff were completing the first part of the anaesthetic assessment, although they may not have completed the training. We asked if they were completing these assessments if they had completed a competency assessment, and were told that this was done following completion of the course. Whilst they mitigated the risk by ensuring that staff who had completed the course were working with staff who had not, we were concerned that some staff may be completing anaesthetic assessments, including listening to heart and chest sounds, and airway assessment, without an assessment of competency.
- The division had introduced the role of assistant practitioner, which has upskilled staff in new core competencies, including venepuncture and cannulation, and intermediate life support.

## Multidisciplinary working

- We saw effective multidisciplinary team (MDT) working in clinical areas, between medical, nursing and allied health professionals. Patient pathways had clear input from members of the multidisciplinary team, including physiotherapy, occupational therapy and other professionals.
- We saw that there were regular formal MDT meetings to determine the most suitable care and treatment plans for patients.
- In trauma and orthopaedics, many patients were dual managed, by a surgeon and an ortho-geriatrician. The ortho-geriatrician also attended MDT meetings for these patients.

- Patients were referred to community services if they required ongoing after care. We saw two patients referred for ongoing care in the community, and that their ongoing needs were clearly planned and arranged for.
- There was a service agreement in place for the treatment of most vascular patients at Colchester Hospital.
- Allied health professionals, including physiotherapists and occupational therapists, received updates from ward staff daily.
- The theatre assistant roles included collecting patients for theatres, as well as circulating to release other staff for breaks. The staff undertaking this role were adaptable and flexible in covering for a number of colleagues within the MDT.

## Seven-day services

- Theatres were in operation seven days a week. The majority of elective surgery was carried out during the week. There was a trauma list for a half day on both a Saturday and Sunday. There was an emergency general surgery theatre and an emergency maternity/gynaecology theatre available 24 hours a day, seven days a week. Day surgery was used on some Saturdays as a waiting list initiative, which was done on a voluntary basis.
- There was access to radiology services over weekends and out of hours, with an on-call rota in place. Staff told us that they were able to access these services when required, and most services were available out of hours.
- We saw that allied health professionals, such as physiotherapists, were available at weekends, and staff reported easy access to them out of hours when they were required.
- Physiotherapy offered a 24 hour on-call service for patients who required urgent chest physiotherapy.
- Since September 2014, occupational therapy provided a seven day a week service.
- We were told that pharmacy support was provided by an on-call pharmacist out of hours and a dispensary team was available Saturday and Sunday providing a service over a weekend.

## Access to information

- Medical records and other information were available when required, including notes transferred from other hospitals.



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## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

- Patients gave their consent before any procedure was carried out. We saw numerous examples of patients giving consent before minor procedures, such as taking blood.
- Surgical patients signed a comprehensive consent form before they had their operation. On occasions, this was signed some time before the operation, such as in clinic, but we saw that staff went over the form and ensured that the patient was happy before they underwent surgery.
- Patients were given information, both verbally and in writing, to enable them to make an informed decision about their care and treatment. Four patients we spoke with told us that they had been given sufficient information and time to make a decision on their treatment.
- An audit of patient satisfaction with the consent process in trauma and orthopaedics showed that a large majority were satisfied with the information and explanations they were given.
- We saw from training records that staff had received training in the Mental Capacity Act (MCA). Staff we spoke with confirmed that they had received this training.
- We viewed a number of completed Deprivation of Liberty applications, and found they had been properly completed and the correct authorisation sought.
- We saw one patient's notes, which indicated that they may not have capacity to make a decision about their care. Whilst the patient had been discussed with the dementia specialist nurse, and it was decided that the patient could make decisions, an explicit consideration of their capacity was not recorded. Another set of records showed that best interest decisions had been correctly considered and taken.
- Staff in the pre-operative admission clinic demonstrated a good knowledge of the MCA, and the use of Independent Mental Capacity Advocates (IMCA).

## Are surgery services caring?

Good



Patients were treated with dignity and respect at all times in theatres, wards and other clinical areas. The Friends and Family Test was positive in two surgical wards, but had high

variation in others, which was likely to be linked to a low response rate. All patients and relatives we spoke with talked very highly of how they had been treated and cared for in the unit. Patients and their relatives/carers were kept informed of their treatment plans and were given information to support them. Emotional wellbeing was provided by all staff, with support from specialist practitioners, who were able to convey complex information, and provided ongoing support and advice when patients had been discharged.

## Compassionate care

- The most recent Friends and Family Test data up to July 2014 showed that response rates were below the England average.
- Martlesham and Stowupland Ward scored consistently higher than the England average. There were significant variations in the number of positive responses received by Lavenham and Needham Wards, which may be due to very low response rates (8% and 6% respectively).
- We saw numerous examples of compassionate care provided to patients. Patient's privacy and dignity was maintained. In ward areas we saw that curtains were pulled around the bed before care was provided, and on one occasion this was done at the patients' request.
- We saw doctors introducing themselves to patients at the start of conversations. Patients spoke highly about their consultant.
- There was obvious rapport between staff and patients. Staff clearly knew the preferences for patients who had stayed for longer on the ward.
- All patients we spoke with told us that they were always treated with care and respect by staff. We spoke with a number of relatives, who told us that they felt well supported by the staff on the ward. One relative we spoke with told us that they wanted to spend as much time as possible with their family, and staff had "gone out of their way" to help them to do this.
- Patients told us that "nothing was too much trouble for the staff" and that they were "really caring".
- A number of patients were assisted with meals and drinks during our inspection. We saw that patients were helped in an unhurried way to eat their meal. The member of staff helping them spoke to them and continued to engage with them throughout the meal.

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- In pre-admission areas we saw that patients changing facilities offered privacy, and they were taken directly from the changing area into theatre, so as to protect their dignity.

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

- Records clearly showed that options for care and treatment had been discussed with patients and their relatives.
- We saw examples of patients discussing treatment options and plans for their care. In theatre admissions, we saw that patients were given information about the procedure and how they would recover in the ward, and they were asked about any preferences they had.
- We spoke with one relative whose family member had been in the hospital for some time. They told us that they had been kept fully involved and updated as to the patient's condition and future care plans.
- We spoke with two patients, who told us they had not had all the information they wanted post-operatively. We brought this to the attention of ward staff, who updated the patients with this information.

## Emotional support

- Several patients we spoke with talked highly of the chaplaincy service at the hospital, and told us they had found their support invaluable.
- A number of specialist nurses gave support to patients throughout the treatment they received. For example, specialist nurses saw patients pre-surgery and then again afterwards, and supported them following discharge.
- Staff told us that they were able to arrange counselling services for patients requiring ongoing emotional support. We spoke with one patient who had had further support following a previous operation.
- On one ward we saw a patient with confusion calling out and wanting to go home. We saw a member of staff approach them, and sit at their level and engage the patient in conversation for some time until the patient was settled.
- In theatres we saw theatre staff welcoming patients into the admission area, and putting patients at ease, discussing their procedure, and answering any questions. They told us that by building a rapport it then made it easier for patients who were about to undergo surgery, as they were amongst familiar faces.

- A PAT (Pets as Therapy) dog visited some of the wards. Staff told us that patients valued and enjoyed these visits.

## Are surgery services responsive?

Good



We saw that services were planned in conjunction with commissioners and other stakeholders to meet the needs of local people. Surgery cancellation rates were low, and length of stay for patients was broadly better than the England average. Most recent data for October 2014 showed that the trust was missing its referral to treatment (RTT) time for general surgery and oral surgery, but was meeting it for other specialities. On a number of occasions we saw that patients were kept for longer than clinically necessary, as ward beds were not available.

Surgical services were responsive to people's needs, and their needs were considered before their admission to hospital, if they were elective patients, through to discharge. A number of patients before and during our inspection spoke of poor communication when they were discharged. We saw that complaints were effectively managed, and that learning was identified and acted upon.

## Service planning and delivery to meet the needs of local people

- We saw from meeting minutes that the surgical directorate engaged with local commissioners and the wider health economy to plan services.
- Some services had been reconfigured; for example, the more complex vascular surgery was now done at Colchester Hospital. We were aware of a public consultation prior to any service design changes, where local people's views were taken into account.
- The surgical division had significantly increased the amount of spinal surgery taking place, in response to local and regional need.
- Physiotherapy staff had audited their workload and found Wednesday to be a busy day. They changed their work pattern to work later on a Wednesday to meet this need.



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## Access and flow

- The surgical assessment unit (SAU) had a seated area for patients who were referred from GP's, the accident and emergency minor's area, and outpatient clinics.
- South Theatres had a patient reception area. This meant that patients were able to be admitted directly to theatres, without the need to attend the ward. A staggered admission time meant that patients were not kept waiting for long periods. Up to 30 patients a day were admitted in this way. Following surgery, patients would be transferred to a ward for post-operative care. Patients spoke highly of this arrangement.
- The pre-operative admission clinic ran a pathway as a walk-in service, where patients could attend following a clinic appointment. This meant a reduction in the number of visits to the hospital for some patients.
- We saw that the physiotherapist worked early evening shifts to facilitate discharges where physiotherapy input was required. Fractured neck of femur patients were prioritised by physiotherapy, and seen daily in line with NICE guidance.
- The hospital was failing to meet referral to treatment times for general surgery and oral surgery. Data from NHS England for October 2014 showed that 64% of patients were treated within the specified time, against a target of 90% for general surgery, and 59% for oral surgery. The trust was meeting referral to treatment times for other specialities, including trauma and orthopaedics, ophthalmology, ENT and urology.
- We were aware that shortly before our inspection, a temporary (Vanguard) operating theatre had been used to address RTT.
- Most recently available data showed that between January and June 2014, no patients, whose surgery was cancelled, had to wait more than 28 days to receive treatment.
- Data provided by the trust showed a low cancellation rate for 'on the day' cancellations for elective operations of less than 1% of all elective and day case operations since April 2014.
- We were aware that, due to pressures on the emergency department and the wider health economy, a number of elective operations, particularly orthopaedics, were cancelled during our inspection.
- We saw four incidences where patients had been held in recovery for up to four hours awaiting a bed on a ward or high dependency area. Staff told us that they were able to get snack boxes for patients, but toilet facilities were located back in the admissions area.
- Data showed that length of stay for elective patients was lower than the England average overall for all specialties, but slightly longer than the England average for colorectal and urology patients.
- Length of stay for non-elective patients was lower than the England average for all specialties.
- The surgical assessment unit had recently employed two nurse practitioners to improve patient flow and pathway through the surgical assessment unit.
- A number of patient's pre-inspection, at the listening event, and who spoke to Healthwatch, told us that communication during the discharge process was not always good, and that it resulted in poor discharge arrangements. We were aware of three safeguarding referrals related to patient discharges.
- Staff told us that on occasions, surgery was cancelled because of a lack of notes or records. Data provided by the trust showed that there were nine reported incidences of cancelled operations due to missing or unavailable notes between February and December 2014.

## Meeting people's individual needs

- In day surgery, we saw that there were processes and arrangements in place to manage patients with complex needs. In day surgery, we saw that they involved the learning disability nurse to give guidance and advice, that patients were seen as swiftly as possible, and that adjustments were made to the area to make it more relaxing, such as dimming lights, and giving patients separate rooms. An anaesthetist, with an interest and specialist skills in caring for patients with specific needs, was available to help reduce the stress of patients and complete an in-depth assessment of their needs.
- Patients and relatives on surgical wards, and trauma and orthopaedics, were able to self-refer to the critical care outreach team if they felt they required a medical review from them. Information and posters alerted patients to this facility, and all patients discharged from the ITU were given it. Critical care outreach nurses informed us that they had received a number of self-referrals since the service began.

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- We saw that the health passport scheme was in place, and being used for patients with a learning disability. We saw these in use in ward areas and day surgery.
- Information was provided in a number of ways, and large print patient leaflets were available.
- The day surgery unit undertook pre-admission visits for children who required surgery, and upon admission they had their own waiting and play area. Where possible, they were given their own room, which had numerous toys, was brightly decorated, and included a DVD player and television. Following surgery, children had their own recovery bays.
- We saw staff were supported by specialist nurses when caring for patients with dementia, and made use of 'This is me' documentation – particularly in the pre-operative assessment clinic. On a number of wards there was a dementia champion.
- In the pre-admission clinic, staff gave information and contact telephone numbers for patients to contact should they have any questions. We spoke with one patient who had been given a second pre-admission appointment, so that they could discuss again their concerns and questions.
- Discharge planning commenced at the pre-operative admission clinic, when a patient's expected discharge date was discussed and agreed, so that patients could make plans for their discharge.
- The pre-admission clinic offered health promotion as part of the assessment, including smoking cessation and healthy living.
- Occupational therapy provided a pre-admission clinic to anticipate patients' needs before their surgery, so appropriate plans could be made for their care as an inpatient and at discharge.
- In South Theatres, patients with complex medical needs, such as diabetes, were seen first and prioritised for surgery at the top of the list.

## Learning from complaints and concerns

- We saw that complaints were responded to and lessons learnt. There was a complaints policy in place, and staff were aware of how to access it.
- Managers told us that complaints were investigated, and any concerns or changes in practice were fed back to staff. We spoke with staff who confirmed this.

- We saw that following one complaint, the patient was invited to a meeting to discuss concerns with senior staff, and the patient was given an apology and a copy of the notes from the meeting.

## Are surgery services well-led?

Good



The surgical services were spread around the hospital site, including five different theatre areas, some with overlapping management (such as the trauma theatre in South Theatres), which made for a complex patient and surgical pathway around the hospital site, and which staff told us made some day-to-day management difficult. There was a clear vision and strategy from senior managers for surgical services, but this was not always clear to staff working in the division. Staff spoke highly of their managers, but they also told us that managers were not always visible in clinical areas.

There were appropriate governance structures in place, and managers were clear of the risks within the division. The culture in the service was open and transparent, and many staff were clearly proud of where they worked and what they achieved; but there were pockets of staff who felt unsupported and undervalued by managers. There were long-term plans in place to ensure sustainability of the division and the trust more widely, and there were some notable innovations, including the use of international benchmarking, and buddying in surgical services.

## Vision and strategy for this service

- Senior divisional management had a clear vision and strategy, both short and long term, for surgical services at the trust, and development of staff within the division. We were aware of a trust and surgical services strategy going forward to 2020.
- Staff we spoke with in theatres were not clear about the vision or strategy of their service. They told us that they believed there would be a review of surgical services, how they were managed, and their configuration, but were unsure if this was the case, or any timelines involved.
- Most staff in ward areas were aware of the vision and strategy locally, but were unclear about the vision for the division.

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- Managers in day surgery had a clear understanding of the strategy for the service, the challenges it faced, and were aware of risks.
- We found that some frontline staff continued to talk of business units, although the surgical division structure had been in place for some 18 months.

## Governance, risk management and quality measurement

- The divisional senior management were aware of the risks in the surgical division, including staffing in East Theatres and more generally, and 'never events' within the service. The risk register clearly indicated staffing as a priority risk, and senior managers told us their strategy for managing this. Actions were in place to mitigate risks identified.
- Governance meetings were held regularly in the division, which considered incidents, complaints and patient experience, and fitted into the overarching governance structure of the trust.
- Within the surgical directorate, managers had a good understanding of the Duty of Candour, their responsibilities to it, and how it is managed locally.

## Leadership of service

- Management on the surgical wards and in theatres told us that the senior management for the surgical division was supportive. However, some staff raised concerns that senior management had a wide portfolio, and they were not always seen regularly in some areas, particularly theatres.
- We were told that it was difficult to arrange team meetings in ward areas, so some wards were having a 'huddle' at the beginning of the shift to give feedback to staff and inform them of any changes. This also allowed effective allocation of staff and resources.
- Two staff we spoke to in specialist roles felt that they were overlooked, and that the focus was on ward areas.
- We were aware of a recent change in leadership on one of the surgical wards. Senior management told us that through audit and supervision, they had identified concerns and taken decisive action to replace the leadership in that area.
- Staff in East Theatres told us that they felt unsupported by leadership locally, and within the trust, and that there had been an absence of leadership within the clinical area for some time, though they spoke highly of

the new manager in that area. Staff in South Theatres also told us that though they felt supported by senior division management, they rarely saw them in the clinical area.

- Senior management were aware of the staff vacancy rate in East Theatres, and confirmed they had tried to mitigate that by agency use. There was a recruitment and retention plan in place. Leadership within the area was now settled after a long period of changing or absent leadership. Senior management were also aware of a fragmented relationship between the different theatre suites across the organisation, and the need to harmonise the relationship and pathway.
- Managers in theatres told us that due to staff shortages, they sometimes helped out in theatre, as well as covering their managerial and co-ordination roles. The Association for Perioperative practitioners recommends that the co-ordination role is separate to a clinical role in a theatre (as a scrub or circulating practitioner).

## Culture within the service

- Most staff we spoke to were proud of the area in which they worked, and were clearly passionate about providing quality care and treatment to patients.
- Staff told us that the culture was open and transparent in most areas, and that they were encouraged to report incidents.
- A number of staff in East Theatres told us that they felt undervalued by the organisation, and that they made a positive contribution that they felt was not adequately recognised. Senior managers told us they were aware of this situation, and had considered re-evaluating some job roles, but were unable to do so.
- Senior managers told us they were driving a culture change so that any member of the theatre team could call a surgical stop.

## Public and staff engagement

- We saw that staff surveys were carried out in the surgical division, and that on some wards, a staff newsletter was completed to update staff with news and developments locally, and across the trust, together with any briefing notes.
- Patient newsletters were circulated to patients and volunteers. We saw one newsletter, and spoke to a patient who valued the publication highly, and said that it kept them up to date with developments at the hospital.







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- We saw that patients were involved in a 'Your views matter' questionnaire that formed part of the Friends and Family Test. There were examples of 'You said, we did', where the trust had responded to patient feedback, for example, providing free Wi-Fi.
- User groups were in place for a number of specialties, providing information for leaflets for other patients.

## **Innovation, improvement and sustainability**

- We were aware that the surgical division, and the trust, as a whole were considering plans for the future to improve the connectivity of theatres suites and the surgical pathway throughout the division, though this may take some time to come to fruition.
- Spinal operations had increased, and the hospital was now providing this service for 1.5 million patients.
- The surgical division had actively sought to increase audit activity, and had submitted audit data of patient outcomes that could be benchmarked internationally (ACS NSQIP).

# Critical care

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

## Information about the service

Ipswich Hospital has an intensive care unit (ICU) providing care for adult elective and emergency patients requiring level two and level three care, as well as emergency care for children.

Level two care refers to those patients requiring more detailed observation and intervention, including support for a single failing organ system, or post-operative care, and those stepping down from higher levels of care.

Level three care refers to patients requiring advanced respiratory support alone, or basic respiratory support, together with support of at least two organ systems. This level also includes complex patients requiring support for multi-organ failure.

The ICU was divided into three cluster areas – cluster A, B and C. Cluster B and C had a maximum of 14 beds, with an additional dedicated paediatric side room (total 15). Bed capacity was flexed dependent on patient acuity and staffing.

Cluster A had been built when the unit originated and, if integrated, would increase the bed capacity up to 22; however, this was designed as part of future planning, and at present, Cluster A was in use by ophthalmology as a day case area.

During the inspection we visited the ICU. We talked with two patients, five relatives, and 26 staff, which included senior and junior medical staff, nursing staff (registered and non-registered), managers, physiotherapists and domestic staff.

We observed care and treatment during the inspection and also reviewed patient documentation. The ICU had a computerised information system (CIS) and we observed this in use, and also reviewed 13 patients' records. Before the inspection we had reviewed performance information provided by the hospital, and information that we requested.

# Critical care

## Summary of findings

Critical care services were safe, effective, caring and responsive to meet the needs of patients and relatives, and the service was well-led. Staff cared for patients with compassion, dignity and respect. Good quality outcomes were evident, and patients received treatment that was based on national guidelines. The overall capacity was adequate, and patients received timely care and admission to the unit; however, delayed transfers out of hours were high due to the unavailability of step down beds on the wards.

Medical and nursing staffing levels were planned, implemented and reviewed depending on patient acuity and turnover, and adhered to national guidance.

Staff competency and training arrangements were embedded, resulting in a supportive environment, and staff morale was good.

Service provision for children was primarily stabilisation prior to transfer; however, the unit treated approximately 20 children a year. There was no written policy for paediatrics in place, and no registered sick children's nurse (RSCN) employed on the intensive care unit (ICU).

The management at service level on the nursing side were clear about their roles and vision for the service; however, this was not as embedded within the medical team. The governance and risk management within critical care was not embedded. During our inspection we identified a number of aspects of care where risks had been identified; however, there were no current risks on the risk register. An example of this was the paediatric patients on the ITU. Therefore, there was no assurance that timely actions were being taken to protect people from avoidable harm.

## Are critical care services safe?

Good



Services within critical care protected patients from avoidable harm. Our analysis of data from our 'Intelligent Monitoring' before the inspection showed no indication of risk in safety for critical care. Staff were aware of the systems and processes in place for reporting of patient and staff incidents, and regular reporting was evident. There was a process for analysis of incident themes and providing feedback to staff.

Medical and nursing staffing levels were adequate and in line with national guidance. We found a good level of consultant clinical involvement and support in place, including out of hours and at weekends.

There was good multidisciplinary working by critical care staff. Regular handover and ward rounds were seen and were well attended by the multidisciplinary team.

Each bed space had dividing walls, which meant reduced visibility when staff were responsible for two (level two) patients in adjacent bed spaces. This was mitigated, when possible, by staff allocation to patients opposite each other, which resulted in a direct view. The display of two patients monitoring was also possible on the CIS system.

The environment was clean and each bed space area was adequate for equipment. Individual locked trolleys were present in each bed space, which allowed patient-specific medication to be easily accessed, and all bed spaces had an individual tracking hoist system. Arrangements were in place for effective control of infection and medicine management.

### Incidents

- There had been 141 incidents reported in ICU between August and December 2014. There was a process in place for incidents to be reviewed, and themes identified and reported as part of the wider governance arrangements. A report was compiled to the monthly senior nurse meeting and then escalated when required to the trust governance group.
- The education charge nurse was responsible for reviewing incidents, analysing themes, and providing report and feedback. Some examples of themes



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identified in December included two medication incidents, seven out-of-hours discharges, and six equipment issues. These were addressed with staff and action taken to reduce the risks identified.

- Feedback was available via written communication and email. Specific issues were identified as 'hot topics', and discussed at handover and on team training days. Learning points were also displayed on the staff noticeboard.
- All pressure ulcers above grade two were reported as an incident on the electronic reporting system.
- Mortality and morbidity meetings were undertaken monthly and were well attended by all staff groups. Minutes of meetings were seen, cases reviewed, and any learning points were identified and documented.

## Safety Thermometer

- We saw that information about staffing levels; mandatory training, staff hygiene, complaints and compliments, were displayed on noticeboards in ICU.
- The productive ward data which was displayed included pressure ulcers, falls and 'no blank' drug omission statistics. Data showed that ICU had had no incidences of venous thromboembolisms (VTE) in the past twelve months, and no avoidable pressure ulcers since February 2014.
- There had been one grade three pressure ulcer, year-to-date (YTD) and we reviewed the root cause analysis documents, which had been completed in a timely fashion, and had a clear and reasonable action plan.
- Risk assessments for patient pressure ulcers and venous thromboembolisms (VTE) were completed on admission and updated regularly, and had been documented in the CIS and nursing notes.

## Cleanliness, infection control and hygiene

- Each of the bed spaces had dividing walls between each patient, and a curtain at the foot of the bed space. This clearly separated different patient bed areas to decrease the risk of patient cross-contamination. Curtains were disposable, and were labelled and dated when changed (which was every six months or as required).
- Each cluster was designed to work as an individual unit, so if necessary, infected patients could be isolated to one cluster.

- An isolation side room was available in both clusters B and C, with controlled positive and negative ventilation as required. Both isolation rooms had controlled entry via an ante chamber.
- We were informed that a colour-coded system was in place for aprons, with each bed space having a different colour; however, this was not seen in practice and we observed the same colour in use in several adjacent areas.
- Each bed space was noted to be visibly clean and have adequate space to allow for equipment and for interventional care to be undertaken.
- Staff were observed to adhere to a 'bare below the elbow' policy, and hygienic hand-washing facilities and protective personal equipment (PPE), such as aprons and gloves, were readily available. We observed staff wearing aprons and gloves when undertaking clinical care with patients.
- The equipment and environment within ICU was noted to be visibly clean; however, there were no indicator stickers in use to identify when items of equipment had been cleaned. Hand gel was available at the entrance to the department and throughout the unit.
- There were sharps bins available for appropriate disposal of sharps at each bedside. All sharps containers were noted to be labelled for identification and tracking purposes, with ICU location, signature and date of assembly.
- The collection point for waste disposal was just outside the ICU, in a locked cupboard; keys were held by the domestic lead and ICU lead. Waste was separated and colour-coded for identification of clinical waste for incineration and non-clinical general waste. All bags were securely tied, with ID tags in use. ID tags had a unique number/code for ICU to allow traceability. We saw a sharps container waiting for collection that had been securely closed, not overfilled, and labelled correctly, with signature, and date for assembly and sealing.
- There was a domestic service provided between the hours of 6.30am and 2.30pm, Monday to Friday, to undertake general cleaning duties. Out of hours, and at weekends, the non-registered member of staff assisted with the cleanliness of the unit.
- There was evidence of routine cleaning of equipment, with daily commode cleaning and bedpan post-use cleaning records seen to be in use.

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- Intensive Care National Audit and Research Centre (ICNARC) data for infection rates (from January–June 2014) showed that there had been no incidence of unit-acquired *C. difficile* infection, and MRSA infection was less than 1%. Incidence of catheter-related blood stream infections (CRBSI) was low, with no more than one a month at any time.

## Environment and equipment

- The unit environment was bright and spacious, and each bed space had adequate room for patient interventions and an individual tracking hoist system.
- The dividing walls between bed spaces had windows with blinds for privacy. This reduced visibility when staff were responsible for two (level two) patients in beds next to each other. Staff mitigated this when possible, by allocating patients opposite each other to one nurse, which resulted in a direct view. The display of two patients monitoring was also possible on the CIS system.
- To ensure equipment was available for use, there was a process in place for regular restocking and checking of equipment, such as the difficult intubation trolley, scopes and consumable stock. This was normally undertaken by the non-registered staff, twice a day. There was a checklist completed once the checks had been undertaken.
- We saw electrical testing stickers that were in date, on items such as portable warming devices.
- There was a process in place for daily checking and restocking of emergency equipment, such as the resuscitation trolley and the difficult intubation trolley. We saw that these were locked, and records had been completed stating the time and individual who had undertaken the check.
- One critical care technologist provided on-site service support for equipment on ICU, Monday to Friday; however, this service was not provided out of hours, or at weekends. However spare equipment was available to use during this time.
- The CIS system in place was fully operational; however, there was no administration support should any problems occur with the system.
- The ICU had a swipe card entry system in place for security.

## Medicines

- We examined the medicine storage area in ICU. Medicines were stored correctly and securely throughout. All medicines, including intra venous fluids, were stored in locked clean utility areas, and access was via a badge and key pad.
- Individual lockable carts were in use in each bed space, which allowed safe storage and instant access to patient's individual medication. In December there were two reported incidents where patient medication had been left in situ in the cart following patient discharge. This was highlighted for learning as a 'hot topic' during the week of 12 December 2014.
- There were adequate security measures in place for the storage of controlled drugs. There were two controlled drug cupboards, which were single cupboards with dual locks, and the keys were held by the two nominated cluster leads. The controlled drugs were checked and accounted for, and daily checks by two members of staff were recorded. We saw that the administration of controlled drugs and stock balance levels were recorded; however, the specified amounts administered and discarded were not.
- E-prescribing was in place via the CIS system, which did not prevent errors occurring, but did provide the benefits that prescriptions were legible, and auditing was easily undertaken. There was an online medical guide (Medusa) for reference that could be accessed at the bedside.

## Records

- ICU had a computer information system (CIS) which provided full medical, allied healthcare professional and nursing notes, and included daily checks by the nursing staff. Staff had individual log-ins for the CIS, which identified the individual making entries. Support and response from pathology and radiology was good, with instant availability, and viewing of films and results available.
- On discharge from the unit, records could be printed from the electronic system; however, staff had informed us that this was not always easy, and some notes had to be had written out, which was time consuming and allowed for possible errors.

## Safeguarding

- Staff confirmed that they had received safeguarding awareness training (adult and children) as part of the mandatory training. Staff were able to describe actions

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that would be undertaken to keep people safe, and were aware of their safeguarding responsibilities. Adult safeguarding training compliance in Critical Care Oct-Dec 2014 was 91%.

- The unit had two safeguarding children nominated link nurses, who provided support and advice to the team, and both had received level three training. Children's safeguarding training at levels 1, 2 and 3 were 95%, 91% and 97% compliant respectively.
- Approximately 20 children were seen in ICU last year, with care provided jointly by a paediatrician and ICU consultant. Provision was primarily stabilisation prior to transfer; however, occasionally children were cared for on the unit. There was no written policy for paediatrics in place, and no registered sick children's nurse (RSCN) employed on ICU. Care was provided by a senior nurse with close support from the medical team. The unit had recently begun to send staff to a paediatric intensive care unit at another trust to address the skill gap, and the education charge nurse identified relevant study events throughout the year that staff could attend.

## Mandatory training

- Mandatory training records showed 94% completion in ICU, with 95% completion of information governance training. The nursing staff were allocated into teams, with an identified band 7 team leader. Training days were in place for each team to complete mandatory training requirements and also to have team meetings. Staff training and attendance was monitored by the education charge nurse.

## Assessing and responding to patient risk

- There was a critical care outreach team providing a 24 hour, seven day service for the management of critically ill patients in the hospital.
- Patients were monitored using recognised observational templates and protocols, such as ARDS (for acute respiratory distress syndrome), VAP audit (for ventilator-associated pneumonia), sepsis care bundle, and standardised analgesia, sedation, and VTE prophylaxis. All risk assessments were documented in the CIS.
- We reviewed 13 sets of records (seven paper and six electronic), and risk assessments were seen for patients for pressure ulcers, falls and VTE, and were being completed appropriately and reviewed at the required frequency. Risks assessments identified required actions to minimise the risks to patients.

- The intranet was available at each bedside via the CIS, providing instant access for staff to view guidelines, policy and procedures.
- The hospital used a modified early warning score tool (MEWS) to alert staff to patients that were deteriorating and needed to be reviewed urgently. We saw that this ensured that staff provided early and appropriate treatment. The outreach team provided a response service to the wards, but also pro-actively visited the wards to help identify any deteriorating patients.
- A deteriorating patient group was in place, which was chaired by the medical director and held at least every two months. Consultants from ICU, respiratory, and surgery attend alongside the resus team and the outreach team.
- The computerised information system (CIS) facilitated good support and responses from other services, such as pathology and radiology, with instant availability and viewing of results and films.
- Face-to-face nursing handovers took place at every shift change. We attended a handover which included a short summary and diagnosis of each patient on the unit. Staff then received a thorough handover for their allocated patients at the bedside. Staff informed us that any changes to patients were communicated via the bedside nurse to the cluster leads, and then to the unit co-ordinator for the shift. We saw that the patient board was updated appropriately when there was a change in condition.

## Nursing staffing

- A supernumerary senior nurse co-ordinated each shift on ICU, and there was a nominated senior nurse identified as lead for both clusters to ensure communication throughout the shift.
- Nursing ratios to patients were in line with national guidance: Nurse to patient ratio was 1:1 for level 3 patients, and 2:1 for level 2 patients. Two non-registered members of staff were allocated on every shift. We observed individual 1:1 care, where appropriate, and this was corroborated with a sample off duty.
- When staffing levels were not met from permanent staff, the unit used additional central bank staff to cover absences. We were informed that there was a small regular group of central staff who were used for consistency, who had received orientation and competency assessments. Agency staff had not been used on ICU since March 2013.

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- New staff were allocated a specific staff rota by the education charge nurse, and remained supernumerary for a period of four to six weeks, dependent on previous experience and individual capability. A buddy allocation was in place to provide support.
- Two band 5 staff informed us that the supernumerary period had taken place, and a mentor was identified and worked with them. Both confirmed that team allocation and support was provided from the beginning.
- A computerised rostering system was in use, as well as a self-roster system. Staff were involved with allocation, and confirmed that they were able to discuss with the cluster/co-ordinating lead if they had any concerns or requests.

## Medical staffing

- Care in the ICU was led by a team of seven anaesthetic consultants, all of whom were members of the Faculty of Intensive Care Medicine. Two consultants were available on site during the day, Monday to Friday, and one overnight and at weekends. Consultants were required to be available within 30 minutes when off site.
- Consultant work patterns adhered to recommendations within the national guidance, Core Standards for Intensive Care Units 2013. Two consultants alternated five and six day blocks over a two week period in order to deliver continuity of care.
- All patients were reviewed by a consultant twice a day. Initial handover was undertaken at 8am, patients were then seen by the senior registrar prior to the 11am ward round. Ward rounds were consultant-led and had full team engagement, including senior and junior medical staff, nursing staff, pharmacist and dietician.
- The CIS was updated 'live' during the ward round, with all notes and prescribing entered onto the system via computer cards. It was noted that keyboard skills were vital for trainees to input data during ward rounds to aide efficiency. Consultants we spoke to confirmed that weekend ward rounds took longer due to inputting data.
- There was a robust induction in place for medical staff. Junior doctors were provided with an information pack, which included familiarisation with the unit, roles and responsibilities, information regarding daily routines, admission and transfers, rota and induction orientation checklist.

## Major incident awareness and training

- The trust had a major incident procedure in place which was accessed via the intranet from all computers. Each designated area had its own action card; ICU was action card 5.7. Staff confirmed verbally that they were aware of the major incident procedure, and were able to find the information quickly. A hardcopy of the ICU action card was also displayed in the office on the unit.

## Are critical care services effective?

Good



Critical care services were effective. The care, treatment and support of patients achieved good outcomes. Positive feedback from both patients and relatives was observed and received during the inspection, regarding both treatment and outcome of care.

Patients care and treatment was routinely assessed, documented and reviewed, supported by the computer information system (CIS), which had a number of preloaded prompts for clinical care. Staff were qualified, in line with best practice, and continuing development of staff skills, knowledge and competency was evident. All staff within the multidisciplinary team were seen to work collaboratively, and were involved in assessing, planning and delivering patient care and treatment.

## Evidence-based care and treatment

- The computer information system (CIS) supported regular monitoring and review of patient care, and good clinical audit. The ITU used a combination of NICE, Intensive Care Society and Faculty of Intensive Care Medicine guidance to determine the treatment it provided. Local policies were written in line with this, and were available on the CIS for staff to refer to.
- We reviewed six patient records and care pathways within the CIS, and a good level of evidence-based care was noted; routine clinical care and daily assessments of patient condition were recorded and reviewed, such as observations, care rounding, positioning, falls assessment, Waterlow score and VTE assessment.
- The CIS system had embedded care pathways to ensure appropriate and timely care for patients in specific conditions, such as ventilated patients. A system of drop

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down options allowed personalisation of care pathways; however, it did not allow free text. A note section provided staff with the ability to type specific action and care given.

## Pain relief

- Medication and sedation was continually monitored, documented and audited within the CIS system, and the patients that were able to speak with us confirmed that they were regularly asked about their levels of pain.
- We reviewed the electronic drug administration process, and observed two nurses checking IV medication according to policy. The CIS system has an integrated pop up box for a second individual to log on to record that the check was undertaken.

## Nutrition and hydration

- We reviewed six electronic records, and there were current risk assessments in place for hydration and nutrition. The malnutrition universal screening tool (MUST) was in place.
- A dietician was available Monday to Friday to provide nutritional assessment and advice, and participated in the 11am ward round.
- We observed that when needed, staff offered patients assistance with eating and drinking.
- Patients who were unable to eat or drink received nasogastric feeding. Total parenteral nutrition (TPN) was manufactured on site Monday to Friday.

## Patient outcomes

- The unit contributed to the Intensive Care National Audit and Research Centre (ICNARC) database. ICNARC data, for the period 1 January to 30 June 2014, showed that mortality outcomes and health care-acquired infection rates were low compared with other similar trusts. Early readmissions were comparative (under 2%), indicating that discharge was appropriate.
- The areas in which the trust performed worse were patients whose discharge was delayed for more than four hours, and out-of-hours transfers from the unit.

## Competent staff

- Of the critical care nursing staff, 60% had a post registration qualification in critical care nursing. This was above the national standard for intensive care services. On going personal development was

supported throughout the service, nurse competency packages were in place that advanced in complexity, and two staff were working towards a critical care qualification at Masters level.

- ICU had a full time band 7 education charge nurse, who provided teaching, supervision and support to all unit staff to enhance clinical skills, and was valued by the staff we spoke to. This role included organising student rotas and staff induction, monitoring of training, and running practical development days. Team days were allocated to allow for learning and development, and for mandatory training to take place.
- Of ICU registered nursing staff, 82% were trained mentors, providing support and guidance for student nurses on the unit, and triennial review for mentors was planned and allocated by the educational lead.
- We spoke with four junior medical staff and trainees who were very positive and felt they received good support from consultants, nurses and, specifically, the outreach team. There was a teaching programme in place which was well attended, and there was also a weekly journal club. Education and clinical supervision was seen in practice, and online assessments were seen to be in place and completed.
- The outreach team were managed by the lead nurse consultant. An appraisal system was in place and new members received a three month induction and mentorship period. Members of the outreach team were part of the outreach network, and attended quarterly meetings to share good practice and gain education.
- Staff we spoke with confirmed that they had received appraisals.
- Practical scenario training was organised and provided by the education charge nurse, for staff to gain experience and achieve competency. There was a band 5 training day during the inspection, and the staff attending confirmed that they felt supported, and that education and development was part of the culture within the unit.

## Multidisciplinary working

- A strong multidisciplinary approach was evident throughout the critical care services. We observed multidisciplinary ward rounds taking place, and they appeared to function well, with involvement of all staff, with representatives from medical, nursing, outreach, and pharmacy.



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- There was one pharmacist working in ICU every weekday morning, who worked alongside the team, and was available for any queries, and attended consultant ward rounds. The pharmacist provided training for junior doctors and nurses.
- The service had a dedicated team of physiotherapists that rotated through surgery and ICU.
- Patients were seen within the first 24 hours of admission, and care plans and treatment were discussed collaboratively with nursing and medical staff. Physiotherapy could not attend the 11am ward round due to staffing numbers, but did attend handover at 8am on Monday, Wednesday and Friday to ensure continuity of care. The physiotherapists also participated in teaching on the team education days.
- All staff reported that the unit provided effective care because of strong 'team working'.

## Seven-day services

- The outreach team were led by a consultant nurse, and provided a 24 hour, seven day week service. The team were proud of the provision, and junior medical staff and nursing staff confirmed the value of the team.
- Consultant cover was provided seven days a week, and ward rounds continued as per weekdays.
- Physiotherapy services were provided over seven days, with patients seen and assessed every day. We were informed that work on a business case had been commenced, to expand service provision to include a follow-up service, in line with NICE 83 guidelines for rehabilitation after critical illness, but this was currently on hold. Patients' physiotherapy goals were documented on transfer to wards, but there was no follow-up in place, and there were issues with the interface between the CIS electronic system and paper records used on the wards.

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

- Patients were, whenever possible, asked for their consent to procedures appropriately and correctly. Patients who were able to speak to us were able to confirm that they were asked to give permission for treatment.
- Frequently, critically ill patients may be unconscious or may be unable to provide their consent. Staff were able to provide examples of patients who did not have

capacity to consent, how they acted in the patient's best interests and, whenever possible, consulted with their relatives. We found that the Mental Capacity Act 2005 was adhered to.

- We reviewed six patient records within the computer system, and found clear and well documented Mental Capacity Act assessments (MCA 1&2) and Deprivation of Liberty Safeguard (DoLS) assessments.

## Are critical care services caring?

Good



Critical care services were caring, and we observed patients and relatives being treated with compassion, kindness, dignity and respect. Staff built up trusting relationships with patients and their relatives by working in an open, honest and supportive way.

We received feedback from relatives and patients confirming that staff kept them fully informed, and involved with decisions about their care. They felt supported and cared for, and were very positive about the standard of care received.

There were accessibility issues identified by relatives, with toilet facilities outside the controlled door access. This resulted in increased waiting times during busy periods.

## Compassionate care

- Patients and relatives we spoke to stated that staff were caring, friendly, approachable and responsive to their needs. Throughout our inspection, we saw patients being treated with compassion, dignity and respect. Examples of comments from patients included "it's how nursing should be with family included", "kind", "courteous" and "helpful" staff.
- Relatives were encouraged to visit, and visiting hours were flexible, at the discretion of the nurse in charge.
- The ICU has a controlled access system, with a main reception area at the Garrett Anderson Centre. There was a small internal waiting area, with access to the clinical clusters once access was granted from the main reception area. However, toilet facilities were external to this, and relatives and staff both stated that during busy times this was difficult, and relatives had an increased



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wait to regain access. We were informed that a business case had been developed to move the secure access to incorporate facilities, but we were not informed of the timescale for this.

- No formal overnight accommodation was available within the ICU itself. However, accommodation was available for families in the paediatric flats near East Theatres. This was not widely known by staff and relatives. One family commented that this facility would be nice if possible.
- Telephones were in situ at each bed space to allow for direct communication, by either the nominated nurse, or patient when able, with any relatives telephoning.
- There was a system in place, called Meridian, for collation of patient survey comments. Patient and relative survey results were displayed on the noticeboard on the unit. When comments were received where a member of staff was identified directly, the staff member received their own copy of this feedback, which could then be utilised in appraisal.

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

- The nature of the care provided in a critical care unit meant that patients cannot always be involved in decisions about their care. However, whenever possible, the views and preferences of patients were taken into account. We spoke with two patients and five relatives, who all confirmed that they were involved in decisions regarding care.
- Patient consent was documented in the CIS system, and discussions with relatives were documented.

## Emotional support

- Relatives that we spoke with said that they had felt very well supported, and that communication from both medical and nursing staff had been very open, with clear explanations of treatment. They felt that sufficient time was given by the staff for discussions. One relative stated "you don't have to wait for information, staff come and find you".
- Immediate support for patients and relatives was through the chaplaincy service, which was available 24 hours a day. There was no direct counselling referral system for staff; however, support could be accessed through occupational health. Staff also confirmed that

the support team on the unit was beneficial. Following any difficult situations, the sister from the support team followed up with the staff involved, talked through the situation, and gave a debrief to those involved.

- There was a relative's room available in cluster A for private consultations and conversations. The ICU provided a bereavement follow-up service, where relatives receive a follow-up call and invitation for a meeting with a senior nurse and clinician, to discuss and go through any questions they might have.

## Are critical care services responsive?

Good



The critical care services were responsive to the needs of their patients, and the overall capacity of the critical care service was adequate, and patients received timely care and admission to the unit. The ICU had a dedicated side room for children – all equipment was trolley based to enable utilisation as an adult bed should this be required.

However, delayed transfers out of hours were high due to unavailability of step down beds on the wards. Patients' notes were transferred to paper records on discharge from the unit to provide ongoing care.

Service provision for children was primarily stabilisation prior to transfer to a paediatric intensive care unit (PICU) by a dedicated retrieval team. However, the unit treated approximately 20 children a year, and no staff were registered sick children's nurses (RSCN). Staff recognised this skill gap, and had recently begun to send staff to a PICU at another trust to gain experience.

## Service planning and delivery to meet the needs of local people

- All admissions and transfers out were discussed and agreed with a consultant.
- There was a comprehensive outreach service in place, providing full 24/7 cover. The team consisted of nine senior staff (band 6 and band 7) and was led by a nurse consultant. The team provided interventional care and education. The outreach team provided pre-discharge visits and follow-up visits to patients on the wards within 24hrs, which were maintained until no longer required.

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- There was also a 'patient activated' critical care outreach service on the surgical wards, where post ICU patients could request the outreach team. Staff confirmed that this was a valued and popular initiative.
- There was a trust-wide initiative to reduce mortality from sepsis, with focus on early identification and intervention. The consultant lead for ICU was also the sepsis lead. Sepsis Six cards, stickers, bundles and treatment reminders had been introduced, and an auditing process was in place. The outreach team provided support and training regarding sepsis, including monthly simulation training days on the wards..
- The children's acute transfer services (CATS) were informed of all paediatric patients and undertook all transfers. ICU followed the CATS protocols and guidelines, available online, for care of children. There was a CATS transfer trolley on site, which was checked daily to ensure that all essential equipment was in place.

## Meeting people's individual needs

- The ICU provided care to people with complex needs; within the clinical teams there were link nurses identified for patients with specific additional needs, such as dementia and learning disabilities, who had additional training and provided support to the team. Additional resource packs were available for patients with learning disabilities.
- There was a dementia care checklist and assessment tool in use within the CIS, and the forget-me-not flower logo was in use to identify these patients on the allocation board.
- Staff demonstrated a good understanding of people's social and cultural needs. Translation and interpretation services were available, both by phone and in person. There were flash cards, symptom cards ('where it hurts'), and sign language cards available on the unit to assist with communication with patients.
- Difficulties in transferring patients, who no longer required ICU/HDU care, to the wards, meant that the unit was challenged to comply with single-sex ward areas, and bathroom and toilet facilities, because patients of different sexes could be accommodated in the same area. There was only one bathroom (with bath and shower) and one toilet on the unit to facilitate patient rehabilitation.

## Access and flow

- ICNARC data between 1 January and 30 June 2014 showed that bed occupancy ranged from three to 13, with the average being nine beds. This enabled the maintenance of an emergency bed, and allowed timely admission to the unit.
- There was the ability to utilise the paediatric side room as an adult bed should the necessity arise, as all dedicated paediatric equipment was stored in trolleys, allowing these to be moved around easily.
- The number of night time/out of hours transfers to the wards, however, was high, at 15-20%. There was evidence that these delays were being reported as adverse incidents in line with NICE guideline 50. Seven were recorded in the month of December.

## Learning from complaints and concerns

- Patients and relatives confirmed to us that they knew how to raise complaints and concerns, and felt comfortable to do so.
- Patient complaints were included in the monthly critical care governance meetings and communicated to staff. One example was an incident where an item of patient property (glasses), had gone missing. Patient property boxes had been instigated, and staff were aware of these and why they had been introduced.

## Are critical care services well-led?

Good



The critical care service sat within the division of surgery. The matron had a large portfolio which included theatres as well as critical care, which was recognised within the division as too extensive, and was something which needed to be addressed.

Governance framework from the local clinical leaders was not embedded. A standard agenda was in place across the trust, which had not been adapted specifically for critical care. During our inspection, we identified a number of aspects of care where risks had been identified; however, there were no current risks on the risk register, an example of this was the treatment of children on the unit. Therefore, there was no assurance that timely actions were being taken to protect people from avoidable harm.

# Critical care

There was good local leadership by the nursing team. Development and learning was encouraged, and staff satisfaction was good. There was a wellbeing group in place that ensured shared learning in the team and support for staff. There was clear nursing leadership, with nominated teams and roles, and leadership training provided; however, no formal leadership training had been provided for the lead clinician or the medical team.

## Vision and strategy for this service

- Staff were aware and understood the vision and values of the trust. Staff were clear about their roles, and behaviours that would achieve these values.
- Clinical research was largely portfolio-based. Two part-time research-based nurses had been employed and were situated in ICU. Recent research studies included sepsis study and leopard medication study. Good consent practice training was planned for juniors, to improve research activity.
- The outreach team had participated in developing a culture of care, with successful projects, such as the trust-wide sepsis awareness and treatment group, a deteriorating patient group, and a patient-activated outreach. However, staff voiced concerns regarding succession planning when the nurse consultant lead retires shortly and is not being replaced.

## Governance, risk management and quality measurement

- There were monthly critical care, outreach and resuscitation risk and governance meetings, and minutes were seen. These followed a general agenda for all areas of the trust, with headings of risk, health and safety, quality, productivity, and workforce. A highlighted report was then completed for the division, which went to the board.
- There were no current risks identified on the risk register for critical care. We were informed that some risks had been identified by the senior team as relevant and added to the register, but had been reviewed at trust-level and had been removed.
- Senior clinical staff were able to identify a lack of paediatric-trained staff, excess out-of-hours transfers to the wards, and no system administration support for the CIS, as risks; however, these were not on the register. Therefore, there was no assurance that timely actions were being taken to protect people from avoidable harm.

- Staff were encouraged to participate and join with nationally-recognised organisations, such as the annual ICNARC conference, and there were dedicated annual clinical team days for the nursing staff, to allow for mandatory training
- The critical care service had a functional participation with the critical care network. Clinical staff attended biannual educational meetings to support quality improvement, and support sharing of best practice.
- The ICU had an identified clinical audit programme (local and national) in place, to monitor and review best practice. Thirteen clinical audits had taken place between April and December 14; nine had been completed, and four were ongoing.

## Leadership of service

- The critical care service was led by a consultant anaesthetist and matron, who provided effective team leadership and were respected by the staff we spoke with. All staff confirmed a friendly and supportive culture.
- The matron was also responsible for theatres and anaesthetics, which she felt was too large a portfolio, and discussions were underway with the director of nursing to review the structure.
- We saw committed and effective leadership at a local level. Staff were divided into teams, with a nominated team leader and area of focus, such as cardiac, respiratory, paediatric, hepatic renal, support and infection control. Staff informed us that they felt supported, both by nursing colleagues and the medical team.
- Nominated link nurses were identified to enable ongoing staff development, and this was then monitored through appraisal. Examples of link roles included dementia champion, diabetes, palliative care, health and safety, tissue viability, spinal, pain, and learning disability.
- Monthly 1:1 meetings were in place for band 7 staff with matron, to identify work plans and discuss issues.
- Ongoing development was clear for the nursing staff and junior doctors; however, leadership and management development was not in place for the senior clinicians.

# Critical care

## **Culture within the service**

- Staff identified a supportive culture and cohesion within the team across all levels of staff. At times staff have to deal with difficult outcomes for patients, and they confirmed that they support each other and have regular 'huddles' to discuss such difficult situations.
- Staff working on ICU spoke positively about the service they provided for patients.







## **Public and staff engagement**

- An action plan was in place to promote staff health and wellbeing in the critical care service. Staff felt involved with the actions, and felt issues were being addressed.

## **Innovation, improvement and sustainability**

- Staff felt able to develop new initiatives. For example, we were informed that guidelines were being developed to enable pets to visit patients on the unit, and draft guidelines for the use of hand control mittens in ICU were seen, for use as an alternative to drug therapy, when appropriate, for patients with delirium.
- Patient diaries had been put in place, an initiative that was led by one of the senior nursing staff. The nurse, carer or relative can record in the diary what has happened on various days, to help the patient understand what has taken place as they recover.

# Maternity and gynaecology

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

## Information about the service

Maternity and gynaecology includes all services provided to women that relate to pregnancy, including antenatal, day assessment unit, labour, surgery, birth and postnatal care. There are two levels of maternity service provided by Ipswich Hospital NHS Trust (IPHT): midwifery-led care for low risk mothers at the Brook Birth Centre at Ipswich Hospital, or at the Gilchrist Birthing Unit located in Hartismere Outpatient Hospital and consultant-led care for higher risk mothers, which are provided on Deben Ward.

The inspection team included one inspector, a specialist midwife, a consultant obstetrician and a consultant gynaecologist. During our inspection, we spoke with 51 staff, and eight patients and three partners. The inspection team visited the antenatal and postnatal services, as well as the labour ward and theatres providing obstetric-related surgery. We observed care on Stour (gynaecology) Centre, and visited Brook Ward midwifery-led birthing unit, which included liaison with the community midwifery teams. There were 3,459 deliveries by Ipswich Hospital NHS Trust last year.

We received comments from our listening events and from people who contacted us to tell us about their experiences. We used information provided by the organisation and information that we requested, which included feedback from young people and women using the service about their experiences.

## Summary of findings

The current safety of maternity and gynaecology services provided to women and babies by Ipswich Hospital was good. There were arrangements in place to implement good practice, learning from any untoward incidents, and an open culture to encourage a strong focus on patient safety and risk management practices. We found no concerns during the inspection of the maternity and gynaecology units regarding infection control practices, and we saw appropriate medication management to promote safe, secure and effective management of medicines.

Staff had identified the things that were most important to delivering safe care in their area, and patients told us that they felt safe in their hands. Mandatory training, including safeguarding measures, were in place, and staff recognised and responded appropriately to changes in risks to people who use services.

The managers had provided safe staffing levels and skill mix, and had encouraged proactive teamwork to support a safe environment. We found that people's care and treatment was planned and delivered in line with current evidence-based guidance, standards, and legislation. This was monitored to ensure consistency of practice. There was good information regarding pain relief available during home or hospital birth.

Patient outcomes for maternity and gynaecology were good at Ipswich Hospital. Waiting times were satisfactory, the current rates of elective and emergency

# Maternity and gynaecology

caesarean section rates were lower than the national average, and vaginal births after previous section were high, which was very good. The clinic organisation and counselling support for women undergoing termination of pregnancy, and those suffering miscarriages, was good, and the service always ensured appropriate placement in a planned side room or bay to support these patients' needs sensitively.

All permanent staff were appropriately qualified and competent to carry out their roles safely and effectively in line with best practice. There were detailed and timely multidisciplinary team discussions and handovers to ensure patients' care and treatment was co-ordinated, and the expected outcomes achieved. We found that the care given was good. Staff in all roles put effort into treating patients with dignity, and patients felt well-cared for as a result. Patients and those close to them were encouraged to be involved in their care, treated as equal partners, listened to, and were involved in decision-making at all levels.

Feedback from people who use the service, those who are close to them, and stakeholders, were positive about the way staff treat people. People were treated with respect and kindness during interactions with staff, and relationships with staff were positive. Care was women-centred, and parents sensitively supported where bereavement occurred.

The specialist inspectors, which included an obstetrician, gynaecologist and lead midwife, noted that service planning and delivery required improvement, as actions for service development, in line with current clinical practices, were not always in place or proactive. Staff acknowledged the lack of specialist lead roles in areas such as bereavement, teenage pregnancy, foetal abnormality and perinatal mental health support, which are seen as key to supporting vulnerable women during and after pregnancy.

Bed flow and capacity management in maternity was satisfactory. Capacity escalation plans were in place to deal with medical outliers appropriately in the gynaecology wards. There were no concerns raised by patients or staff regarding waiting times. Delays and cancellations were minimal, and managed appropriately. There was openness and transparency in how complaints were dealt with. Complaints and

concerns were always taken seriously, responded to in a timely way, and listened to. Improvements were made to the quality of care as a result of complaints and concerns.

The majority of maternity and gynaecology staff understood the vision and strategy of the trust, but whilst clear on current quality and safety practices, they were not so clear on the division's strategic goals for developing the services. The management team instigated a thematic review of maternity services (September 2013 - March 2014). This resulted in a maternity action plan, encompassing improvements in governance, risk management and quality measurements across the unit, which was noted as good practice. We saw through meetings and staff consultation that the risks at team and management level were identified and captured, and staff recognised their role within the risk management system.

We found the midwifery leadership model encouraged co-operative, supportive relationships among staff, and compassion towards people who use the service. Staff saw the head of midwifery as a strong effective leader, who had a voice at board level. Staff said that candour, openness, honesty and transparency were at a high level, and they would challenge poor practice where required. They were confident in the support of their managers and the senior executive team.



# Maternity and gynaecology

## Are maternity and gynaecology services safe?

Good



The current safety of maternity and gynaecology services provided to women and babies by Ipswich Hospital was good. There were arrangements in place to implement good practice, learning from any untoward incidents, and an open culture to encourage a strong focus on patient safety and risk management practices.

We found no concerns regarding infection control practices, and we saw appropriate medication management guidelines in line with the Nursing and Midwifery Council's rules and standards available for staff reference, to promote safe secure and effective management of medicines.

Staff had identified the things that were most important to delivering safe care in their area, and patients told us that they felt safe in their hands. Mandatory training, including safeguarding measures, were in place, and staff recognised and responded appropriately to changes in risks to people who use services.

The managers had provided safe staffing levels and skill mix, and had encouraged proactive teamwork to support a safe environment.

### Incidents

- It is mandatory for NHS trusts to monitor and report all patient safety incidents. We looked at incident reporting policies, a database which included maternity incidents raised by staff, and Maternity Risk and Governance Group (RAGGM) safety meeting minutes, and found that there were arrangements in place for reporting of patient/staff safety incidents and allegations of abuse, which were in line with national guidance.
- During the period of October 2013 - March 2014, maternity services at Ipswich Hospital NHS Trust declared six Serious Incidents, three of which were in March 2014; we also noted delay in closure of some lower risk incidences over the last year. The Division 3 management team instigated a thematic review, which found some overlapping themes across the cases, but most findings were more case-specific, and in view of the small number of cases it was not possible to make

any definite links between the incidents that could reflect a broader issue. Key recommendations had been made from all areas of the review. We saw an action plan for maternity services development, which included recommendations from the maternity thematic review 2014, such as the review and re-enforce clinical escalation plan, with the majority of actions completed, and reasonable time frames for completion of those outstanding.

- We looked at four reviews of unplanned admissions to the neonatal unit, a 'never event', and an investigation into a maternal death, and the findings and recommendations were reviewed by the Maternity Risk and Governance Group (RAGGM) senior team, and presented at the departmental perinatal meetings. Staff were aware of these incidences, and of practice changes, such as the introduction of vaginal swab stickers following a retained swab incident. Recommendations were shared and monitored in the RAGGM and morbidity meetings, including case reviews by multidisciplinary teams, to consider any changes to practice to improve outcomes for patients.

### Safety Thermometer

- There were information boards clearly displayed outside each unit for staff and visitors, which included some monthly key safety indicators, such as 100% hand-washing compliance, and 78.8% initiation of breastfeeding for Brook Ward. Labour ward information stated that one-to-one care was 98.8%, and vaginal deliveries following section rates were 69%, which was good.
- We saw three different maternity dashboards with various indicators, such as management of the deteriorating patient, prevention of blood clots assessment practices, and infection control indicators. We saw that most of the indicators were compliant at the time of inspection, including below national average rates for elective and emergency section rates, which was good. The senior managers were developing a computer system to streamline the data to improve reporting systems.

### Cleanliness, infection control and hygiene

- We found no infection control concerns during the inspection. Ward and clinic areas appeared clean, and we saw staff regularly wash their hands and use hand gel between patients. 'Bare below the elbow' and

# Maternity and gynaecology

isolation policies were adhered to. A recent hand hygiene audit scored 100%, and 'I am clean stickers' were on equipment. Of clinical staff and obstetricians, 95% had up-to-date infection control training.

- We saw information which noted that visitors must keep contact with babies to a minimum, and should wash their hands thoroughly both before and after, and that all visitors, including partners, should not sit or lie on beds.

## Environment and equipment

- Staff told us that there were adequate storage facilities and levels of equipment for safe monitoring. We saw that resuscitation equipment was in line with national guidance, and checked regularly. There was training provided to relevant staff regarding using equipment, which included 92% attendance at manual handling training.
- We saw additional equipment, such as blood pressure (BP) monitoring equipment, and bilirubin meters, being ordered, and formal consideration being made for increasing the number of oxygen monitors for newborns. Staff were pleased that four monitoring (cardiotocography / CTG) machines arrived earlier in the year; and approval for four more CTG machines had been agreed in October 2014 and ordered, with delivery expected January 2015.

## Medicines

- Staff we spoke with were aware of medicine management policies for reference purposes, and monitoring systems were in place to pick up medication errors. There were locks installed on cupboards containing intravenous fluids, and key locks on doors for secure medicine practices.
- Staff told us, and records showed, that there was an annual medicine management update, with 96% attendances. We saw that new guidelines were being ratified for the use of transdermal sterile water injections during labour, which was noted as good practice.
- Reconciliation of controlled medicines occurred daily on both gynaecology and maternity units.

## Records

- We saw evidence of information governance breeches being investigated and acted upon, including undertaking spot checks on processes and procedures

within the maternity services by 31 January 2015 to safeguard patient's personal information. Of the staff, 90% had recently attended information governance training to heighten awareness. Four records we looked at were comprehensive, although lacked signatures and dates in some instances. We saw that clinical record-keeping was audited on a regular basis, with recommendations where needed.

## Safeguarding

- We found that the managers identified the things that were most important to protect people from abuse and to promote safety. Staff we spoke with were aware of the named safeguarding midwife, who attends the safeguarding meetings and approves protocols. There was a safeguarding vulnerable adults policy, which included contact numbers for local safeguarding teams, and staff were familiar with the process for raising concerns.
- The training records showed that appropriate safeguarding training was being provided at the right level. The provider had a flag alert system to show when staff were due for refreshers, and there was current compliance with trust policy at 96%.
- Safeguarding children training was undertaken and current compliance with levels 1,2 and 3 were 96%, 98% and 87% respectively across the service.

## Mandatory training

- Mandatory training was regularly monitored, with triggers in place to pick up non attendees. The current levels, ranging between 91% basic life support, and equality and diversity 89%, were satisfactory, and staff noted that the content was appropriate.
- Maternity midwives and assistants had training passport booklets, which they were accountable for maintaining, which was good practice. Overall compliance for mandatory training was 93% for clinical staff, and 80% for medical staff. Chasing letters were observed where staff had missed a session.

## Assessing and responding to patient risk

- Staff confirmed training sessions, which included maternity early observation warning systems (MEOWS) to manage the deteriorating patient. There were escalation policies in place for the acutely ill patient, and monitoring systems to ensure the scoring system was effective.

# Maternity and gynaecology

- In response to incident reviews, we saw a 'lack of escalation to senior staff for management of complicated labour clinical escalation' guidance update sent to the staff intranet in January 2015. There were also quarterly reports on compliance, with the 'Fresh Eyes' report being actioned in line with monitoring foetal heartbeat (CTG interpretation).
- We looked at four records and saw the use of obstetric warning scoring systems, which had been completed appropriately, and escalated where needed to manage patients at risk.

## Midwifery staffing

- Midwifery staff we spoke with were confident that managers ensured that the right staffing levels and skill mix, across all clinical and non clinical functions and disciplines, were sustained at all times of the day and week to support safe, effective patient care, and levels of staff wellbeing.
- Midwife to birth ratio was the same as the England average at 1:30. Staff gave examples of increased staff numbers when demand was high, such as calling community midwives into the hospital, and said that managers were responsive to changing needs and circumstances, such as cover for long-term sick leave or study leave. There were on-call community midwives for home births and emergency care each night. The ratio of supervisor of midwives (SoM) to midwives was 1-11, which was good.
- Staff were willing to be flexible where needed, and told us that they were proud to work there, and that patient safety was a priority. Staffing levels were displayed for patient reference, which was good practice. All the patients we spoke with were very positive about the approach to safe care on the unit.
- We saw that assessments of future workforce requirements using established birth rate plus tools were being completed to identify the number and experience of staff required to provide appropriate and safe cover in all maternity care settings at Ipswich Hospital. The trust used the safe staffing metric for ongoing monitoring, to ensure safe staffing levels were maintained.

## Medical staffing

- Doctors we spoke with noted the right medical staffing levels and, although the obstetric middle grade staffing

has continued to be low, the skill mix across all clinical disciplines had been sustained using locums at all times of the day and week to support safe, effective patient care and levels of staff wellbeing. There were 51 hours of consultant cover, with a further three consultants currently being recruited, which would increase this to 60 hours, with full on-call support out of hours and at weekends. We saw that the medical staffing for the unit was appropriate for the current levels of activity.

## Major incident awareness and training

- Staff were aware of guidelines, which included potential closure of the maternity unit, with contingency planning to ensure that any decision to close the unit was appropriate and consensual.
- There were other escalation policies available to staff, including an abduction policy. Staff we spoke with were confident regarding reporting mechanisms, and that support from senior managers and the head of midwifery would be good in the event of a major incident.

## Are maternity and gynaecology services effective?

Good



People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, and legislation. This was monitored to ensure consistency of practice. There was good information regarding pain relief available during home or hospital birth.

Patient outcomes for maternity and gynaecology were good at Ipswich Hospital. The current rates of elective and emergency section rates were lower than the national average, and vaginal births after previous section were high, which was very good.

The clinic organisation and counselling support for women undergoing termination of pregnancy, including those suffering miscarriages, was good, and the service always ensured appropriate placement in a planned side room or bay to support these patients' needs sensitively.

All permanent staff were appropriately qualified and competent to carry out their roles safely and effectively, in

# Maternity and gynaecology

line with best practice. There were detailed and timely multidisciplinary team discussions and handovers to ensure patients' care and treatment was co-ordinated, and the expected outcomes achieved.

## Evidence-based care and treatment

- A supervisor of midwives (SoM) was on the guideline development group, and also the Maternity Risk and Governance Group (RAGGM), which is responsible for approving evidence-based care guidelines. We saw that spreadsheets were maintained with all guidelines with review dates, and work in progress was monitored through a tracking device, which also provided the reasons for the guideline and whether it was a result of an incident or complaint. It also stated the owner/responsible officer, and provided details of the Royal College of Gynaecology (RCOG) reference and any other associated party. This was good practice.
- Staff told us that a newsletter was produced indicating changes to guidelines and practice, and that training was updated to reflect changes to practice when required via the maternity action plan. We saw examples of updated policies in line with national guidelines, such as twins and multiple births guidelines updated and implemented in December 2014.
- Departmental audit leads were responsible for identifying their audit programme for the year, to include mandatory topics, national audits (including NICE), trust priorities and discretionary topics. We saw a local audit plan and examples of national audits being actioned, such as the Heavy Menstrual Bleeding National Audit (2010-13) final 4th report published recently, and the National Pregnancy in Diabetes (NPID) Audit; national results for the 2013-14 audit were published in October 2014.
- It was reported that there was an overarching clinical audit and effectiveness committee reporting to the patient safety and clinical effectiveness group, and departmental audit meetings to monitor the practice developments to improve outcomes for patients.

## Pain relief

- We saw good information regarding pain relief available during home or hospital birth. Patients we spoke with confirmed that they were offered regular pain relief during labour, and we saw the recording of pain scores in four patient records we reviewed.

- We saw that Hypnobirthing courses were available to help prepare parents for the birth, and a SoM was working on the introduction of transdermal sterile water injections for pain relief in labour; this followed attendance by two SoMs at a training session, and development of a guideline, patient group directive, and training programme for midwives.

## Nutrition and hydration

- Through examination of four records we saw that people have comprehensive assessments of their needs, which included consideration of clinical needs, physical health and wellbeing, and nutrition and hydration needs. The expected outcomes were identified, and care and treatment was regularly reviewed and updated. Special diets were supported, including halal, kosher, vegan and multi-intolerance diets, as well as any health-related requirements.
- We saw the provision of peer breastfeeding supporters visiting the postnatal ward on a daily basis, as well as the provision of community-based breastfeeding support. The unit had level one Baby Friendly accreditation, which supports breastfeeding, and was due to be assessed for level two in January 2015.

## Patient outcomes

- Patient outcomes were good at Ipswich Hospital. The information received by the Care Quality Commission did not highlight any concerns against national benchmarks with other acute NHS hospitals. The current rates of elective (9.9%) and emergency (10.9%) section rates was lower than the national average, and vaginal births after previous section (VBAC) of 69% were high, which was very good.
- For pregnant women, 98% were booked by 12 weeks six days gestation for an antenatal (AN) visit with the community midwife. It was reported that the average number of days between referral and appointment were monitored and were satisfactory. 'Did not attend' (DNA) rates averaged 2.4%.
- There were 1,671 midwife-led care births (MLC) booked in 2013/14, which resulted in 43% births, 38% AN transfers, and 19% intrapartum transfers. There was little variance in the number of women booked for MLC and the outcomes over the past three years. The home birth rate was 4%, which was good.

# Maternity and gynaecology

- We saw that midwives were monitoring blood clot assessments (VTE), which should be 98%, but at the present rate were 94.8%.
- The clinic organisation and outpatient care for medical termination of pregnancy was good. There were allocated side rooms for medical or surgical termination above nine weeks, and the service always ensured appropriate placement in a planned side room or bay to support these patients' needs sensitively. Disposal of foetal tissue was in line with national guidance, and two records checked were in line with the Abortion Act 1967.

## Competent staff

- All permanent staff were appropriately qualified and competent to carry out their roles safely and effectively in line with best practice. Staff told us that there were effective induction programmes, not just focused on mandatory training, for all staff, including students and midwifery care assistants.
- We were shown competency-based assessments, which all midwives were required to complete, and training passports which they are accountable for maintaining, and attendance at specified training, which included six monthly CTG training and obstetric emergencies.
- Staff told us that they were supported to deliver effective care and treatment, including thorough, meaningful and timely supervision and appraisal. Relevant staff were supported through the process of revalidation, and junior doctors and midwives were positive regarding the education opportunities within the trust. The appraisal rate across the division was low at 55% for medical staff, but satisfactory at 90% for clinical staff.
- The appointment of a clinical practice facilitator was being actioned to develop and maintain the preceptorship programme, and was being recruited to.

## Multidisciplinary working

- Staff we spoke with, including community midwives and students, were aware of the importance of joined up working with health visitors, GPs and school nurses to support patients care pathways, both in hospital and back in the community. Patients we spoke with said that the care package was joined up between the hospital and community settings.

- We found by observing ward areas, and listening to focus groups, and individual doctors, midwives, gynaecology nurses, support workers and administration staff, that there were detailed and timely multidisciplinary team discussions and handovers, to ensure patients' care and treatment was co-ordinated and the expected outcomes achieved. Care and treatment plans were recorded, and communicated with all relevant parties to ensure continuity of care, although staff noted that the link with mental health community services, and support for hard-to-reach groups, such as the Romanian communities, was lacking at times.
- We saw examples of external meetings incorporating key workers, such as the minutes of the family nurse partnership advisory board, November 2014, which showed discussions regarding the need for mental health and long standing disorders focused especially with vulnerable young mothers, and also the maternal mental health task and finish group minutes, 18 November 2014, highlighting the need for additional mental health support services.

## Seven-day services

- The SoM team ensured that there was access to a SoM at all times 24 hours a day, 7 days a week by participating in a 24 hour on-call rota, which ensures all midwives have continual access to a supervisor of midwives (SoM).
- The specialist inspectors found that the consultants provided adequate cover for the maternity unit, with full on-call cover out of hours.
- Availability of out-of-hours imaging/pharmacy/occupational therapy/physiotherapy and screening services were in place, and staff said that they were satisfactory.

## Access to information

- We saw, and patients confirmed, that they carried their antenatal hand-held notes with them when attending appointments at Ipswich Hospital or the Gilchrist Birthing Unit. This meant that staff could access the information they needed to assess, plan and deliver care to people in a timely way; particularly when people move between services or during transition.



# Maternity and gynaecology

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

- Six records, including termination of pregnancy, showed us good consent practices in line with national Royal College of Obstetricians and Gynaecologists (RCOG) guidelines. Patients told us that they were well informed regarding the risks, such as for elective caesarean sections and the use of epidurals. Partners told us that they felt involved where necessary in the decision-making process.
- We saw that the safeguarding policy links with legislation and guidance, including the Mental Health Act Code of Practice (DH, 2008 and 2007) and Deprivation of Liberty Safeguards: A guide to hospitals and care homes (DH, 2009), for staff reference, and that 98% of staff had attended low risk mental health training to heighten awareness.

## Are maternity and gynaecology services caring?

Good



We found that the care given was good. Staff in all roles put effort into treating patients with dignity, and patients felt well-cared for as a result. Patients and those close to them were encouraged to be involved in their care, treated as equal partners, listened to, and were involved in decision-making at all levels.

Feedback from people who use the service, those who are close to them, and stakeholders, were positive about the way staff treat people. People were treated with respect and kindness during all interactions with staff, and relationships with staff were positive.

People felt supported, and said staff cared about them and their partners. There were positive views from a breadth of patients and those close to them about the care provided, which were supported by the views of the staff. Care was women-centred, and parents were sensitively supported where bereavement occurred.

## Compassionate care

- We found by observing ward areas, and listening to focus groups, and individual doctors, midwives, gynaecology nurses, support workers and

administration staff that staff in all roles were patient-centred, responded compassionately when people needed help, and supported them to meet their basic personal needs as and when required.

- All key staff (99%) had received customer care training, and this was apparent when we observed interactions with patients. We saw a dignity and respect charter displayed, and also a visitors' charter, which also recognised the needs of partners.
- Friends and Family Test (FFT) results were currently above the England average for birth, antenatal and postnatal, and community services, which is good. Also, in the survey of women's experiences of maternity services 2013, all but three measures were similar to the national average. The response time to answering call buttons was good.

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

- Feedback from people who use the service, those who are close to them, and stakeholders, was positive about the way in which staff treat people. People were treated with dignity, respect and kindness during all interactions with staff, and relationships with staff were positive. People felt supported, and said staff cared about them and their partners.

## Emotional support

- Staff helped people and those close to them to cope emotionally with their care and treatment. Brook Ward is a midwife-led ward. There are three birthing rooms for natural childbirth in a quiet environment. Feedback from patients on emotional support was good.
- Four volunteer midwives and a midwife support assistant with an interest in counselling and bereavement support provided a monthly reflections meeting, to bring people together to speak about their experience and loss. There is a specific bereavement room, with a cold cot for providing a quiet place for parents to spend time. One of the midwives has developed information, such as 'after your baby has died', which included different cultural recognition.
- There was spiritual support through a chapel in the hospital, and a chaplain of different denominations was available to visit on request. People were informed that their own spiritual advisor could visit where required.



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- Counselling support for women undergoing termination of pregnancy, and those suffering miscarriages, was good.

## Are maternity and gynaecology services responsive?

Requires improvement



Maternity service planning and delivery required improvement, as actions for service development in line with current clinical practices were not always in place or proactive. Staff acknowledged the lack of specialist lead roles, such as for bereavement, teenage pregnancy, foetal abnormality and perinatal mental health support, which are seen as key to supporting vulnerable women during and after pregnancy.

Bed flow and capacity management in maternity was satisfactory. Capacity escalation plans were in place to deal with medical outliers appropriately in the gynaecology wards. There were no concerns raised by patients or staff regarding waiting times. Delays and cancellations were minimal and managed appropriately.

There was openness and transparency in how complaints were dealt with. Complaints and concerns were always taken seriously, responded to in a timely way, and listened to. Improvements were made to the quality of care as a result of complaints and concerns.

### Service planning and delivery to meet the needs of local people

- Maternity service planning and delivery required improvement, as actions for service development in line with current clinical practices were not always in place or proactive. The needs of the local population were not always fully identified or understood, or taken into account when planning services, or there were shortfalls in doing this. The following are examples of these concerns:
  1. No specific antenatal clinic for women with complex medical needs, such as epilepsy or haematology, to accelerate referrals for specialist advice.
  2. No specific clinics for women with multiple pregnancies.

3. No transitional care facilities on the postnatal ward, which led to the avoidable separation of mother and baby.
  4. Postnatal women transferred to the labour ward if observations of MEOWS are required, more frequently than four hourly, when this should be managed on the postnatal ward. This can increase anxiety and put too much emphasis on making the experience for women more medical when the risk is not high.
  5. Low risk inductions carried out in the labour ward, which again, put too much emphasis on medicalising the experience for women when the risk is not high.
  6. There was no quiet room in the antenatal clinic for breaking bad news.
  7. Currently, Ipswich Hospital undertakes approximately 60% surgical terminations of pregnancy, which is much higher than national average. The expectation is 80% or above medical terminations to reduce surgical risks.
  8. Lack of outpatient hysteroscopy services.
  9. Day stay gynaecology patients mixed with higher dependency patients.
- We saw that the maternity unit was given money by the Department of Health to refurbish the delivery rooms, adding more en suites and replacing toilets, basins, baths and showers with new ones. Delivery rooms are now more welcoming, with the addition of mood lighting to help relax women in labour, and create a better ambience for them and their partners. The money has also provided 19 reclining chairs to make it more comfortable for antenatal women and the partners of women in labour. Plus, another 33 recliners have been added for breastfeeding mums, together with 11 chairs for women with a high body mass index. The project also supported comfort for partners, and was in line with national recommendations for involving partners in maternity care.

### Access and flow

- An outreach clinic, including screening, midwifery and obstetrician services, was set up, and sessions increased in Stowmarket to support patient demand and easier access for outpatient maternity management. This was noted as good practice.
- We followed through the appropriate integrated care pathway (ICP) for termination of pregnancy, and noted that it complied with the Abortion Act 1967. The staff

# Maternity and gynaecology

ensured good access and flow to guarantee a designated clinic for advice, with a registered nurse for consultation, and an independent trained counsellor if required, before seeing a consultant gynaecologist, or registrar for final consultation and consent for procedure.

- The trust does not currently collect data relating to the time taken for patients to be seen by a midwife within 30 minutes, or the percentage of patients seen by a consultant within 60 minutes. However, there were no concerns raised by patients or staff regarding waiting times. We also noted that the 18 week waiting time for gynaecology patients was 99.1%, which is good. Bed flow and capacity management in maternity was satisfactory. Capacity escalation plans were in place to deal with medical outliers appropriately in the gynaecology wards.

## Meeting people's individual needs

- People who use the service were asked about their spiritual, ethnic and cultural needs, and their health goals, as well as their medical and nursing needs. We saw in their records, and patients told us, that their care and treatment was planned and delivered to reflect these needs, as appropriate; 89% of staff had attended equality and diversity training within the last year.
- Staff acknowledged the lack of specialist lead roles, such as for bereavement, teenage pregnancy, and perinatal mental health support, which are seen as key to supporting vulnerable women during and after pregnancy. The risk register acknowledged the lack of mental health lead support, and the labour ward forum minutes in December 2014 noted the need for improved bereavement processes and paperwork. External working parties had been recently set up regarding mental health needs, but there was minimal assurance that proactive steps were being taken to develop these services in a timely manner.
- Information was available for people who had difficulty in understanding or speaking English, interpreter services (including sign language interpreters) could be arranged, although community staff had difficulty in accessing some Romany local dialects.
- Staff were aware of the learning disabilities liaison nurse and the safeguarding midwife, who both provide advice

and support for people in vulnerable circumstances, as well as for their families and carers. They also supported people who lacked capacity, and staff had safeguarding training, which incorporated the Mental Capacity Act.

- We observed the action plan for maternity services, and it demonstrated appropriate actions taken, such as an improvement in the availability of choice for partners staying overnight, with recliner seats and amenity beds.
- There were feedback boards outside the units, which indicated to people that they were in safe hands and that any feedback received would be acted upon, such as “You said, we did”; an example of this concerned additional information around managing personal data safely.

## Learning from complaints and concerns

- People we spoke with knew how to raise concerns or make a complaint. Staff told us that they encouraged people who use services, those close to them, or their representatives, to provide feedback about their care. The dashboards on each unit encouraged people to provide feedback to improve services, and reported on practice changes learning from complaints and concerns.
- Staff were aware of the maternity service development plan, which included actions for complaints management, such as improving analysis of incidents and complaints, and shared learning through dissemination of information in newsletters and multidisciplinary training.
- We saw evidence of follow-up on actions from audits, complaints and incidents, through the maternity risk and governance group, to implement a tighter process, to ensure actions were followed through and to provide assurance of completion.

## Are maternity and gynaecology services well-led?

Good



The majority of maternity and gynaecology staff understood the vision and strategy of the trust, but whilst clear on current quality and safety practices, they were not so clear on the division's strategic goals for developing the services.

# Maternity and gynaecology

The management team instigated a thematic review of maternity services, September 2013 - March 2014. This resulted in a maternity action plan, encompassing improvements in governance, risk management and quality measurements across the unit, which was noted as good practice.

We saw through meetings and staff consultation that the risks at team and management level were identified and captured, and staff recognised their role within the risk management system.

We found the midwifery leadership model encouraged co-operative, supportive relationships among staff, and compassion towards people who use the service. Staff saw the head of midwifery as a strong effective leader, who had a voice at board level. Staff said that candour, openness, honesty and transparency were at a high level, and they would challenge poor practice where required. They were confident in the support of their managers and the senior executive team.

## Vision and strategy for this service

- The senior executive team provided inspectors with a statement of vision and values encompassing key elements of the NHS constitution, such as compassion, dignity, respect, and equality, with quality and safety as key priorities. The majority of maternity and gynaecology staff understood the vision and strategy, but whilst clear on current service and safety practices, they were not so clear on the division's strategic goals for developing the services.

## Governance, risk management and quality measurement

- During the period of October 2013 - March 2014 maternity services at Ipswich Hospital NHS Trust declared six Serious Incidents, three of which were in March 2014. The Division 3 management team instigated an Ipswich Hospital NHS Trust thematic review of maternity services, September 2013 - March 2014. The purpose was to identify any underlying trends, review the governance process in the maternity unit, highlight areas of good practice, and instigate any remedial action in any areas identified, as required. A project board to lead the review was identified, and the terms of reference for the thematic review were agreed with the trust executive. This was good practice.

- We saw that key recommendations had been made from all areas of the review, and that staff were familiar with practice changes actioned, such as:
- Review content and format of CTG training package to include 'Fresh eyes' approach, and provide multidisciplinary in-house staff training to incorporate approach.
- Review Training Needs Analysis and mechanism of monitoring and reporting of compliance with maternity mandatory training.
- We saw through meetings and staff consultation that the risks at team and management level were identified and captured, and staff recognised their role within the risk management system. Staff gave examples, and there was evidence in the three labour ward forum minutes, October to December 2014, of quality improvements and practice changes resulting from reported incidents, audits and complaints. The performance dashboards were currently being developed as the computer system had been difficult to extract data from until recently.
- The risk registers reflected the key risks recognised by the staff we spoke with, such as the distance of the obstetric theatres (eighth floor) to the maternity wards (on lower floors). A clear risk assessment was in place, demonstrating actions taken to mitigate the risk and safeguard patients.

## Leadership of service

- We found that the midwifery leadership model encouraged co-operative, supportive relationships among staff, and compassion towards people who use the service. Staff saw the head of midwifery as a strong effective leader, who had a voice at board level.
- We found that leadership appeared focused on maintaining quality and safety; however, emphasis on service development was lacking.

## Culture within the service

- Staff said that candour, openness, honesty and transparency were at a high level, and they would challenge poor practice where required. They were confident in the support of their managers and the senior executive team. We saw that the 'Duty of Candour and being open' guidance was updated in December 2014 for staff reference purposes.

# Maternity and gynaecology

## Public and staff engagement







- Following a long period of time without a user group for maternity services, a SoM was directly responsible for setting up and developing the maternity service user group (MSUG). The first meeting was held in April 2013. There is a new chair person who links with the Ipswich Hospital User Group. It was reported that the plan for the coming year is for the MSUG members to be involved in maternity service development and a review of maternity services. The head of midwifery noted in the minutes that staff were keen for all improvements to be consumer-led rather than service-led.
- Comprehensive development of the website content, including a virtual tour, had been completed. Ongoing work on the maternity section of the trust website had also commenced, involving key staff groups, the trust communications team, and the maternity services user group. It was reported that the service was also beginning to explore other IT concepts, such as 'apps' that will provide a cutting edge approach to information provision for modern maternity care.
- In the survey of women's experiences of maternity services, 2013, all but three measures were similar to the national average. The Friends and Family Test (FFT) is currently above the England average for birth, antenatal and postnatal, and postnatal community, for Ipswich Hospital, which is good. No data was provided from 2014.

- Staff told us that they felt respected, valued, consulted and supported, and that leadership communicated effectively, and were visible to community teams, as well as hospital staff. The staff survey did not raise any significant concerns.

## Innovation, improvement and sustainability

- The hospital's maternity team became the third NHS hospital in the UK to offer mothers Hypnobirthing.
- The maternity team had achieved of stage one accreditation from the UNICEF Baby Friendly initiative to support breastfeeding. The maternity unit are currently applying for stage two in January 2015.
- A midwife had been awarded Quality Improvement Fellow, to look at induction process and implement changes regarding the Introduction of Propess in October 2014.
- The Gilchrist midwifery-led Unit had five deliveries in the last year, with one transfer into hospital; sustainability is a question being considered by the maternity user group currently.
- A comprehensive publication relating to 'Choices for place of birth at Ipswich Hospital' is currently being commissioned, and should be ready for release in early Spring.

# Services for children and young people

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

## Information about the service

The Ipswich Hospital paediatric service cares for children up to and including the age of 16 years. The service includes an inpatient ward with 21 beds, a paediatric assessment unit (PAU), a day surgery unit, and a paediatric investigations unit (PIU). There is a level 2 neonatal unit (NNU) where babies who require additional support following birth are cared for, and a children's outpatient department.

During the inspection, we visited all areas of the paediatric service. We talked to 17 parents, nine children, and 28 members of staff. This included support workers, nurses, senior managers, senior clinicians and the clinical lead. We observed care, and looked at records relating both to patients and the running of the service. Before our inspection, we reviewed performance information from, and about, the trust.

## Summary of findings

The children and younger people's service was caring and compassionate. We received positive feedback from the majority of children and parents that we spoke with. We were told that staff demonstrated a caring attitude. The service had a good incident reporting culture; however, more work was needed to embed and demonstrate a learning culture. Staff were clear in relation to their responsibilities with regards to safeguarding. We saw safe medicine practices being adhered to, and equipment was safety checked.

Improvement was needed with regards to the provision of a service for children with more complex needs. We found that although not commissioned to provide a high dependency care for extremely sick children, there was a local need for this service. This meant that the children's department was providing this type of care without sufficient numbers of trained staff. The critical care pathway for children was not well defined, and there was a lack of consistency in explanations with regards to roles and responsibilities. The critical care operational policy highlights 'paediatrics as a very small part of admissions, but as such represents significant risks'. Provision for critically ill children was primarily stabilisation prior to transfer.

Processes were in place to determine best practice guidance, which related to the children and younger people's service. There was a lack of local initiatives and auditing to monitor and measure patient outcomes. Data provided by the trust showed that training in

# Services for children and young people

paediatric intermediate life support (PILS) had been completed by 90% of the staff who required it. Children and younger people's individual needs were taken into account, and there was a good approach to multidisciplinary working when delivering care and treatment.

There were many initiatives in place which demonstrated that this was a responsive and sustainable service. For example, we heard examples of how the service had been redeveloped, based on feedback from patients, and initiatives to grow and expand areas of the service. Every member of staff that we spoke with was passionate about providing the best care possible, and were keen to input into improvement. There was an open culture, and staff felt valued and well supported from the leaders within this department.

However, despite staff telling us that capacity was one of the biggest risks within the service, we were not provided with information which demonstrated that the department was safely managing increases in service demand.

Governance systems required developing which meant that the risk management system was not effective; we found a risk on the register which had been present for seven years. There was a lack of evidence to support continuous monitoring and improvement over time, and a poorly developed audit programme. Senior members of staff within this unit however agreed, and had already identified that this was an area in which improvements were needed.

## Are services for children and young people safe?

Requires improvement



The service had a good incident reporting culture; however, more work was needed to embed and demonstrate a learning culture. Staff were clear in relation to their responsibilities with regards to safeguarding. We saw safe medicine practices being adhered to, and equipment was safety checked.

Improvement was needed with regards to the provision of care to extremely sick children. We found that although not commissioned to provide HDU care, there was a local need for this service. This meant that the children's department was providing this type of care without sufficient and trained staff. The critical care pathway for children was not well defined, and there was a lack of consistency in explanations with regards to roles and responsibilities.

### Incidents

- Staff described how they would report incidents via Datix, and managers were clear about their responsibilities for reviewing and escalating Serious Incidents.
- We saw that root cause analysis (RCA) was carried out when a Serious Incident took place. We reviewed the last five; however, only two of these had occurred during the 12 months prior to our inspection. We noted that lessons learnt were identified and disseminated to the divisions risk and governance meeting.
- Whilst on inspection we were shown a dashboard which demonstrated that incidents were trended and themed on a quarterly basis. However, it was unclear where these reports were discussed and actioned; there was no reference to these reports in the risk and governance meeting where incidents were regularly discussed.
- When we asked how learning was disseminated, we were told that a 'round robin' email was sent to staff, and an information cascade was in place.
- We could therefore not be confident that action was being taken to make improvements or learn from themes in incident reporting. For example, we were told that the service had identified that it reported a high number of medication incidents and that this was being



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monitored through the services governance meetings. However, it was unclear what action was being taken as a result of this. Minutes of the risk and governance meeting demonstrated that these were being reviewed, but no learning or improvement actions had been identified.

## Cleanliness, infection control and hygiene

- All areas that we visited were visibly clean.
- Cleaning checklists were in place, and we noted that these were well completed, demonstrating that toys in outpatient area were cleaned regularly.
- During our observations on the children's ward we noted that staff routinely washed their hands between patients.
- Personal protective equipment, such as gloves and aprons, were available for use by staff in clinical areas. We were asked to abide by infection control procedures during our inspection and saw this equipment in regular use.
- Isolation bays were in place so that should a patient present with an infectious disease, they could be separated from other patients to maintain safety. At the time of our inspection there was a dedicated bronchiolitis bay, which had increased infection control precautions in place.
- Appropriate waste management systems were in place. This included the use of clinical waste bins and sharps disposal boxes, which were correctly labelled.
- The trust provided us with audits which demonstrated that it regularly audited areas such as hand washing, environment and equipment. Scores were generally high; however, again it was unclear where results and any need for improvement were discussed.

## Environment and equipment

- Access to areas where children were cared for were secure. Access to the ward and day surgery unit was by entry phone or swipe card.
- All resuscitation equipment that we looked at was checked regularly and stocked appropriately.
- Other equipment, such as monitors and electrical equipment, had been checked in line with their testing requirements. We noted that labels were in place to confirm the last check date.

## Medicines

- All medications were stored securely in locked cabinets, and there were appropriate arrangements in place for the storage and use of controlled drugs.
- All fridges, which stored medicines, had their temperatures checked on a daily basis, and these were within the correct parameters.
- Medication administration records which we reviewed were up to date with no errors.

## Records

- Records were kept confidential on the wards, and stored securely in locked cabinets.
- Records across children and young people's services were found to be well completed, accurate and legible.

## Safeguarding

- The service had in place an up-to-date safeguarding children policy.
- There was a lead nurse and clinician in place for safeguarding children. At the time of inspection the current nurse had only been in post for three weeks; however, they demonstrated a good level of understanding and knowledge of the local systems for safeguarding children.
- Staff were clear that they had received training in safeguarding. Nurses had been trained up to level 3. Mandatory training records confirmed that at the time of our inspection, 87% of staff were up to date with Level 3 training, 96% with level 1 training and 99% with Level 2 training.
- All staff spoken with were clear that there was a named safeguarding person, who could be contacted if there were any concerns identified or raised.
- At the time of our inspection the trust was not involved in any serious case reviews; however, learning would be embedded from other local or national cases.
- We were told that the service remained involved in any referrals made, and that feedback and support was provided to staff involved in these situations.
- It was, however, recognised that a review of the safeguarding supervision policy was needed. This would ensure that staff took part in regular safeguarding supervision for support and learning.
- A quarterly safeguarding report was sent to the safeguarding committee, which looked at issues

# Services for children and young people

surrounding safeguarding within the service and the wider health economy. This enabled lessons to be learned so that improvements to the service could be made.

## Mandatory training

- All staff spoken with reported to us that they were up to date with their mandatory training.
- Mandatory training courses included manual handling, safeguarding, fire, infection control, medicines management and conflict resolution.
- Trust data we reviewed confirmed that overall, 93% of staff were up to date with mandatory training.

## Assessing and responding to patient risk

- There were clear processes in place to deal with the deteriorating patient. Early warning score systems (EWS) were in place in the majority of areas visited. EWS are generated by combining the scores from a selection of routine observations of patients, such as pulse, respiratory rate and consciousness levels. Where deterioration is seen, the score increases, and early interventions can take place to stabilise the child's condition.
- The paediatric early warning score system (PEWS) was in use on the wards.
- During our review of records we saw that early warning scores were regularly reviewed and updated, and that where appropriate, interventions and escalation of concerns took place.
- There were, however, concerns with regards to the provision of care for extremely sick children at this hospital.
- At the time of our inspection, we found that the service which was not commissioned to provide HDU care however was, on regular occasions, providing this care, where children had met the criteria for HDU intervention. We heard of one example of where six patients in one day had met the criteria for HDU care.
- We noted that the service had implemented an HDU guidance, and risk-assessed HDU demand on a daily basis. However, we found that no staff had been trained in HDU care, and staffing numbers were not increased to care for HDU patients in line with best practice guidance. For example, where HDU patients are cared for in a side room, staffing should be 1:1; we saw that this was not in place during our inspection.
- We were told that regular discussions were being held with local commissioners and the local HDU network. However, we requested evidence to support this and none was made available to us.
- We were concerned about the lack of concern from leaders within this service. We were told by one senior member of staff that funding had not been made available for HDU training. This was, however, disputed by another member of staff, who stated that such training had never been requested. We also found that a risk assessment, in relation to the provision of HDU care, had been completed, but there was no regular monitoring at either the risk and governance group, or the services clinical delivery group, about the safety or effectiveness of the service. We were also concerned about the provision of critical care for children. We reviewed the operational plan for the critical care unit, and found that this contained only four short paragraphs about the paediatric provision in this area. This was the only documentation we were provided with to describe the role of this unit for children. It did not describe roles or responsibilities, and did not adequately describe transfer arrangements.
- Approximately 20 children were seen in ICU last year, with care provided jointly by a paediatrician and ICU consultant. Provision was primarily stabilisation prior to transfer; however, occasionally children were cared for on the unit.
- Transfers were undertaken by the children's acute transfer services (CATS). ICU followed the CATS protocols and guidelines, available online, for care of children. There was a CATS transfer trolley on site, which was checked daily to ensure that all essential equipment was in place.
- There was no written policy in place for paediatrics, and no registered sick children's nurse (RSCN) employed on ICU. Care was provided by a senior nurse with close support from the medical team. Links have been established with the tertiary PICU to facilitate additional training for ICU nurses which has started but is in its infancy.

## Nursing staffing

- In general, and excluding the concerns with regards to HDU care, staffing on the ward and surgical unit was safe and in line with recommended numbers.
- The PAU was staffed regularly with two registered nurses and the support of a nursery nurse.

# Services for children and young people

- We reviewed the staffing rotas for the NNU and saw that staffing levels were flexed to meet service demand.
- The service had access to bank and agency staff in order to increase and cover staffing as necessary. We were informed that bank and agency usage was low.
- Regular handover meetings took place so that up-to-date information about each individual patient could be shared.

## Medical staffing

- There were a sufficient number of junior and middle-grade doctors on duty to ensure safe and effective care. There was a consultant paediatrician on-call, which ensured that there was consultant availability 24 hours a day.
- We saw on-call rotas which confirmed appropriate staffing was maintained.
- Junior doctors spoke positively about working for the trust. One junior doctor told us that they would be happy working for the trust on completion of the training. Another said that they felt well supported.

## Are services for children and young people effective?

Requires improvement



Multidisciplinary working was embedded within the children's department, with other services in the trust, and with external organisations. This ensured that patients received continuity of care. Staff were confident that care was being provided in line with evidence-based practice; There were some local guidelines, as well as documentation based on regional and national guidance. Staff had access to regular appraisals, and learning and development opportunities to support them in their roles. Every member of staff we spoke with felt well supported by their peers and colleagues. However, there was limited patient outcome monitoring. For example, we only found one local audit in addition to national audits on the services audit plan. In addition, a number of local audits were shown on the departmental quarterly audit reports.

## Evidence-based care and treatment

- There was a process in place for determining whether or not updated or new National Institute for Health and Care Excellence (NICE) guidelines were applicable to the service. We saw reference to this in the minutes of the services risk and governance meeting.
- Many policies and guidelines were in place with clear links to the evidence-based care they related to, such as guidance issued by the Royal College of Paediatrics and Child Health.
- However, we asked to review a sample of clinical guidelines specifically for asthma, bronchiolitis and epilepsy. The trust could not provide these to us as whilst some of the documentation in use reflected current guidance there were no pathways for conditions such as epilepsy. We could not be assured that all relevant best practice guidance was being adhered to. Furthermore, when we checked the services policy and guideline tracker reference for such guidelines being in place, these were not documented.
- We were told that the service did not have its own local procedure for epilepsy, relying solely on NICE guidance. Best practice would be for the service to have its own policy and guidance, which meets the needs of its local patients, and which details the roles and responsibilities of key members of staff within this service.
- The neonatal toolkit was in place and being adhered to on the NNU.

## Nutrition and hydration

- The service gave children and young people a choice of meals.
- We received positive feedback from three children using this service. One child stated "it's better than my mum's cooking". We were told that food options were flexible, and variations to the set menu could be requested.
- Paediatric dieticians were involved in developing care plans for children, and providing advice and guidance. We spoke with a child, who had recently been diagnosed with type 1 diabetes, and with their family, and heard extremely positive feedback about the advice and guidance that had been given with regards to diet.

## Patient outcomes

- The children's service participated in national audits for which it was eligible. These included paediatric diabetes

# Services for children and young people

and asthma, performance of which was in line with England averages, and the neonatal intensive and special care (National Neonatal Audit Programme) audits.

- We noted that the service also performed worse than average for readmission rates for those patients with epilepsy. We discussed this with the clinical lead and matron for the service; it was demonstrated that an epilepsy nurse had been appointed in order to improve performance.
- There was a lack of initiatives to measure and monitor patient outcomes. For example, there was only one local audit listed on the services 2014-15 audit plan. We spoke to senior members of the team who acknowledged that this was an area in which improvements were needed.

## Competent staff

- All members of staff that we spoke with told us that they had regular access to appraisals and support from their managers. The trust data showed us that 90% of staff within the women's and children's directorate had received an appraisal within the last year.
- Junior medical staff told us that they had good support from consultants, and told us that they always responded or came in when they were on-call to provide support in complex cases.
- Staff had good access to learning and development courses to help support them in their roles.
- Evidence from the trust demonstrated 90% of staff had undertaken paediatric intermediate life support training (PILS).
- Staff reported that they regularly took part in simulation sessions. The sessions were simulations of potential paediatric emergencies, and allowed staff to utilise their skills and learn from any failings; but we were not made aware of how any learnings were communicated.
- All staff received equipment training, and this was monitored via individual training logs kept on the ward, which we were shown.

## Multidisciplinary working

- Handovers were multidisciplinary to ensure that all staff had up-to-date information about the needs of children within the service.
- We also saw that perinatal mortality and morbidity meetings were held on a monthly basis. These meetings

were held to discuss complex cases or areas of concern, so that learning could be shared. These meetings were also multidisciplinary, and involved staff with particular expertise.

- There were good multidisciplinary relationships between paediatrics and the neonatal services.
- There was sometimes a delay in the child and adolescent mental health services reviewing paediatric patients who had been referred to them. However, this service was not provided or commissioned by the trust, and we heard how multi-agency working was taking place to try and improve this service.
- The children's acute transport service (CATS) provided the regional retrieval service for paediatric patients requiring intensive care therapy.
- The governance meetings were attended by a multidisciplinary staff groups. From the minutes we reviewed, we saw that the meetings were attended by paediatricians, paediatric nurses, specialist nurses and members of staff from the NNU.
- We noted good practice between the paediatric service and the surgical team. A surgical committee was in place, so that the service could discuss issues, and work together in order to provide effective care and treatment to children and young people when undergoing surgery in this hospital.
- There were clear transfer arrangements in place between the A&E department and paediatrics
- There were two play assistants in post; however, these did not provide for seven day working as is best practice.

## Access to information

- Information leaflets were available on a number of health topics, including gastro-oesophageal reflux, bronchiolitis and urinary tract infections. These were available in both inpatient and outpatient settings.
- Ward and outpatient areas had trust policies and procedures available, which were accessible to staff on the trust's intranet.
- We saw excellent practice in the day surgery unit to prepare children for surgery. Children were brought in for their pre-operative assessment, and were shown a DVD of what would happen during their stay on the unit.

## Consent

- We spoke with staff, who confirmed that patient consent would be sought prior to any procedures or tests being undertaken.

# Services for children and young people

- Children and parents we spoke with told us that they had been involved in decisions relating to the treatment offered to them. This evidenced that staff were aware of the Gillick competency assessments.
- We reviewed four sets of records, which confirmed that consent had been sought for individual interventions.

## Are services for children and young people caring?

Good



This service was caring and compassionate. We found that the majority of parents and children felt well-informed and that staff demonstrated a caring attitude.

### Compassionate care

- All areas seen maintained people's privacy and dignity. There were side rooms for children who were particularly sick or needed isolation, and all beds had privacy curtains.
- Parents were able to stay with their children during the night, and facilities had been provided in order for them to prepare their own meals and drinks.
- All of the parents on the NNU reported that staff demonstrated compassion and understanding. One parent stated that all staff were "polite and professional" and another parent said they "couldn't fault the nursing care".
- The feedback from children on the children's ward was all very complimentary about the care they had received from the doctors and nurses. One child commented "the nursing staff are all very friendly and they talk to me when I am on my own". Another child told us about an activity they had mentioned to staff and how this had been set up for them.

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

- Parents told us that they had been kept up to date with their children's needs. We were told that, in general, information was forthcoming, and they did not have to keep asking for updates. One parent of a child on the NNU told us that they regularly saw the doctors, and explanations of care were good and given in plain English. Another parent commented "doctors always inform you about what's happening and talk in way you can understand".

- Parents said they felt listened to, and that their concerns regarding their child's health had been taken seriously and their anxieties alleviated. One parent in particular stated "it was nice to come here and be listened to and believed".
- Parents and children we spoke to within the outpatient departments were also positive about the communication from staff and their caring attitudes.
- We observed the play assistant provide information to a child who was apprehensive about an MRI (magnetic resonance imaging) scan which they were about to have. In order to prepare the child we saw they had visual aids, such as photographs and models, and also a taped recording of the sounds which they were likely to hear in the scanning room. The information provided was clear and consistent, and the child was happy with the explanations given to them.

### Emotional support

- Whilst we were on the NNU we were told about the emotional support available to women and their partners when things went wrong with their pregnancies, or following birth. There was a dedicated bereavement nurse within the unit, and women would be offered the use of a counselling service.
- These services were also available within the wider children's services. One parent we spoke with told us about the emotional support and counselling services they were offered when their child was diagnosed with cystic fibrosis. Another parent told us that they felt the emotional support offered to them was "excellent".

## Are services for children and young people responsive?

Good



The children's and younger people's service at this hospital was responsive to the needs of the people that it was caring for. There was good access to the service, which was flexible in meeting the individual needs of patients.

### Service planning and delivery to meet the needs of local people

- The children's department provided a supportive age-appropriate environment, offering a range of activities for children. However, during our observations we noted a lack of age-appropriate materials for older



# Services for children and young people

children and teenagers. This was supported by one older child, who told us that they thought the decoration was “babyish” and that the playroom was “childish”. The trust told us that age-appropriate materials for older children and teenagers were available in the allocated adolescent area on demand.

- There was no separate adolescent unit. However, we saw that areas had been developed within the service, which were allocated for the use of adolescents.
- There was an escalation policy in place, and staff were aware of this.
- There were a range of initiatives in place in order to improve service delivery for local people; this included a one-stop allergy clinic, and the development of community services to provide care closer to home.
- Whilst there was a dedicated children’s outpatient department, children were also still seen in various other outpatient areas, such as the fracture clinic, dental clinics, and ENT clinics. We visited these areas, and spoke to staff to ensure that they were maintaining appropriate facilities for children. We found that all areas had dedicated play areas and toys available. There was also appropriate age-related information and guidance available.
- We saw good practice with the recent introduction of a paediatric nurse supporting some of these clinics. We saw how they had made improvements, such as a dedicated children’s clinic room, which had pictures on the walls, distraction toys, and other modifications, such as the relocation of sharps boxes, and the introduction of safety equipment specifically for children.
- Based on patient feedback, we heard how the PIU had reconfigured its services to provide dedicated oncology and cystic fibrosis clinics without other clinics happening at the same time.
- There was a neonatal outreach service in place. This service ran seven days a week, and provided support to families in their own homes, with the aim of getting neonatal babies home sooner. We heard that the service provided education to parents, including basic life support, and skills such as tube feeding. The feedback for this service was extremely positive, and it was an initiative that staff were particularly proud of.
- The environment within the service was well maintained. It was colourful and had lots of paintings and art work (done by children) on display. There were play areas in each area that we visited.

- However, the outpatients department was not well lit, leading to a dark feeling atmosphere.

## Access and flow

- There were various admission processes on to the ward within this trust. Referrals to the PAU could be made by A&E, the community nursing team, or GPs.
- Some children and young people could access the service at any time they required, without the need for referral, in line with the services open access policy.
- Only children up to the age of 16 could access services within this department. For patients aged between 16 and 18, there was no choice as to where they wanted to be cared for. They would automatically be placed within adult services, with access to the hospital school teachers and play team.
- This exclusion did not apply however, for children with complex needs, where it was more appropriate for them to be cared for on the children’s ward.

## Meeting people’s individual needs

- There were specialist paediatric nurses employed, such as nurses specialising in epilepsy, diabetes, respiration and oncology. We spoke with the oncology specialist nurses about how they had recently developed their service to include a part-funded post to take care out into the community, and to where patients needed it, such as at home or in schools. We heard that a social worker also worked closely with the team to support families.
- In order to support children with cancer, we noted that this service shared care with Addenbrooke’s Hospital. Close links were also in place with the local hospice. Each cancer patient was an ‘open-access’ patient, and had access to the ward whenever they required. Nursing staff had recently started a programme of oncology training to strengthen the support provided on the ward within this service.
- Advanced neonatal nurse practitioners (AANP) were employed. This meant that there was senior cover on the majority of day shifts, to ensure that staff had access to support for children with complex needs.
- Staff reported that there was access to translation services, should this be required.
- Information on how to access hospital services was available for people to access.



# Services for children and young people

## Learning from complaints and concerns

- Complaints were handled in line with the trust complaints policy. Signposting to the Patient Advice and Liaison Service was evident within the service.
- We heard from one parent who had complained to the service, and they told us that this had been dealt with effectively, and they still had trust in the service.
- Complaints and lessons learnt were discussed at the services risk and governance meetings, and at their clinical delivery group meetings, which were held on a monthly basis.
- Learning actions were disseminated more widely to staff in the form of a 'round robin' email to staff.

## Are services for children and young people well-led?

Requires improvement



The leadership of the children's service required improvement as the governance systems required developing. For example, the risk management system was not effective; we found a risk on the register relating to co-location of services which had been present for seven years. Actions had been taken during this time to mitigate this risk and the risk was regularly reviewed. There was a lack of evidence to support continuous monitoring and improvement over time, and a poorly developed audit programme. Senior members of staff within this unit however agreed, and had already identified that this was an area in which improvements were needed.

There were many initiatives in place which demonstrated that this was a responsive and sustainable service. For example, we heard examples of how services had been redeveloped based on feedback from patients, and initiatives to grow and expand areas of the service. Every member of staff that we spoke with was passionate about providing the best care possible, and were keen to input into improvement. There was an open culture, and staff felt valued and well supported from the leaders within this department.

## Vision and strategy for this service

- There was a five year strategy in place for this service, which had been recently developed.

- All of the senior members of staff we spoke with confirmed that they had an opportunity to contribute to the services development plans. We heard that a strategy workshop had been held.
- There was consistent feedback from all staff we spoke with about future plans in line with the strategy.
- The trust had an overall vision, which was well embedded and understood within children's services.

## Governance, risk management and quality measurement

- The service held monthly governance meetings to discuss areas such as risk, incidents and complaints. However, whilst relevant topics were considered, from our review of the minutes of these meetings it was apparent there was a lack of emphasis on improvement and learning lessons.
- The service was not managing risk appropriately. The risk register we were provided was not up to date, and not being reviewed effectively. For example, we saw that one risk that had been identified in 2008, and was not due to be closed until 2017. One senior member of staff could also not tell us what the three main risks for the service were. They could only recall two, and these did not align with the services risk register. This is not effective management of risk. The governance leads within this service recognised that work was required to embed better risk management.
- We asked to review risk assessments for various high risk activities within the service, however there was no overarching risk assessment on this issue.
- There was not an effective audit programme in place with only one audit documented; following our inspection we were provided with a copy of the departmental quarterly audit report which showed some audits had been completed with the CCG, for example prolonged jaundice. However, the majority of staff we spoke with were not aware of the departmental quarterly audit report. There was only one audit listed on the services 2014/15 plan, and continuous improvement through audit could not be demonstrated.
- We noted that there was no reference to patient feedback, such as the 'pants and tops' initiative, or feedback from listening events in the minutes of the risk and governance meetings that we reviewed. This meant we could not identify improvements which had taken place as a result of patient feedback.

# Services for children and young people

- We heard how the children's ward would be flexible, and could open up to 27 beds in order to deal with pressures, such as an increased Winter demand. Senior members of staff recognised capacity as the highest risk within the service, and from our review of minutes we saw that in December, an incident occurred where 35 patients required admission to the ward or assessment on the Paediatric Assessment unit on the same day. We therefore asked the trust to provide us with a copy of an overarching risk assessment in relation to capacity, and to provide comment on this incident, how capacity was being managed and whether or not an improvement plan was in place. The information supplied included reactive risk assessments which were completed on that day and did not provide us with assurance that there were sufficient plans in place to safely manage an increase in demand for this service.

## Leadership of service

- We saw effective and committed leadership at team and senior clinician level, and staff told us that they were generally well supported by their managers.
- Staff told us that the clinical leaders of the service were supportive and welcoming.
- We heard how the executive team were visible within the clinical areas, and heard, on a number of occasions, how the chief executive had dressed up at Christmas time and visited the children's ward.

## Culture within the service

- Staff we spoke with told us that morale within the service was good. They felt that the culture was open and transparent, with managers being approachable and supportive.
- Nursing staff told us that they felt valued, and were able to contribute to the development of the service.







## Public and staff engagement

- We saw the 'pants and tops' initiative in place, to gain the feedback of children and their families. Children were encouraged to provide comments in the outline of a pair of pants to communicate what they did not like about the service, and do the same in a top (t-shirt) outline to communicate what they felt was good about the service. This feedback was displayed with the service, and was mostly positive.
- We saw an action plan had been implemented, following a listening event with patients who had received mental health care at Ipswich Hospital. This was regularly reviewed, and was on track to be delivered.
- We saw that the trust had given each member of staff a lanyard with their role written on. This meant that doctors and nurses were easily identifiable, and assisted with parents and children knowing who they were speaking with. This had been implemented following the patient listening event mentioned above. Staff took part in the NHS staff survey, and we saw that the trust had developed an action plan to improve areas where they had scored unfavourably.

## Innovation, improvement and sustainability

- There were various initiatives in place to look at the sustainability of the service. For example, we heard how the oncology specialist nurses were to support other local hospitals, particularly with teaching and education.
- Plans were also in place to develop a sleep clinic, to include children from wider catchment areas, so as to provide income.

# End of life care

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

## Information about the service

End of life care encompasses all care given to patients who are approaching the end of their life and following death, and may be delivered on any ward, or within any service of a trust. It includes aspects of basic nursing care, specialist palliative care, bereavement support, and mortuary services. End of life care which relates to terminations of pregnancy, miscarriages and stillbirths at any stage of a pregnancy are inspected under maternity services. The trust reported 524 deaths between April 2014 and September 2014.

The trust has a palliative care team including 3.0 WTE nurses and a 0.6 WTE consultant, with the consultant's hours being shared between the hospital and the local hospice. The palliative care team sits divisionally within the medical and cancer service directorate, which is led by a head of nursing and clinical director.

## Summary of findings

Services for end of life care were good, with some improvements required in effectiveness. We found that whilst the new end of life care programme was in its infancy, patients were receiving safe care in most areas. Staffing levels for the palliative care service required review due to the number of referrals outweighing the number of staff available. A targeted education programme for consultants and ward staff on new end of life care tools was implemented, although this was not trust wide for all staff. The tools required improvements to ensure that all elements of care, including holistic, spiritual and emotional needs, were considered in line with NICE guidelines.

Staff at Ipswich Hospital provided very compassionate care to patients leading up to the time of their death. Locally, staff spoke highly of the care offered by the palliative care, mortuary, chaplaincy and bereavement teams.

The end of life care and palliative care team supported the provision of rapid discharge, and rates of discharge within 24 hours were in line with the England average. Relatives were being invited to share their experience to learn and improve the delivery of end of life care. Locally, those providing end of life care within departments led the provision of this well.

# End of life care

## Are end of life care services safe?

Good



End of life care services protected patients from the risks of preventable harm. We found that whilst the new end of life care programme was in its infancy, patients were receiving safe care in most areas. Equipment to support patients in hospital and at home with pain relief was available. Staff received e-learning training on end of life care and one-to-one care was being provided on the end of life care paperwork through link nursing staff, and via the palliative medicine consultant. Staffing levels for nursing and doctors in the palliative care service was not always sufficient due to the number of referrals outweighing the number of staff available; however, the hospital informed us that there were plans to increase staffing levels. The mortuary was spacious and had sufficient deceased patient storage. The service was prepared for high capacity and contingency. The area was in need of refurbishment and proposals were in place to refurbish the mortuary through a staged approach. Funding had been secured to commence this. Visits to other Trusts took place in Nov & Dec 2014 with the aim of developing ideas for refurbishment. However the mortuary staff we spoke to were not aware of these plans.

### Incidents

- The trust used a recognised online incident reporting tool. We spoke with staff across the wards we visited, who understood what constituted an incident, and what they should report in relation to end of life care.
- There had been a few end of life care incidents reported; however, numbers reported were low. We spoke with three staff members on Lavenham Ward, who informed us that they were aware of an incident relating to end of life care where a patient's referral to the palliative team was delayed by four days. Staff informed us that they had learnt lessons from it, and that learning from this incident was shared on the ward newsletter for all staff to see.
- We reviewed the minutes of the end of life care group meeting held between January and November 2014, which did not identify any incidents or learning from incidents. Work is needed to recognise incidents that occur when a person is receiving end of life care, to identify learning from any event to improve patient care.

## Environment and equipment

- The specialist palliative care team have purchased and are using six syringe driver pumps, specifically to provide care to patients at the end of their life. This is in addition to the syringe driver pumps available for inpatient use. These items can be taken with patients on the rapid discharge programme into the community.
- When the community team take over care of the person, their procedure is to transfer the patient onto the community syringe driver and to return the hospital syringe driver as soon as possible. We were informed that this system worked well.
- The mortuary was a sufficient size to meet demand; however, capacity was sometimes pushed. The mortuary had 125 fridges, the environment was spacious, and there were plans for further expansion.
- The fridges were well maintained and serviced, which meant that temperature of the storage area was consistently at the best levels for the patients.
- The environment within the mortuary was dated in parts, and required some refurbishment. Proposals were in place to refurbish the mortuary through a staged approach and funding had been secured to commence this.

## Medicines

- The hospital had clear guidance in place for 'Anticipatory Prescribing in the Last Few Days of Life'. This guidance was available in the wards we visited and on the intranet site. This document covered medicines that could be given for agitation, breathlessness, nausea and pain.
- A review by our pharmacist, on patients who were receiving end of life care, established that they had been prescribed and were receiving appropriate medicines. However, some concerns were noted on Sproughton Ward and Kirton Ward, where a prescribed anti-anxiety medicine was not administered in a timely way, despite being prescribed. We shared this with the ward managers for each ward to review.

## Records

- We examined the records of 20 patients receiving end of life care, or those with an advanced decision for end of life care in place. Written records were legible and clear to read. However, some doctors did not always write their GMC number on the recorded entries.

# End of life care

- Records of discussions between medical staff and families regarding decisions of end of life care were not always recorded. We were particularly aware of this on Sproughton ward, where decisions regarding end of life care could have been more clearly recorded.
- Nursing and medicines records were stored outside each bay. Medical records were stored in a medical records trolley, which was located near a nurse station and could be secured.
- We found that there were robust consent arrangements in place for managing tissue removal after death. The last Human Tissue Authority (HTA) inspection concerns related to environment, but found no concerns with the records maintained. The HTA regulate organisations that remove, store and use tissue for research, medical treatment, post-mortem examination, teaching and display in public.

## Safeguarding

- We examined the training records for the palliative care team, and found that 100% of the staff had received training in safeguarding adults and safeguarding children. Trust-wide safeguarding adult training compliance was 94%.
- Staff across the medical areas we visited were able to explain what constituted a safeguarding concern, and the steps required to report such concerns.

## Mandatory training

- Of the 3,080 staff employed by the trust 1,379 had received training on end of life care. This included medical, nursing, midwifery, allied health professional and support staff.
- We spoke with 16 nurses and support staff across various grades, from health care assistant to matron, as well as three doctors; not all were clear in identifying when a person would be at the end of their life. It was recognised in the trust by the palliative care team that further education and development of staff was required to recognise when a patient was in the last days and months of their life.
- We examined the training records for the nursing staff and consultants in palliative care, and found that all had received up-to-date training in mandatory subjects, including infection control and life support, as well as statutory training, including health and safety, fire, and moving and handling.
- The palliative medicine consultants also provide palliative and end of life care teaching to each set of first

and second year foundation doctors. Additional consultant-led teaching has been provided to doctors from elderly care teams, the surgical department, acute medicine and respiratory departments, and hospital-wide, in the form of grand rounds to launch a new approach to documentation and care in the last days of life.

## Assessing and responding to patient risk

- The hospital uses a recognised national early warning score (NEWS) to monitor patients at risk of deteriorating clinical conditions.
- When a patient is defined as being in need of receiving end of life care, such as in the last days or hours, the trust procedure is that assessing a person's NEWS should no longer be calculated. On Shotley Ward and Sproughton Ward we observed, through examination of records, that the NEWS was still being assessed and discussed with medical staff, despite the patient's end of life status.

## Nursing staffing

- There were 3.0 WTE nurses who work in the palliative care team. We were informed that there were reviews on staffing levels for the palliative care team with a view to increasing numbers.
- A 'link nurse' programme was in place throughout the wards. The link nurses are provided with regular updates and education to cascade information, and act as a point of support for any ward-based palliative care, prior to specialist palliative care involvement, or when no specialist involvement is required.

## Medical staffing

- The service has 0.6 WTE consultants working in the palliative care team. The consultant's time is shared between the hospital and the hospice.
- During 2014, the palliative care service accepted 776 referrals. This is a strain on the number of medical and nursing staff, and therefore, staffing levels for consultant palliative care cover may not always be sufficient.

## Major incident awareness and training

- The mortuary staff had received training in emergency planning and resilience. The service had a current major incident plan, and was aware of what procedures to follow in the event of a major incident.
- We were informed that the mortuary team had received no official instruction or guidance on the recent World



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Health Organization (WHO) release about the Ebola virus, which provides guidance to departments to check and be prepared for any patients suspected as having a contagious virus.

## Are end of life care services effective?

Requires Improvement



Effectiveness of end of life care procedures required improvement. A targeted education programme for consultants and ward staff on new end of life care tools was implemented, although this was not trust wide for all staff. The tools were not sufficient and required some improvements, to ensure that all elements of care, including holistic, spiritual and emotional needs, were considered in line with NICE guidelines.

There was good multidisciplinary working within the teams providing care on the wards; however, further work was needed on MDT discussions around decision-making at the end of a person's life. Medical staff were aware of nutritional and hydration requirements of a person at the end of their life; however, throughout all wards there was a lack of undertaking mental capacity assessments, which meant that the Mental Capacity Act 2005 was not always being adhered to.

Currently, the hospital was only able to offer a palliative care service Monday to Friday; however, there were plans in place to increase this to seven day cover in the future. The local hospice provided out of hours advice and support.

### Evidence-based care and treatment

- The trust adhered to National Institute for Health and Care Excellence (NICE) End of Life Care Quality Standard (QS13 August 2011). We viewed meeting papers from the end of life care group, which demonstrated that the trust had considered and agreed how to improve the service.
- The Department of Health asked all acute hospital trusts to undertake an immediate clinical review of patients receiving end of life care. This was in response to the national independent review, 'More Care, Less Pathway: A Review of the Liverpool Care Pathway (LCP)', published in 2013. This review required that the LCP was replaced with a different trust- and patient-specific pathway.
- The service had recently implemented their new end of life care pathway in September 2014, and its use and staff understanding were still in their infancy.
- The individualised care plan for a person at the end of their life was not individual to the person. We examined six in use during the inspection, and saw that it was used as a 'tick box', and there were no personalised features specific to the patient included by ward staff.
- The form was physically and medically orientated. For example, one box asked if physical, psychological and spiritual needs have been assessed. We concluded that these need to be addressed separately. Emotional needs, fears and anxieties were not included. Therefore, this form was not individualised as did not meet all patient needs.
- In regards to following NICE guidance, the new individualised care plan does not enable a comprehensive holistic assessment to be carried out. We were unclear how this worked with the integrated care records and recording of communication with families.
- The policies, guidelines and procedures for end of life care were new, and not all staff were aware of them. We asked five staff on the wards to locate the end of life plans on the intranet site, only two were able to do so.
- The current Palliative and End of Life Care Strategy was not due for review until January 2016 however it did not reflect recognised national best practice and required review. The strategy was under review and approval was expected in January 2015.
- Audits of 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms, and advance care planning for patients on respiratory wards at Ipswich Hospitals, had been undertaken. The audit consisted of 20 questions; however, these were restrictive, closed questions and meant that learning opportunities could be missed; for example, a question was 'discussed with patient and answers were yes or no'. There were no questions or references to a patient's mental capacity status.
- The audit showed that in 30% of cases (10 records checked) decisions regarding resuscitation had been discussed with the patient and recorded in the patient's records. In 60% of cases, the decision had been discussed with the family and recorded in the patient's records.



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## Pain relief

- Anticipatory medicines were being prescribed, and equipment to deliver subcutaneous medication, such as pain relief, was readily available.
- Staff reported that generally, there were no concerns with regards to obtaining anticipatory medicines for patients who require them. However, it was reported to us that due to a low number of junior doctors on duty at night for medical and surgical wards, there were often delays out of hours locating a doctor to authorise a prescription for anticipatory medicines.
- The hospital had syringe drivers for people needing continuous pain relief. A syringe driver is an alternative method of administering medication and may be used in any situation when the patient is unable to take oral medication.
- We found that the 'Symptom Assessment Form' was not sufficient. This is because the form required just the initialling of the severity of a symptom, which is not an assessment. The form used a three point scale, particularly for pain, which is not broad enough.
- Pain needs to be assessed in terms of where the pain is, whether there is more than one pain, and the type of pain (to help in identifying cause and appropriate intervention). Similarly, with nausea and vomiting, the cause needs to be identified to help with identifying the appropriate treatment.

## Nutrition and hydration

- There was no specific dietician support for the palliative care team, as dietician support was provided by the trusts dietetics team. We saw good input from dieticians in the medical notes, and observed staff referrals and discussion with the dieticians on the wards. Nursing staff on the wards told us that they could always ask for dietetics advice.
- The trust had a speech and language therapy service, which provided support for nutritional and hydration needs where available. We observed an example of this being provided to a patient receiving end of life care on Shotley Ward.
- We spoke with three doctors across the medical wards we visited. All were aware of the General Medical Council (GMC) requirements for nutrition and hydration at the end of a person's life; this included the option of clinically-assisted feeding.
- For the five patients we observed on end of life care during the inspection, none had a mental capacity

assessment undertaken. This meant that medical staff may not be adhering to the GMC's clinically-assisted nutrition or hydration clinical decision model for adult patients who lack mental capacity. We spoke with medical and ward nursing staff, who said that discussions were had; however, these may not have been recorded. Records of discussions and decisions required improvement.

## Patient outcomes

- The trust had taken part in the National Care of the Dying Audit of Hospitals (NCD AH) 2013. The trust achieved the KPI score for 2 out of 7 on organisational indicators, and were above the England average for five of the 10 clinical indicators.
- The trust scored particularly low on 'multi-disciplinary recognition that the patient is dying', with a score of 28 compared to the England average of 61.
- The trust scored 74, which was better than the England average of 59 on 'a review of the care after death'.
- The trust undertook an audit survey of staff confidence in providing end of life care in the respiratory wards, Kesgrave and Kirton in July 2014. The audit showed that 87% felt very or absolutely confident in recognising when a patient is in the last days of their life, and 91% of staff felt confident or very confident in providing care to a person in their final days. This demonstrated that good levels of staff understanding around end of life care had been developed on these wards.

## Competent staff

- We observed from minutes of an end of life care group meeting held on 30 July 2014 that the new pathway documents were placed on the intranet; however, not all staff had received training on their use.
- Minutes from the meeting on 24 September 2014 stated that the end of life care plan had officially been rolled out; however, there were some who had still not received training.
- We established that training on the end of life care plan was provided by the palliative care team on a ward-by-ward basis, cascading information through senior nurses, and direct one-to-one teaching and discussion on wards. There were plans to roll out a formalised training programme for staff during 2015; however, this had not commenced at the time of inspection.
- We found that not all staff had received update training on the use of syringe drivers. We asked three ward

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managers about competency assessment checks, and were informed that outside of clinical supervision, there were no formal competency checks on the use of syringe drivers.

- The palliative care team had all received an appraisal during the past year. Revalidation was done jointly between the trust and the hospice for the consultant, and revalidation was achieved.

## Multidisciplinary working

- The 'Care Plan Guidelines' decision should be made by the MDT; however, it was listed to be made by a senior clinician, plus a consultant. Communication between professionals, and with patients and their families, is pivotal in end of life care to ensure best care. If communication is not robust, similar concerns to those from the use of the LCP will arise.
- The palliative care team members attended regular multidisciplinary team (MDT) meetings for specialist teams, such as cancer services, renal and respiratory. The end of life care doctor also attended some of these meetings as part of the clinical specialty, and could strongly advocate end of life care needs.
- The multidisciplinary team available worked well together, to ensure that patients care and treatment was planned and co-ordinated. Of the 20 records we examined, we saw a good level of multidisciplinary input into patient care.
- There were effective working relationships with local hospices to co-ordinate people's end of life care, where the hospice was their preferred place to die. Equally, if a person preferred to die at home, arrangements could be made to facilitate this. The use of the palliative care team ensured continuity of care when working with community teams.

## Seven-day services

- The trust operated a Special Palliative Care Team, which worked 9am to 5pm, five days a week. There was no provision for weekend cover, although a business proposal has been put forward for seven days a week cover.
- The consultant cover was limited on site due to there being 2 employed consultants covering a 0.6 WTE contract, although the consultants were dedicated, and provide support where they could.
- Out-of-hours support was available 24/7 through the local hospice.

## Access to information

- Staff had access to electronic information, such as policies, national guidance, newsletters and the minutes of some meetings.
- If patients required support, staff could access palliative support through the out-of-hours service, or review the information available on the intranet for guidance.
- There was information available for relatives on end of life care, which was available in each ward.

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

- In most cases, staff followed the consent systems appropriately when patients did not have capacity to consent to care and treatment. The record of consent was documented in the care records. However, in one case on Sproughton ward, we identified that a patient had an invasive procedure where an appropriate consent or best interest decision were not well recorded; there were also concerns with regards to the same patient around the assessment and documentation of potential deprivation of their liberty.
- This incident was escalated to the matron, head nurse, director of nursing, medical director and chief executive. The team were very responsive to our concerns about the care of this patient, and they investigated immediately. The trust recognised that improvements were needed around the recording of consent, mental capacity, and best interest decisions because there were questions regarding the appropriateness of the procedure however these were handled by the trust following our escalation. The patient concerned was not deprived of their liberty, and prior to completing the inspection, they were receiving appropriate care. We were pleased that the trust took appropriate action.
- We examined the records of 20 patients with 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms, to determine if their mental capacity had been assessed prior to completing the decision not to resuscitate. In 12 cases, the form had been completed stating that the patient did not have mental capacity; however it was not recorded that mental capacity assessments had been undertaken. Therefore, medical staff were not always following the Mental Capacity Act 2005 in relation to making best interest decisions for end of life care.

# End of life care

## Are end of life care services caring?

Good



Staff at Ipswich Hospital provided very compassionate care to patients leading up to the time of their death. There was good recognition of the importance of family and friends as life ended.

Locally, the teams within the wards we visited, which included respiratory and care of the elderly, spoke highly of the care offered by the palliative care team.

Within the mortuary, the team were very receptive at provide a caring service to the families and to the deceased. Staff within the mortuary service demonstrated their passion for making a difficult situation better for those involved, and worked to deliver this with the limited resource available.

### Compassionate care

- Since April 2013, the hospital has consistently scored above the England average for positive patient experiences. The results from July 2014 showed that the hospital overall had a score of 74, although the response rate was low at 19%.
- On NHS Choices in January 2015, it noted that 93% of patients recommended this hospital from a total of 695 responses.
- We spoke with one patient and five relatives about the end of life care they, or their relative, received on the wards. All were very positive about the care they experienced.
- One family were visiting their relative on the hyper acute stroke unit; their relative had come through the emergency department into the unit. They told us, “the staff have been amazing from the minute we arrived at hospital, they answered all our questions and they cannot do enough for us”.
- We saw through meeting minutes that the bereavement survey results showed that Ipswich Hospital scored above the national average on three questions, below average on two questions, and met the national average on one question. The hospital scored well above average (76%) on ‘being involved in care at the end of life’, with 96% of relatives saying they were involved.

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

- We spoke with one patient and five relatives about the care they were receiving and information that they were provided with. All we spoke with were highly complementary about the information that they had been provided with by the staff, and felt that staff could not do enough for them.
- The National Care of the Dying Audit (NCDA) 2014 identified that health professional’s discussions with both the patient and their relatives/friends regarding their recognition that the patient is dying were in line with the England average, with a score of 71%.
- The audit identified that ‘assessment of the spiritual needs of the patient and their nominated relatives or friends’ was lower than the England average, with a score of 14%.

### Emotional support

- The hospital had a range of clinical nurse specialists employed to support patients with identified illnesses, including cancer, respiratory disease and dementia.
- Chaplaincy support was available 24 hours a day via an on-call system. The ordained chaplains were supported in their work by chaplaincy volunteers. The chaplaincy service was stretched, as there were only 0.2 WTE Roman Catholic chaplains, 2.0 WTE trust chaplains, and 0.8 WTE Church of England chaplains. However, through goodwill, the service was always supported by chaplains.
- The Chaplaincy service was praised by the emergency department for their input into the trauma service. The chaplaincy team were bleeped when a trauma was en route, and they would attend a short time afterwards to sit with, and provide support to, the families. All in the department spoke very highly of the value this added to the service with families experiencing devastating situations.
- Assessments for anxiety and depression were undertaken on the wards as part of the end of life care plan; however, we saw on Kirton Ward and Sroughton Ward that staff did not recognise or act on anxiety or depression by ensuring that appropriate medicines administration were considered for two patients.

# End of life care

- The bereavement team were visible throughout the hospital and were available to provide support to families who required it. This team also acted to get as much done for families as possible, to help relieve any pressure or stress from the bereavement process.
- The bereavement team had a good working relationship with the mortuary, and visited daily to provide information and support to the mortuary staff, with families attending throughout the day to view their relative or collect any items required.
- The chaplaincy service identified that they could do more to support the mortuary staff with the number of relatives attending for viewings, and could offer additional support to this service.
- Counselling and therapy services were available to those that required it. Communication training was provided to staff by the counsellor and complementary therapy specialist employed by the trust and hospice.

## Are end of life care services responsive?

Good



The end of life care and palliative care team supported the provision of rapid discharge, and rates of discharge within 24 hours were in line with the England average. For patients who were deemed to be nearing the end of their life, the normal visiting times were waived when relatives visited the hospital, and discounted parking fees were also available.

The chapel and the mortuary public areas were designed towards people of any faith, and there was a garden area where people could pray, with areas set up for different religions. The relatives rooms we observed throughout the hospital contained many information sources for people, giving details on what to expect at the end of life and for bereavement. The new room for relatives in A&E was very responsive, and provided a comforting area for people to wait in following the receipt of bad news.

Complaints were being recognised and lessons were being learnt from the concerns. Relatives were being invited to share their experience, to learn and improve the delivery of end of life care.

## Service planning and delivery to meet the needs of local people

- Of the 776 referrals last year, and the 387 referrals so far this year, 85% of referrals were cancer patients. Of the new referrals, the palliative care team had seen a 51% increase in the number of referrals in one year. There were plans in place to increase the service provision to seven days a week, as well as increasing staff to meet growing demand.
- The service held end of life care meeting groups, which looked at key issues regarding end of life care, including the withdrawal of the LCP, and the introduction of new end of life care tools, CQUINs (a quality and innovations initiative), and staff training.
- For those patients who were not successfully discharged, the discharge co-ordinator still provided a supportive role to the patient and family.
- The trust was undertaking persons preferred place of care/death audits, or any formal audit of care of the dying internally however they did partake in the national care of the dying audit.
- On each ward we visited, we asked the person in charge, and a nurse or health care assistant, to identify the patients on the ward who were receiving end of life care, or were nearing the end of their life. All wards could clearly detail who was to receive this level of care, and were aware of what was required of them.
- The exception to this was on Sproughton Ward, where we were informed that two people were receiving end of life care. When we asked to see the patients there was confusion on the ward. We established that both patients had died during the night; this had not been communicated to all staff at the 7am handover. This was not responsive.
- The mortuary had clear plans to meet the needs of the local population, and had clear escalation protocols in place to ensure that people could receive appropriate and safe placement when deceased. Agreements with local undertakers, and neighbouring hospitals, were in place to cope with increased demand in this area during busy periods, including the Winter.

## Meeting people's individual needs

- Translation services were available 24 hours per day through a telephone service.
- We spoke with staff throughout the medical and surgical wards, and all were knowledgeable about learning disabilities, including the palliative care team, and what

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do if a patient admitted has a known learning disability. Each area had a link staff member to seek guidance and support from; there was also a named specialist nurse for learning disabilities.

- The mortuary team were responsive to the needs of families who wished to view their deceased relative. The service had a large number of patients (up to 125), and there were three people to facilitate viewings. The service achieved the delivery of this service 24 hours a day, 7 days a week, despite low staff levels, which demonstrated their passion for being responsive to people's needs.
- There was a newly-built relatives room, for bereavement and breaking bad news in the emergency department. This had been well designed, and the layout, colours and information available was very responsive to people who received bad news.
- There was a relatives room on Haughley Ward, where we were informed that families could stay overnight should their relatives be at the end of their life. Staff showed us the pictures and adjustable lighting. This was a very small room, and could have been made more comfortable, but it was positive that staff had identified that it was required for relatives of patients on this ward.

## Access and flow

- The trust works with a full time Marie Curie discharge nurse to help fast track discharge, and acts as an additional source of support and guidance to patients and families.
- There were approximately 30 patients using this process a month, with between 55% and 75 % of patients being successfully discharged in each month of the past three months (August to October 2014). The main reasons for not being able to achieve discharge were rapid deterioration, or lack of care availability.

## Learning from complaints and concerns

- Learning from complaints from end of life care was visible throughout the trust. We observed information on ward newsletters, as well as patient stories on the trust's internet page, where learning was shared publicly.
- There had been five reported complaints relating to end of life care since April 2013. These were discussed at the end of life care group, with a view to inviting people to come in and share their experience with the group or with the trust board, so that lessons could be learned.

## Are end of life care services well-led?

Good



Locally, those providing end of life care within departments led the provision of this well. The palliative care consultant and nurses demonstrated good leadership, and clearly wanted to drive improvement around end of life care. The director of nursing was the executive director for end of life care. The end of life care strategy was a board focus, and the end of life care group was chaired by the director of nursing to ensure that it was a priority subject for the organisation.

Whilst the strategy and process for end of life care were in the early stages of development, there was clear engagement from staff and public into the end of life care agenda.

The chaplaincy and bereavement services had clear objectives for achievements they wished to work towards over the coming year, and recognised that continual focus on the subject would drive improvement.

The mortuary was a well-led local unit; however, the mortuary team were not always included in key discussions around end of life care, nor were they included as part of the end of life care group to discuss their role in the vision strategy.

## Vision and strategy for this service

- The hospital has a 'Palliative and End of Life Care Strategy', which was implemented in November 2012. We were informed that this was subject to review, as it has reference to historic information which is no longer relevant to end of life care.
- There is a named member of the trust board for care of the dying, and a formal discussion and reporting process regarding care of the dying within the trust clinical and quality governance structure.
- A recommendation from Norman Lamb after publication of the review of the Liverpool Care Pathway in his letter to NHS Trusts Chairs and Chief Executives in July 2013 is that there should be board level responsibility and oversight for End of Life Care, with



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preferably a lay member whose focus will be on the dying patient, their relatives and carers. At the time of the inspection, there was no non-executive director with responsibility for end of life care.

## Governance, risk management and quality measurement

- The end of life care group, the director of nursing, and the palliative care team, were measuring the different governance arrangements required for the end of life care strategy, to ensure its success.
- Audits on referrals and DNA CPR had been undertaken. Action plans for improving each area were established and monitored by the divisional group (Division 3) and the end of life care group.
- The end of life care group monitored the CQUINs (targets set by the commissioners with financial reward for achievement) established for end of life and palliative care. There was a nurse CQUIN lead, who was tasked with monitoring the CQUIN. The group discussed progress and monitoring at each meeting, with a plan to achieve each target.

## Leadership of service

- The director of nursing was the executive director responsible for end of life care, and chaired the end of life care group. Staff we spoke with felt that this was positive as it provided executive oversight on end of life care.
- Locally, the mortuary was well-led, with all staff feeling supported within the division.
- The chaplaincy and bereavement team had strong leaders with oversight from the executive team who met with the teams on a regular basis.
- Locally within the wards, we observed that the care for people with end of life needs was well-led.
- The palliative care consultant and palliative care nurses demonstrated good leadership in the clinical areas, and staff we spoke with on the wards recognised who they were.

## Culture within the service

- The focus on end of life care was beginning to shift hospital-wide, with staff commencing the new procedures, and recognising the changes and importance of end of life care.
- Staff on the wards felt that they could contact the palliative care team, chaplaincy or bereavement team at any time, and receive the support they required.

- There was a trust-wide recognition for improving end of life care, which was led through the chief executive, who shared patient experiences feedback and stories on the internal intranet, and externally on the trust's internet.

## Public and staff engagement







- The mortuary department was a well-run service; however, they are not always included in the picture of end of life care; for example, they are not members of the end of life care group. The end of life care group discusses the mortuary; however, they are not represented or included in the meetings.
- We were told that staff engagement with end of life care had improved in the months leading up to our inspection; this was predominantly due to the focus from the end of life care group. This included inviting relatives of patients into the trust, to share their experience openly to improve the service.
- The service promoted the completion of the national bereavement survey, and was aiming to improve their response rates from the public.
- The service undertook a staff survey internally for staff to provide feedback on how they feel end of life care is provided trust-wide. The results of the recent audit were positive, with most staff feeling that the wards and departments they worked in provided good end of life care.

## Innovation, improvement and sustainability

- There were plans to improve the storage capacity and facilities within the mortuary, which would ease capacity on demand.
- The palliative care consultant was included in the trust-wide mortality and morbidity meetings to discuss where deaths could be prevented, but to also highlight where people have died where their care could have been improved.
- The palliative care team were working to increase the provision of service they provided trust-wide, and had developed a business case to support this based on increased demand for support.
- The hospital planned the improvement of end of life recognition trust-wide through specialised training which was due to be rolled out during 2015. Further work was needed across end of life care services to integrate the core service into the hospital, and ensure that the work being introduced becomes embedded.



# Outpatients and diagnostic imaging

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

## Information about the service

Ipswich Hospital NHS Trust is a medium acute trust, providing services to a population of over 443,000 people who live in and around Ipswich and east Suffolk. During 2013/14, the hospital had 514,860 outpatient attendances (first and follow-up).

The service is not run to the usual central outpatient model, as seen commonly in hospitals. The Ipswich Hospital NHS Trust uses an outpatient model, where outpatients as a function sits within each of the clinical divisions. This means that each division is responsible for the outpatient function that sits within their clinical service, such as cancer, surgery, etc. There are three divisions led by a divisional director, head of nursing, clinical lead, and head of operations.

The radiology and diagnostic service is predominantly based at Ipswich Hospital. The service consists of X-ray, CT and MRI services and includes Ultrasound, Breast imaging and Nuclear Medicine. Dedicated services are also provided weekly to support the running of the fracture clinic. The hospital had a new heart centre to provide care to patients with heart concerns; however, most diagnostic testing on patients for heart and lung matters are sent to a specialist hospital.

## Summary of findings

As part of this inspection we visited most outpatient areas. We spoke with 29 patients and relatives. We also spoke with 47 members of staff, including doctors, nurses, allied health professionals, support staff and managers.

Outpatient and diagnostic imaging services required some improvement. The outpatient ENT department decontamination room was not fully HTM compliant, and required improvement to ensure the risk of infection was minimised. (Health Technical Memoranda, or HTMs, from the Department of Health, give guidance on the design, installation and operation of specialist technology relating to healthcare.)

The equipment within the diagnostic centre was aged, and there were plans formally in place with a timeframe to upgrade equipment. There were insufficient numbers of radiographers employed, which meant that some on-call arrangements for staff were very frequent, and did not allow sufficient rest time.

The effectiveness of outpatients will not be rated, due to insufficient data being available to rate outpatients effectiveness nationally at present. We found that improvements were needed in the diagnostic service provided by the hospital. We found that due to the age of the equipment, NICE guidelines were not being met,

# Outpatients and diagnostic imaging

due to out-of-date software and hardware. There were no immediate plans to upgrade these items of equipment. Seven day working did not take place, either in outpatients or in diagnostic imaging.

The care provided by staff to patients in the outpatient and diagnostic imaging services was good. We spoke with 29 patients and relatives during the inspection, and the majority of feedback from people who use the service was positive about the way staff treat people.

The service was responsive when planning the provision to meet the needs of local people. Patients were able to access their outpatient and diagnostic appointments in a timely way, with the trust performing well on the 18 week pathway, and the diagnostic six week pathway, and better than average on the cancer waiting times pathways.

Outpatients was well-led locally. We found that the local managers demonstrated good leadership within the department. Staff told us that they enjoyed their work, were proud to work at Ipswich Hospital and that there was an open culture. The structure of the outpatients department meant that there was no overarching outpatients lead, and there was a disconnect between how each outpatient service was run, because it was run by each division.

## Are outpatient and diagnostic imaging services safe?

Good



Outpatient and diagnostic imaging services were mostly safe, but required some improvement. Outpatient services were run through one of three clinical divisions. Staff were knowledgeable about incidents and how to report them; however, often lessons learned were not always shared, because information was not always passed back to the reporting area.

The outpatient ENT department decontamination room was not fully HTM compliant, and required improvement to ensure risk of infection was minimised by ensuring that the clean and dirty areas were clearly identified for decontamination. The equipment within the diagnostic centre was aged, and whilst it was noted on the vision for the service that equipment was aged, there were plans formally in place with a timeframe to upgrade the equipment.

Medical records were readily available for outpatient clinics, and there were enough staff members to provide outpatient services in each division. There were insufficient numbers of radiographers employed, which meant that some on-call arrangements for staff were very frequent, and did not allow sufficient rest time.

### Incidents

- All staff we spoke with were knowledgeable about the incident reporting systems, and we were provided with several examples of incidents that had been reported appropriately.
- Within the radiology services, no recent IRMER incidents (relating to Ionising Radiation (Medical Exposure) Regulations) had been reported.
- There have been no 'never events' or Serious Incidents requiring investigation reported in outpatients for any division within the trust.
- There was evidence of learning from incidents through review of the incident forms. Locally, some staff were aware of what lessons had been learned from incidents; however, in the orthopaedics department, and in radiology, it was noted that feedback from management on incidents was limited, which staff felt was due to how busy those managers were.

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## Cleanliness, infection control and hygiene

- We found that there were no records in place for the cleaning of outpatient rooms or equipment within outpatient rooms.
- We found the urology clinic to be unclean, and the urology investigation unit could not demonstrate that the equipment in there had been cleaned between the treatment of each patient.
- Staff in the outpatients department were complying with the trust policies and guidance on the use of personal protective equipment (PPE), and were adhering to 'bare below the elbow' guidance.
- There was hand-sanitising gel available throughout the area, and we observed staff using it in accordance with good practice.
- In the ENT outpatients department, we observed that there was a decontamination room for scopes. We spoke with two members of staff, who informed us that this had recently been redesigned. However, the room was not fully compliant with the requirements of HTM-01-06 Choice Framework for local Policy and Procedures 01-06 – Decontamination of flexible endoscopes: Design and installation.
- There was no distinction between clean and dirty sides of the room, and no clear signage of pathway in or out of the room. There were two doors; however, we observed a staff member enter one door and exit through the same door, not following the recommended pathway. The clean scopes were stored in trays in a rack, which was mostly on what would be defined as the 'dirty side' of the room.
- Endoscopes were cleaned with chlorine dioxide wipes (Tristel) in accordance with ENT UK guidelines. Records were kept on the cleaning and testing of each scope to ensure that the risk of infection was minimised.

## Environment and equipment

- Equipment within the department had been portable appliance tested (PAT) for electrical safety.
- Equipment was mostly being appropriately stored within store rooms, with the exception of the ENT clinic, where clean scopes were stored in the waiting area in the corridor outside patient rooms, and not in the rooms themselves. These scopes were covered with a protective film, and staff informed us that if this had been broken, they would get another scope prior to using it on a patient. However, the location and storage of clean scopes should be reviewed.

- We examined the resuscitation trolleys located throughout the department. Medicines and stock inside the trolley were appropriate, had been checked daily, and the defibrillator had also been tested.
- Within the radiology department, we noted that equipment was dated. X-rays were processed on cassettes, and the MRI and CT scanners were also aged. Equipment in the Orthopaedic X-Ray room is aged and had not been upgraded since 2000. MRI equipment is aged (installed in 2004/5) and frequently breaks down. CT scanners were upgraded in 2010. There was a business case in place to fund equipment upgrades in imaging services. Staff informed us that the equipment often breaks down, and this can cause delays in the service. We viewed maintenance requests within the department where staff had reported breakdowns which confirmed what we were told.
- Whilst we noted the clinical strategy and journey document dated March 2014, which identified the age of equipment as a concern, when asked if there was a plan for the department for gradual improvement and replacement of equipment, we were informed that a business case was being developed for the MRI machines and this had been signed off by the trust board.

## Medicines

- Medicines were stored in locked cupboards, and there were no controlled drugs or IV fluids held in the department.
- All outpatient clinic areas had a minimum of one registered nurse on duty during clinic opening hours, and they signed for the medication storage keys for that area.
- Lockable fridges were available for those drugs needing refrigeration; temperatures were recorded daily when the department was open. However, in the main outpatient department, we observed that a fridge temperature was recorded daily, yet the reading was abnormal and had been higher than it should have been since 30 December 2014, but no action had been taken.
- Prescription pads were stored securely, and their appropriate use monitored.

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## Records

- The on-site medical records library held all patient records for patients. Medical records were available and ready for patient's outpatient appointments. Staff confirmed that there were no concerns in relation to obtaining records for patient appointments.
- Patient records within the outpatient department were kept in secure locations.

## Safeguarding

- The trust had a chaperone policy that was followed in the outpatient department.
- Staff within the service had access to a safeguarding policy, which was available through the trust's intranet site.
- Training in adult safeguarding was available; however, trust-wide only 58% of staff had received safeguarding training for adults and children.
- The staff we interviewed were clearly able to explain their role in raising safeguarding, and how they would escalate concerns. It was explained to us that there were safeguarding link staff, and that staff could contact the safeguarding named nurse for adults or children for advice if they had any concerns.

## Mandatory training

- We examined the mandatory training data for the outpatient services. We found that the majority of staff received access to training in subjects including health and safety, fire safety, and infection control, through e-learning modules.
- Staff working within outpatients were required to complete basic life support training (BLS). Training records examined showed that the majority of permanently employed staff had completed this training.

## Assessing and responding to patient risk

- In some departments, signs were available for people informing them to alert a nurse if they felt unwell or required support.
- The inpatients who required CT, X-ray or MRI services, who may potentially be unwell, were closely monitored by staff whilst being scanned. Staff had clear protocols to call for assistance in the event of patient deterioration. We were informed that if a patient was particularly unwell, medical and nursing staff would stay with that patient.

- Within interventional radiology, the staff undertake the World Health Organization's (WHO) checklist on safer surgery techniques, to ensure that safe care is provided to patients prior to each intervention.

## Nursing staffing and Allied Health Professionals

- Nursing staff and support staff vacancy rates are included in the overall divisional vacancy rates, and are not defined as outpatient-specific. Within Division 1 (medicine & therapies) there are 5.66%; Division 2 (surgery) 5.15%; and Division 3 (cancer, women & children) 3.6% vacancy rates for nursing staff.
- For allied health professionals trust-wide, there were 8.31% vacancies.
- There were notable vacancies due to problems in recruiting trained skilled and experienced radiographers in radiology. This is a regional problem, and the service was working to develop and upskill staff to improve the service internally.
- The use of agency/bank staff across the divisions had been consistent for a period of more than twelve months, with the exception of Division 1, which had seen a 2.5% increase.
- Within the diagnostic centre, we examined the staff rotas for radiographers, including on-call arrangements for out-of-hours and weekends. Due to an insufficient number of senior staff, the same group of senior staff were required to undertake on call out at weekends. In some cases, this meant that a senior radiographer was on-call for two weekends per month. We were informed that recruitment was ongoing; however, it was a challenge to recruit senior radiographers.

## Medical staffing

- There were a sufficient number of medical staff to support outpatient services. We found that the majority of clinics were covered by consultants, with support from their specialist registrars.

## Major incident awareness and training

- The trust had a major incident plan and procedure in place, which was detailed on the trust's intranet site.
- Staff we spoke with in the outpatients department were aware that they would need to take instruction from their manager or site manager in the event of a major incident. This would be from three divisional majors for the three divisional outpatient services.

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- We asked five members of staff, in various roles throughout outpatients, about major incident training, and most could not recall receiving specific training.
- Within radiology, they were prepared for a major incident, and senior staff we spoke with could refer to their roles within the major incident plan.
- The three divisions and radiology each had a business continuity plan in place.

## Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

The effectiveness of outpatients will not be rated due to insufficient data being available to rate outpatients effectiveness nationally at present. Overall though, improvements were needed in the diagnostic service provided by the hospital. We found that due to the age of the equipment, NICE guidelines were not being met, due to out-of-date software and hardware. The MRI machines were not able to comply with the image requirements of NICE guidelines on gynaecology, dynamic prostate, and stroke. However there were plans in place to upgrade this equipment.

Seven day working did not take place in outpatients or in diagnostic imaging. An on-call service was provided by diagnostics, and weekend clinics were only run when capacity and demand required it.

## Evidence-based care and treatment

- Adherence with NICE guidelines was monitored in the divisional governance meetings.
- The division had identified on their risk register that they were unable to meet the NICE guideline on providing diabetic macular oedema treatment due to equipment availability. During the inspection, we found that this was now being met following the implemented changes in ophthalmology.
- NICE clinical guideline CG101, for patients with chronic obstructive pulmonary disease (COPD), was being followed within the respiratory service.
- NICE and best practice guidance was available to staff through the trust's intranet.
- Staff were provided with regular updates when guidance was reviewed or practice changed.

## Pain relief

- The majority of patients who attended outpatients did not require pain relief. Should pain relief be required for a medical concern then this was available in most clinics. However, two patients who had waited for a significant amount of time for their appointment in the fracture clinic, were not offered pain relief, despite being in the department for long lengths of time.
- For inpatients attending diagnostic services, pain relief was to be offered on the wards prior to sending a person for a scan or a test.

## Equipment

- The equipment used within the diagnostic centre was aged, and dated back to 2000, without replacement or upgrades on X-ray, CT and MRI scanning. The X-rays are taken mainly on cassettes, which are slow in producing, and take longer to process, as they are not digital images.
- The MRI machines are aged, and due to the length of time they have been in place, the software and hardware is not up to date, which means that the service is not able to comply with the image requirements of NICE guidelines on gynaecology, dynamic prostate, and stroke.

## Patient outcomes

- At Ipswich Hospital, of the 514,860 outpatient appointments, 66% were follow-up appointments. Since February 2014, the hospital has seen a gradual rise in the number of follow-up to new patient appointments. The follow-up to new rate is within the top quartile nationally.
- There was evidence of validating of the 18 week pathway, which was undertaken to monitor the patient access policy, and ensure that patients' treatment was being appropriately recorded to avoid any errors in clock stopping on a pathway.

## Competent staff

- Within the outpatient department, we found that 100% of staff had received their annual appraisal.
- There were developmental programmes within the diagnostic centre to upskill and train staff, to ensure that they were competent to undertake their roles. This offered additional development and promotional opportunities to those who sought them.
- Medical staff revalidation was monitored by each of the three divisions.



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## Multidisciplinary working

- There was multidisciplinary working between nursing, medical, operational and support staff within each division. However, we found little evidence of multidisciplinary working between the three divisions on providing outpatient services.
- The service has a new heart centre, which had opened during 2014. Due the requirements of imaging needing to be of a higher quality, there was an agreement in place to send all patients for heart and lung imaging to the specialist hospital in Cambridgeshire to be scanned.

## Seven-day services

- The outpatient department is not open seven days per week. There are additional clinics run to cope with increased demand at busy periods, but a seven day service is not provided routinely.
- A seven day service is available for inpatients. Monday to Friday 0800-2000 plus weekend mornings and then through an on call rota.

## Access to information

- Patients reported to us during the inspection that they had no concerns regarding access to information relating to their care or treatment.

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

- Staff training and guidance on the Mental Capacity Act 2005 was through e-learning via the intranet. Within the diagnostic centre, we found that staff were aware of some, but not all, of the requirements of the Mental Capacity Act 2005.
- Within the radiology service, we found that patients who required Mental Capacity Act assessments on them prior to receiving a contrast injection or an MRI or CT scan, were not having the assessments undertaken. However, staff were aware when it was not appropriate to go ahead and scan a patient who required support, including those patients with learning disabilities or living with dementia. The assessments were often not completed in the community prior to the person attending for their scheduled appointment.
- Prior to having a scan or procedure undertaken in outpatients, patients consent was obtained verbally and signed in their records.

## Are outpatient and diagnostic imaging services caring?

Good



The care provided by staff to patients in the outpatient and diagnostic imaging services was good. We spoke with 29 patients and six relatives during the inspection, and the majority of feedback from people who use the service was positive about the way staff treat people.

People who use these services understood the treatment and choices available to them. In most cases, patients reported to us that they were treated with dignity and respect, and had a good experience of using the outpatient services. Support was available through nursing staff, doctor's chaplains, and support works to meet people's emotional needs.

## Compassionate care

- We spoke with 29 patients throughout the inspection, about their experience of using outpatient services at Ipswich Hospital. The majority of people reported positive experiences of using services, with four reporting that their experience of using the services was not good.
- Reasons for not having a good experience from patients included not being provided with adequate time during their outpatient appointment to discuss diagnosis, and staff being abrupt. One patient told us that they were told in their outpatient appointment that they had cancer and were then "shown the door"; they did not have time to ask questions. Another patient reported that in the fracture clinic staff could be "abrupt" when the service was busy.
- We were provided with many examples of positive experiences from patients, including that staff were friendly and respectful. Comments included that staff were "wonderful", "excellent", "brilliant" and "good". Overall, the majority of patients were happy with the care they received in outpatients and diagnostics.
- The Friends and Family Test (FFT) assesses whether patients would recommend a service to their friends or family, and whether or not staff employed by the service would recommend the service to their family to receive care. The NHS choices website showed in February 2015



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that 93% of patients would recommend the inpatient service to family and friends, and 79% of Ipswich Hospital staff would recommend the trust to their friends and family.

- The FFT response rate was 19%, which was below the England average of 31%.

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

- Of the 29 patients we asked, all except four felt that the information provided to them before, during and after their appointment, was clear and easy to understand.
- Of the four that reported concerns around information, one told us that in ophthalmology, the “administrative process is diabolical”; they had to chase the hospital for the follow-up appointments and surgery, which had cost them money on telephone calls. They were concerned that this could affect their condition.
- Three other patients reported that information around appointments was not always clear, and that the boards were not always updated with correct waiting times, which could be frustrating as they were unclear how long they would have to wait.
- A total of 25 patients informed us that all information and processes concerning their outpatient appointments were clear; they had no concerns with information provided in the letters; and there was information available to read relating to their conditions should they wish to read it.

## Emotional support

- For each speciality clinic there were clinical nurse specialists, sisters and lead nurses available for patients to talk to about their conditions. Clinics were sometimes run by nurse specialists, which meant that support was more often available for patients with long-term conditions.
- There were a range of emotional support avenues available for people to speak about their conditions, including access to chaplains, social workers and community support staff.

## Are outpatient and diagnostic imaging services responsive?

Good



The service was responsive when planning the provision to meet the needs of local people. Whilst the ‘did not attend’ (DNA) rate was above the England average, the service had implemented some local measures to help reduce it, although more work was required. Patients were able to access their outpatient and diagnostic appointments in a timely way, with the trust performing well on the 18 week pathway, and the diagnostic six week pathway, and better than average on the cancer waiting times pathways. The pathways were continually monitored to enable improvements to be made to meet the needs and demand of the population.

We identified that the diagnostic centre may not always be adhering to the East of England’s policy on delivering same-sex accommodation. We observed inpatients in the CT area who were of mixed sex, and who were accommodated in the same waiting area whilst waiting for their scans. Some patients on beds were observed wearing hospital gowns though their dignity was maintained with patients being covered by blankets.

Staff worked to address any concerns raised by patients at first point of contact, and this resulted in few formal complaints. Of the concerns that we observed being reported, many were resolved through the Patient Advice and Liaison Service process, and many concerns were often linked to delays in waiting for appointments when clinics ran late.

## Service planning and delivery to meet the needs of local people

- The 18 week referral to treatment (RTT) pathways for outpatients have been consistently above the standard and the England average, with non-admitted patients being seen within the timeframe on 96.2% of occasions between April 2014 and the time of our inspection.
- The percentage of diagnostic patients waiting six weeks or more for a test has been consistently better than the England average since December 2013, with 1% of patients having to wait more than six weeks.
- The number of patients on the waiting list had significantly reduced since December 2013, when it was

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noted that there were delays in accessing diagnostic services within six weeks. The service utilises a contracted mobile unit to support the service delivery when demand reaches peak capacity. This system worked well, and there were clear plans in place to minimise the likelihood of future delays over six weeks.

- In outpatients, cancer waiting times were in line with the England average, and better than the England average for two week wait appointments, with 97.1% of patients being seen within two weeks.

## Access and flow

- During 2013/14 the hospital had 514,860 outpatient attendances (first and follow-up).
- The Ipswich Hospital NHS Trust overall has seen a gradual increase of follow-up to new rate appointments compared to the England average. The follow-up to new rate is within the top quartile nationally.
- The 'did not attend' (DNA) rate at 9% was above the England average of 7%. The trust had clear plans in place to address the DNA rate, and make improvements, including offering later clinics, earlier clinics, and evening clinics. We were informed that the DNA rate was decreasing.
- The data provided by the trust on DNA rates showed an average for 2014/15 across all outpatient specialties of 4.97%, with the highest DNA rate being for children's diabetic medicine with 21.89%, and the lowest in anticoagulant services with 0.06%.
- We found that people often had to wait longer than would be expected for their outpatient appointment on arrival in fracture clinic. On the day of our inspection, the delay in fracture clinic exceeded two hours. However, the boards were not routinely updated, and the actual wait was near three hours, which was frustrating for some patients. Two patients told us that staff would come out and update patients when they could.
- The hospital undertook a review of central outpatient clinic times in April 2014, following some areas of concern around performance identified in 2013. The review showed that for 87 clinics (25%), the clinician arrived late, which was similar to 2013. For 224 clinics (65%), the first patient was seen late, with an average waiting time of between 19 and 40 minutes. In 90/309 clinics (29%) the last patient was seen after the official end time of the clinic. The average time between the end time and the patient being seen was 26 minutes.

## Meeting people's individual needs

- Staff had received some basic awareness in understanding patients living with dementia through e-learning training, but no formalised training had been provided.
- We spoke with staff in the diagnostic centre about undertaking scans on patients with dementia or other cognitive conditions, and whilst no formalised training had been provided, the staff were very clear when it would be inappropriate undertake a scan on a person who did not understand the tests they would be undergoing.
- Staff had not received training specifically in how to support patients with learning disabilities, in person, but information was available through an e-learning course. There was a learning disabilities nurse available within the trust, and staff understood when they would need to contact them.
- Patients with forms of learning disabilities are treated in the department, and staff could benefit from training in understanding conditions and learning disabilities, and the requirements of the Mental Capacity Act 2005. This could improve their overall safeguarding awareness between the community and the acute care setting, to ensure that best interest decisions are agreed in advance, prior to patients attending for a diagnostic test.
- Translation services were available through the main switchboard, 24 hours per day.
- Within the CT service in the diagnostic centre, it was identified that inpatients who were brought down for their scans, were not separated into single sex. This potentially could class as a single sex breach in accordance with the East of England's Delivering Same-sex Accommodation policy.
- The policy defines a mixed-sex occurrence as 'the placement of a patient within a clinical setting ... where the patient occupies a bed in a bay or room that is occupied by a patient of the opposite gender'. We observed this during our inspection and informed staff of this.

## Learning from complaints and concerns

- We viewed the governance report meeting minutes for the three divisions, which showed that learning from complaints was shared.
- Of the complaints received, the outpatient services received more Patient Advice and Liaison Service

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enquiries and complaints, which meant that complaints were being resolved at a local level. The majority of concerns being raised were regarding waiting times within the hospital, due to late running clinics, particularly in ophthalmology and fracture clinic.

- In most clinics, information on making complaints and compliments was available; however, we did not observe any signs to inform the public of this process in the fracture and orthopaedic clinics.
- Information was clearly displayed on the trusts intranet site, including experiences and shared stories about complaints, and how the organisation could learn from complaints.
- We spoke with staff members throughout the inspection, who were working in the outpatients and diagnostic imaging department, and who informed us that they were aware of complaints that had been reported, and what actions were being taken to resolve them.

## Are outpatient and diagnostic imaging services well-led?

Good



Overall, the service was well-led locally. Staff felt that their line managers were approachable, supportive and open to receiving ideas on how to improve the service in most areas, with the exception of the radiology service, who did not always feel supported. Staff in the majority, were aware of the vision and values of the trust, and felt that there was always a view to improve services.

We found that the local managers demonstrated good leadership within the department and the directorate; however, there was a disconnect between the radiology team and the senior management team. The radiology team were under pressure due to staffing shortages, with a continually increasing workload.

Staff told us that they enjoyed their work, and were proud to work at Ipswich Hospital. The culture within the services was open, and staff were comfortable to speak about their concerns if they had any.

The structure of the outpatients department meant that there was no overarching outpatients lead, and there was a disconnect between how each outpatient service was run,

because it was run by each division. Whilst there was little evidence that this impacted on service delivery, it did impact on the visibility and accessibility of the senior management team, whose time was predominantly taken up by inpatient areas.

## Vision and strategy for this service

- The trust vision and values were displayed throughout the hospital. When asked, the staff spoke about the vision and values for the trust and for their local department.
- There is a high use of radiology services. It was identified in the trust's 'clinical strategy - our journey' document issued in March 2014 that imaging had been under-invested in previously, including staffing levels, and it was stated that additional staff are required to meet demand. The visions the trust hold around providing a higher level of cardiology care and orthopaedic care, as well as other complex procedures, did not automatically include the use and provision of diagnostics.
- Some of the equipment within the diagnostic centre was aged; we asked what the vision and future plans were for the service, including business cases and plans. We were informed that there were plans to replace some items.

## Governance, risk management and quality measurement

- Each of the three divisions had a risk register, which was maintained within the division, and any high risks were escalated to the board for information. All risks we observed on the risk register were monitored, and were reported on at the divisional governance meetings.
- There was no quality measurement for an overall outpatients service, because the services were split and run between the three divisions; so there was no comparable data on the performance of outpatients as an entity.
- The divisions held governance meetings with the senior managers and representatives from each department. These were minuted and disseminated to staff.
- Governance systems internally within the division demonstrated that information was shared and lessons were learnt about events that occurred; however, shared learning across the three divisions directorates was more limited in relation to outpatient services.

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## Leadership of service

- Staff informed us that the chief executive officer was visible throughout the hospital, and it was spoken about positively that they were visible and approachable. Staff spoke positively about most members of the executive team who were visible.
- The three divisional leads had the overall management responsibility for the outpatient functions in their clinical remit. All leads had large divisions, and the matrons also held the responsibility for the inpatient ward areas. There was no overarching lead for the outpatient function.
- In areas including orthopaedics and medical outpatients, this was noted to be a challenge, as there was limited support from senior management, which staff attributed to how busy the managers were for the divisions.
- The divisional leads had large areas to cover, and this could prove challenging without an overarching link between the three outpatient services to ensure that as a function, the service is being delivered effectively.

## Culture within the service

- We spoke with staff openly across the outpatient diagnostic division about bullying, harassment and whistleblowing. All felt that there was an open culture within the service, and had not experienced any bullying.
- Staff we spoke with across the three divisions did not always believe that outpatients and diagnostics were seen as a priority, as managers were busy dealing with inpatient areas predominantly, and their workloads were vast.

- Within the diagnostic service, concerns were raised about the trusts plans to continually increase the outpatient, cardiology and orthopaedic services, without increasing the support to the diagnostic centre. We were informed that the operational divisional managers were aware of these concerns, but were extremely busy as the division they worked in was large.

## Public and staff engagement

- The public were regularly encouraged to provide feedback on the service on site, as well as through NHS choices and social media.
- Information was displayed on message boards throughout the outpatient areas, to engage the public in messages about the service, as well as encouraging feedback.
- Within the diagnostic service, concerns were raised about the trusts plans to continually increase the outpatient, cardiology and orthopaedic services without increasing the support to the diagnostic centre. We were informed that the operational divisional managers were aware of these concerns, but were extremely busy as the division they worked in was large.

## Innovation, improvement and sustainability

- Within outpatients, there were many highly specialised nurses providing nurse-led care to patients around cancers, allergies, ENT and dermatology; however, there was no forward succession planning should one of those nurses become unavailable for any urgent reason, or if they should retire. This could impact on the delivery of services.

# Outstanding practice and areas for improvement

## Outstanding practice

- The emergency department's (ED) escalation protocol was efficient through innovation. The department used a trigger tool via an electronic tablet, which was carried by the ED shift co-ordinator and key managers within the trust, and which was linked to demand management in the whole trust. This supported and allowed people to access the ED services in a way, and at a time, that suited them.
- The hospital responded well to seasonal increases in activity. There was separation of the accident and emergency department and other urgent admissions, as well as early consultant assessment of admissions. The trust had created flexibility through provision of escalation wards and appropriate staffing changes. Escalation wards were also consultant-led, which resulted in continual support for patient plans of care and discharge.
- The surgical division had taken a robust approach to audit, and was benchmarking patient outcomes internationally; one of only two trusts to use the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP), it was buddied with a high performing trust in the United States to manage and improve quality and performance. We saw these changes in practice, and the sharing of best practice in surgical site infection between pre-assessment staff, nurse specialists, and medical, surgical and ward staff.
- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, such as details of their current medicine.
- The chaplaincy service carried a trauma bleep in order to provide emotional support to the relatives of trauma victims.
- There was a comprehensive outreach service in place, providing full 24/7 cover, including a 'patient activated' referral for the team.

## Areas for improvement

### Action the hospital MUST take to improve

- Review the end of life care paperwork to ensure that it is more individualised and providing a holistic approach in line with National Institute of Health and Care Excellence (NICE) guidelines.
- Provide training to staff providing end of life care, on how to identify patients approaching the end of life, and on how to use the new care plans.
- Ensure that discussions with patients and families regarding end of life care, or advanced care planning decisions, are clearly recorded in the person's medical records.
- Ensure that prior to undertaking a procedure, or completing an end of life care order, the person's mental capacity is appropriately assessed in accordance with the Mental Capacity Act 2005.
- Ensure that all clinical areas in outpatients, including the equipment in rooms, are cleaned regularly, and the cleaning is evidenced.
- Ensure that the decontamination room in ear, nose and throat (ENT) outpatients is compliant with guidelines on decontamination Hospital Technical Memorandum.
- Review medicines management in South Theatres within the surgery division, to ensure medicines are stored securely.
- Clearly define a critical care pathway for children and review the provision of services for children requiring high dependency of care, including staffing numbers, competency and provision of registered sick children's nurses (RSCN).

### Action the hospital SHOULD take to improve

- Review reporting incident mechanisms within the surgery division, including reviewing working arrangements to help facilitate timely reporting.
- Review monitoring equipment within surgery, with a view to standardising the equipment available.

# Outstanding practice and areas for improvement

- Review service planning and delivery within maternity, to ensure actions for service development are in line with current clinical practices, and consider the requirement of specialist lead roles.
- Ensure governance procedures and risk registers are active and maintained in children's services and critical care, and ensure a robust system of audit, including patient outcome monitoring, to improve learning.
- Review the staffing levels for the palliative care, mortuary and chaplaincy service, to ensure that there are sufficient staffing levels to meet the demand for services.
- Review the audit tools used for end of life care, including 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms, to ensure that they are more dynamic to improve learning.
- Ensure that a full review of staffing in diagnostic services is undertaken, to ensure that current staffing levels versus service demands is achievable.
- Develop and agree a reasonably timed plan for the refurbishment and upgrade of diagnostic machines, to ensure that the images meet the NICE guideline requirements.
- Review working arrangements to share learning and information across the outpatient services between the three divisions.
- Ensure that waiting times are clearly displayed in the outpatients department, to ensure that people are informed of up-to-date delays to appointments when they attend clinic.
- The trust should consider ways in which waiting times could be reduced within the outpatient department.
- Ensure that pain relief is offered to patients in the fracture clinic.



## Compliance actions

### Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services</p> <p>People who use services and others were not protected against the risks associated with assessing and meeting their needs in that:</p> <p>End of life care documentation does not include a holistic and individualised approach to care.</p> <p>Discussions regarding end of life care are not documented an evidenced that these have included the person or their family.</p> <p>Decisions regarding care should reflect a decision on the mental capacity of the patient in line with current legislation.</p> <p>Critical care for children is provided in line with published guidance and reflects their individual needs.</p> <p>In line with Regulation 9 (1) (a) (b) (I)(ii)(iii) HSCA 2008 (Regulated Activities) Regulations 2010 Care and Welfare of service users.</p>
Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control</p> <p>People who use services and others were not protected against identifiable risk of acquiring an infection by:</p> <p>Appropriate decontamination processes for endoscopes in the ENT outpatients department.</p> <p>Effective systems in place to ensure cleaning of the outpatients areas.</p>

This section is primarily information for the provider

## Compliance actions

In line with Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control.