Care Quality Commission

West Suffolk NHS Foundation Trust
West Suffolk Hospital
Quality Report

Hardwick Lane
Bury St Edmunds
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Unannounced inspection 23 March 2016
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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	Good	●
Medical care (including older people's care)	Outstanding	☆
Surgery	Good	●
Critical care	Good	●
Maternity and gynaecology	Good	●
Services for children and young people	Good	●
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 8 and 10 March 2016. We also carried out an unannounced inspection on 23 March 2016. We carried out this comprehensive inspection as part of our regular inspection programme.

The West Suffolk Hospital site, in Bury St Edmunds, is where the majority of the services offered by West Suffolk NHSFT occur. The trust also offers outpatient and community services at Newmarket Community Hospital, Haverhill Health Centre, Thetford Healthy Living Centre, Stowmarket Health Centre, Sudbury Health Centre, Botesdale Health Clinic and Mildenhall Clinic.

During this inspection we inspected the trust's sites at Bury St Edmunds and Newmarket Community Hospital. We did not inspect at the other locations as they only offer outpatient services at these sites. West Suffolk Hospital serves a population of approximately 275,000 people, over an area of roughly 600 square miles.

During this inspection it was evident that the trust had an established staff base that was proud to work at the hospital. Many staff had worked at this location for a long time. This meant that challenges were addressed quickly and efficiently. However, documentation of recorded actions was not consistent but this did not impact on the care of patients. The trust and its staff placed the patient at the centre of care provided and strove on a daily basis to enhance the patient experience of healthcare.

Our key findings were as follows:

- All staff were helpful, open and dynamic. They were aware of what good looks like and were striving to implement this in daily practice. Staff were proud to work at West Suffolk Hospital.
- Staff felt well supported by their managers and were impressed at the visibility of the chief executive.
- Feedback from patients, relatives and carers was extremely positive throughout the hospital and at the listening event.
- There were some excellent leaders in a number of areas, especially in the gynaecology and post-natal wards. The interim head of midwifery was providing good support to her team; however they would benefit from further support.
- Staff were overwhelmingly caring in delivering care to patients. We witnessed some examples of excellent compassion and all staff we met put patients at the center of the care provided.
- Many good ideas for improvement and innovation were from the junior, ward level staff.
- Staff awareness and understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards was not consistent.
- Medical cover at night was not consistent and was not in line with good practice guidelines.
- In the maternity service there had been a previous bullying culture that was beginning to decline. However pockets of this still existed.
- Staff could not adequately explain the governance arrangements.
- Information governance and data protection within medical photography was not assured. Systems for audit and documentation records and consent were not embedded or monitored effectively.

We saw several areas of outstanding practice including:

- The porters' display of respect for the transport of the deceased to the mortuary especially in respect of baby deaths.
- The virtual fracture team who were dedicated to ensuring diagnosis of fractures was not missed in the emergency department (ED).
- The receptionist in ED providing CPR to a collapsed patient and summoning immediate assistance.
- Two consultant pediatricians learnt hypnosis to reduce the need for sedation in children requiring MRI or CT scanning.

Summary of findings

- Trust performance against national audits was outstanding especially in the Sentinel Stroke National Audit Programme (SSNAP) and Myocardial Ischaemia National Audit (MINAP).
- Consultant paediatricians worked to provide access for patients. They set up outreach clinics in GP premises and held telephone clinics so that patients could stay in their own surroundings
- Staff who went the extra mile to drop off take-home medications or provide decaffeinated tea bags for a patient.
- The arrangement of a linked funeral service for the wife of the deceased who could not leave the hospital.
- The pharmacy service was excellent in providing take-home medications for patients.
- Additional support for critical care patients was provided by a follow-up nurse and a critical care outreach team, who also provided a cross-department education programme.
- In critical care, staff were encouraged and supported to undertake novel research projects, which they were able to present at national conferences as a knowledge-sharing strategy.
- Senior critical care staff had developed a robust five-year service plan in collaboration with unit staff, which was further evidence of the cohesive and supportive work culture we found.

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

Importantly, the trust must:

- Review and ensure robust processes are in place to provide compliance with mixed sex accommodation regulations especially within CDU, critical care (in relation to level one patients) and recovery when it is utilised for stepdown from critical care.
- Review its 'Escalation Plan and Resuscitation Status' (EPARS) forms to ensure, specifically, that the Mental Capacity Act and Deprivation of Liberty Safeguards aspects are appropriate.
- Review its Mental Capacity Assessment, Deprivation of Liberty Safeguards and EPARS policies to ensure they are compliant with law and reflect good practice.
- Ensure a robust process for data management with regard to medical photography and comply with all information governance protocols including informed consent, data protection, tracking and tracing and appropriate audit systems implemented to ensure quality improvement.

In addition the trust should:

- The trust should review the reporting of mortality and morbidity (M&M) discussions and learnings in surgery services to ensure consistent and effective documentation across the service.
- The trust should ensure staff compliance, across all staff groups, with mandatory and statutory training requirements.
- The trust should review referral to treatment times and aim to improve to ensure that surgical patients receive care within 18 weeks.
- The trust should ensure robust oversight of cancelled clinics and review theatre utilisation to support access to services and reduce patient treatment delays.
- The trust should ensure that the nutrition, hydration and toileting needs of patients are met when recovery is utilised as a step down area from CCU.
- The trust should ensure the principles of infection control are appropriate and monitored within the critical care unit for caring for potentially infectious patients.
- The trust should ensure appropriate senior staffing support to promote patient safety, including midwifery support in the management of complex cases on labour ward, appropriate supervision for high dependency patients and appropriate level of supervision within outpatients.
- The trust should consider quality measurements such as local targets for induction of labour, assisted deliveries and return of women with perineal problems.
- The trust should have action plans where it is not reaching national standards in maternity.
- The antenatal and postnatal ward F11 should review the practice of overnight stays for all partners on the ward.

Summary of findings

- The trust should review the succession planning and development for staff in seconded or interim roles within the maternity service.
- The trust should consider developing strategic planning arrangements including action plans to achieve service goals, a performance dashboard for children's services and a comprehensive transition policy to help all teenage patients adjust to adult health services.
- The trust should review the availability of staff with play specialist skills.
- The trust should review the options and nutritional value of food offered within the children's service.
- The trust should review medical staffing, particularly within end of life care services to ensure consultant cover meets recommended national guideline levels.
- The trust should ensure that nurse staffing levels for children meet recommended national guideline levels.
- The trust should include sepsis monitoring on the maternity dashboard for inpatient areas.
- The trust should consider midwifery staffing and specialist midwives roles to support vulnerable groups.
- The trust should review the way patients in the last days or hours of life have their needs holistically assessed and how this is documented.
- The trust should review it's specialist palliative care service for medical staffing and provision of a seven day service
- The trust should ensure that records management is secure and appropriate in all areas
- The trust should ensure a robust process for oversight and management of all policies and procedures.
- The service should ensure that risk scrutiny in governance meetings is robust and recorded so that there is assurance of management of risk.
- The trust should ensure dissemination of outcomes from audits and meetings is robust across all services.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good 🟢	Urgent and emergency care services were rated as good overall, with safe as requiring improvement. There were clear protocols for the management of stroke and sepsis and care pathways were completed appropriately. There were good examples of multi-disciplinary team working such as the early intervention team and psychiatric liaison team. There was good evidence and robust management of staff training. Patients and families were positive about the care and service received. Between August 2014 and October 2015 the percentage of patients who would recommend the ED department ranged between 91 and 95% which was significantly higher than the England average. There was a dedicated fast track process for gynaecology patients, and examinations occurred in a dedicated assessment area which enabled additional privacy and dignity for these patients. The nursing workforce was a well-established team. There were clear indications of good engagement and staff felt confident in the leadership. The clinical lead and service manager had clear visions for the service and department. There was evidence of information sharing and staff had the opportunity to contribute to the development of the electronic patient records system. Nursing and medical staff worked effectively together and nurses felt well supported by consultant colleagues. Safety of the service required improvement because the children's emergency waiting area was not fit for purpose and was located within the main waiting area. There was no clear policy or escalation process for observing children for signs of deterioration. The trust told us that the reception staff would inform parents to escalate concerns but we did not see this at our inspection and staff were unaware of this process. Nursing observations for both adult and paediatric patients was inconsistent. Documentation was inaccurate in 23 sets of notes out of 40 reviewed, and not escalated when observations were outside the recommended range. Nurse staffing levels were insufficient for both registered nurses (RN) and paediatric nurses. This impacted on the

Summary of findings

clinical decisions unit, which admitted patients with a predicted length of stay of less than 24 hours. Nursing staff from the emergency department (ED) were often utilised to work in CDU but remained in the overall ED numbers. The current, and proposed increase in paediatric nurses, did not allow for overnight cover. The department discussed complaints at governance meetings and issued a newsletter but there was no evidence of learning from complaints and implementing and embedding changes to improve patient care. The policy and practice for admitting patients to CDU had the potential to not be compliant with the Department of Health 2010-2012 guidance on eliminating mixed sex accommodation which includes all admissions and assessment units including clinical decision units. The trust CDU policy states that patients that requiring a stay of less than 24 hours are admitted to CDU.

Medical care (including older people's care)	Outstanding ☆	Medical services at West Suffolk Hospital were rated as outstanding overall because patients were protected from avoidable harm and abuse and the concept of 'safe' was embedded in medical care service practice. Quality improvement strategies were developed and outcomes were monitored and acted upon. Standards of hand washing and cleanliness were consistently good and regularly audited. Incident reporting was embedded amongst nursing and allied health care professionals and learning from incidents was promoted. Staffing levels reflected the needs of the patients and the trust was proactive in its recruitment of staff. Trust performance against national audits was outstanding especially in the Sentinel Stroke National Audit Programme (SSNAP) and Myocardial Ischaemia National Audit (MINAP). The trust was able to provide evidence of changes made in response to the feedback received. It was clear that staff and senior leaders saw clinical audit as an effective improvement tool. Patients received compassionate care and were treated with dignity and respect and their privacy was preserved. Patients and relatives felt involved in their care and stated that they were given adequate information about their care and treatment. The trust had a higher response rate to the friends and family test than the England average. Complaints were used as a means to improve services.

Summary of findings

The medical service was responsive to patients' needs. Staff worked hard to reduce avoidable admissions and improve early discharges. Whilst out-of-hours transfers still occurred, these were kept to a minimum and reported to senior team members.

The acute medical unit was regularly used for inpatient beds during periods of escalation. This meant ambulatory care was either restricted or suspended on a regular occasion with patients having to attend the AMU separately or remain in the emergency department. Leadership within the medical care service was good. Clear accountable governance structures existed and individuals owned and identified risks and were appropriately held to account. The culture within the medical care service was open and honest. The trust wide objectives were well known by all levels of staff and volunteers.

Surgery	**Good**	🟢	Surgery services at West Suffolk Hospital were good overall.

Incident reporting and management were robust, with evidence of investigation, scrutiny and learning. Harm free care was actively promoted on wards, and risk assessments and checks were in place for all four harms (falls, pressure ulcers, urinary tract infections and venous thromboembolisms), including a regular audit and learning cycle. Equipment and resuscitation equipment was regularly safety checked and maintained. There were processes for checking and security of medicines, including controlled drugs. Management of surgical and nursing staffing was good with low sickness and vacancy rates.

Patient care was in accordance with national guidelines and best practice recommendations. National, regional and local clinical audits were completed. A range of clinical governance groups provided oversight to ensure the trust adhered to best practice guidelines and responded to changes in legislation. National and local guidelines were accessible to staff and local and national audits were performed regularly. The service performed better than the England average in the Hip Fracture audit and performance was good in the 2014 Lung Cancer Audit.

Staff were caring, compassionate, and treated patients in a professional and considerate manner with dignity and respect. Friends and family test (FFT) and patient survey results were consistently positive. Patients

Summary of findings

reported feeling involved in planning their care and received enough information about their conditions. Specialist nurses provided emotional support to patients.

Overall, lengths of stay were better than the England average and surgical outliers rarely occurred. The surgical wards worked together to ensure that access and flow through the service was well prioritised. Discharge planning was effective and involved a multidisciplinary team and the patient. Patients requiring additional support at home had their discharge facilitated by a dedicated complex discharge planning team.

The service was proactive in planning for known events such as industrial action. There was a high focus on meeting the needs of people living with dementia, including the use of hospital passports and bespoke knitted items. Complaints management had improved year on year.

Local leadership was good with staff feeling able to raise concerns.

Critical care

Good ●

Overall critical care was rated as 'good'. Safe and caring were rated as good, effective and well led rated as outstanding and responsive rated as requires improvement.

This reflects consistently good staffing levels of doctors and nurses, which met the safe standards established by the Faculty of Intensive Care Medicine, the Royal College of Physicians and the Royal College of Nursing. Two dedicated professional development nurses managed mandatory training in the unit and provided substantial development support and opportunities to nursing staff. There was consistent, seven-day input from a multidisciplinary team of specialists. The standard of medicine management was very high and the unit had a dedicated full time pharmacist. A follow-up nurse, audit nurse and technologist significantly extended the scope and effectiveness of the critical care service.

Staff practiced evidence-based care and treatment based on the best practice guidance of the National Institute for Health and Care Excellence and developed plans to improve the service by using the results of local and national audits.

There was a demonstrable focus on providing individualised care based on feedback from patients and their relatives and from the outcomes of pilot

Summary of findings

projects conducted by critical care staff. Additional support for critical care patients was provided by a follow-up nurse and a critical care outreach team, who also provided a cross-department education programme.

Staff were encouraged and supported to undertake novel research projects, which they were able to present at national conferences as a knowledge-sharing strategy. Senior staff had developed a robust five-year service plan in collaboration with unit staff, which was further evidence of the cohesive and supportive work culture we found.

Dedicated housekeeping staff maintained a very high level of cleanliness and hygiene and infection control evidence reflected this.

There were a number of areas within the service we judged to require improvement. For example, staff did not always understand or use incident-reporting processes and investigations did not always result in demonstrable learning. There was a lack of governance in relation to incidents.

The principles of infection control were not always evident in the unit for a patient who was potentially infectious. Staff did not always provide continuous and appropriate supervision for high dependency level two and level one patients when they were cared for in side rooms.

Maternity and gynaecology

Good

Maternity and gynaecology services were rated as good overall. Safe, effective, caring and responsive were rated as good with well-led rated as requires improvement. All investigations of incidents were reported via an electronic incident reporting system. Approximately 70 incidents were reported on average per month from maternity and gynaecology services. Between December 2014 and November 2015 there were 835 incidents reported, of which two were classified as catastrophic, one classified as major, three classified as moderate, with 48 minor and 11 negligible. There was clear evidence of learning from these incidents with development for staff and changes in practice embedded. There was one never event declared from this service following a retained swab during gynaecology surgery. There are no separate obstetric theatres because patients are transferred to theatres for surgery under the care of the theatre staff.

Summary of findings

The maternity service provided a ratio of one whole time equivalent (WTE) midwife to 29 births, which was against the national standard of 1:29. Between April 2015 and July 2015 the reported ratio was as high as 1:30, whilst In January 2016 the ratio was reported as 1:26. The last completed review of maternity staffing levels was in 2011. The Trust consistently achieves an average birth to midwife ratio of 1:29 using community and specialist midwives. This achieved a better than average coverage of 1:26 in January 2016.

Emergency drugs were stored securely and were not at risk of theft or tampering.

Appraisal rates for maternity and gynaecology nursing, midwifery, support and clerical staff was 95% overall. However, medical staff appraisal rates were reported at 93%. The six medical staff we spoke with all confirmed that they had completed their appraisal which supported revalidation.

Community midwives had access to information technology. However, we were informed that the wireless internet connection was more problematic for staff based at Bury St Edmunds rather than in the rural parts of the county. Senior staff were aware of this and the issue was recorded on the risk register which meant that the trust wide team were aware that this required addressing.

The gynaecology waiting times for 2015 received from the trust and discussed with the gynaecology lead consultant informed us of targets achieved. The 18 week to admission target had been achieved in 2015. There were no closures of the maternity unit between January 2015 and January 2016, which meant that the maternity team were consistently working to meet the needs of the local population. Quarter 1 report for 2015/16 showed the bed occupancy did not exceed 33%.This meant that staff had the capacity to deliver high quality care during this time.

The maternity service was operating with ratified guidelines but there was guidance cited relating to reviews that had no date.

Not all staff were aware of the vision of the maternity service which meant that it was not fully embedded. There were links to the trust wide strategy of "putting you first", one vision with three priorities and seven ambitions, all displayed on the wards.

The national targets for unassisted birth, caesarean section and instrumental delivery rates had been met. There was an anaesthetic consultant on-call rota for the maternity service 24 hours a day, seven days a week providing epidurals when requested.

The women's experience survey 2015 showed that the trust performed approximately the same as other trusts for all measures on the care they received and that they were supported to make informed choices.

There was 68% of medical staff trained to level three. The trust were supporting further training to promote staff awareness of safeguarding but had no action plans for addressing shortfall in safeguarding training.

The maternity service and the maternity services liaison committee (MSLC) was established but with recent multiple changes in leadership and interim cover there remained some instability. At the time of our inspection, there were no identified links with the trust and the clinical commissioning group (CCG) to improve care for women.

There had been a reported bullying and unsupportive culture involving a small number of senior staff since April 2015. The trust informed us of a number of actions which it had taken to address the situation. However, staff appeared unaware of these plans. Staff had some unease regarding the sustainability of improvements. PROMPT (practical obstetric multi-professional training), compliance was 85% for midwifery staff.

At the time of our inspection, there were no identified links with the trust and the clinical commissioning group (CCG) to improve care for women.

Services for children and young people	**Good** ●	Services for children and young people at West Suffolk Hospital were good.

The children's wards and treatment areas were visibly clean.

Management and storage of medicines was appropriate and safe.

Staff knew how to safeguard children and undertook relevant specialist paediatric training.

The services managed risk well and used a paediatric early warning system to identify if a child's health was deteriorating. There had been no serious incidents in the services in 2015 and staff learned from minor incidents and shared their learning.

The services planned and delivered children's and neonatal care in line with national, regional and local

guidelines and carried out clinical audits. Nursing staff and doctors had high levels of skills and competencies and worked well with other teams in the hospital to find the best solutions for children.

There was seven-day access to diagnostics and fast tracking was available for children's x-rays for the same morning/afternoon if needed.

Nursing staff and doctors were compassionate and dedicated to the welfare of children. Care was tailored to individual children. The services offered a high level of psychological and emotional support.

Consultants worked to provide access for patients. They set up outreach clinics in GP premises and held telephone clinics so that patients could stay in their own surroundings. Staff saw and treated children promptly in the hospital in most cases.

Nurses, doctors and managers had a vision for children and neonatal services which reflected the trust's strategy of working with other providers in the community. There was clear leadership in the services and staff told us they enjoyed working for the services. Staff listened to children and their parents and had made improvements in response to feedback.

End of life care

Good ●

End of life care at West Suffolk NHS Foundation Trust was rated good overall. Safe, responsive and well led were all rated as good and caring as outstanding, with effective rated as requires improvement.

Staff knew how to report incidents involving patients at the end of life and evidence of this was seen throughout the inspection.

Staff adhered to infection control practices, particularly within the mortuary. The specialist palliative care team (SPCT), mortuary, chaplaincy and bereavement staff had all completed 100% of their required mandatory training. Patient records were accurate and completed in a timely manner.

Patients were able to access food and drink when they required it, and were assisted to eat if needed. Pain relief was prescribed and administered in a timely manner and in accordance with trust policy. The trust scored well in the March 2016 National Care of the Dying Audit, meeting four out of the five clinical outcomes. The trust's policies around the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) were ambiguous and left staff confused about how to

Summary of findings

interpret the MCA and when to apply for a DoLS. The completion of the trust Escalation Plan and Resuscitation Status (EPARS) was inconsistent and often did not reflect the patient's medical notes.

Patients and their families were cared for with dignity, compassion and in a respectful way throughout the inspection. Staff gave examples of exceptional practice that enhanced patients' physical and emotional wellbeing. Staff used their initiative in often difficult situations to ensure patients and their families received the care they required.

There was a mixture of patients with and without cancer referred to the SPCT. We saw care planning was documented and implemented across all clinical areas inspected.

The chaplaincy was able to contact religious leaders of other faiths; however this was limited and rarely used. The trust had a clear strategy and vision for end of life care. Although no substantive medical leadership was in place, the SPCT practice development matron met weekly with the executive lead for end of life care for senior guidance and support. The trust demonstrated multiple initiatives to improve and ensure sustainability within the service. Formal staff and public engagement was lacking, however informal feedback was sought from staff on a regular basis through discussions within ward areas.

| Outpatients and diagnostic imaging | Good 🟢 | Overall we rated the diagnostic and outpatient services at West Suffolk Hospital as good. |

Staff were safety and risk aware, knew how to ensure provision of a safe service and could describe how to escalate incidents and learning from these when things had previously gone wrong.

Cleanliness was good. The trust monitored this through audits, for example for hand hygiene.

There was a process for maintenance of equipment within the departments and the trust had plans for replacement, maintenance or service interruption through major incidents.

Medicines were securely stored and monitored, and information was available for patients regarding potential side effects. The trust used evidence-based guidance to treat patients and monitored outcomes.

Staff were aware of their responsibilities to protect patients from abuse or harm and could describe how to

Summary of findings

escalate concerns or seek help. Staff could describe appropriate processes for protecting people who were vulnerable through intellectual disabilities such as dementia.

Caring was good as staff were able to describe how they go 'the extra mile' for their patients and we observed staff interact with patients, relatives and their colleagues respectfully and treat them with dignity. Patient feedback showed that people were very happy with the care they received.

We saw that staff from different professional disciplines worked well together to provide the most appropriate care for their patients. The trust was achieving target times for referral to treatment for most services.

There were governance processes and risk management for most of the services. Risks were appropriately captured and documented.

Staff were universally positive about local and trust wide leadership. The executive team supported staff, encouraged them to suggest and make changes to improve patients' experience, and supported implementation of these.

However there were gaps in mandatory training and appraisal for some groups of staff such as nursing staff in radiology. We could not be confident that outpatient clinics were appropriately staff by skilled and qualified staff, for example paediatric dermatology.

Some outpatient areas, for example audiology, were very cramped.

Policy making in the outpatients department lacked timeliness, trust-led scrutiny or endorsement.

West Suffolk Hospital

Detailed findings

Services we looked at

Urgent and 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 and diagnostic imaging;

Detailed findings

Contents

Detailed findings from this inspection

Background to West Suffolk Hospital

Sites and locations

West Suffolk NHS Foundation Trust comprises of eight locations registered with CQC.

West Suffolk Hospital in Bury St Edmunds provides district general hospital services for the local population. The trust also provides community services and a range of outpatient clinics from a number of sites throughout Suffolk and Cambridgeshire. The trust became a NHS Foundation trust in November 2011. The trust has around 491 beds covering a wide range of specialties.

Population served:

West Suffolk Hospital serves a population of approximately 275,000 people, over an area of roughly 600 square miles. The area is predominantly rural with pockets of urban areas.

Deprivation:

The Suffolk area is significantly better than the England average for deprivation, with the majority of the population in the 2nd and 3rd least-deprived quintiles. There are some 18,900 children living in poverty in the area. However this is significantly better than the England average.

Our inspection team

Our inspection team was led by:

Chair: Richard Quirk, Medical Director, Sussex Community NHS Trust

Head of Hospital Inspections: Fiona Allinson, Care Quality Commission

The team included nine CQC inspectors and a variety of specialists including two executive directors, a clinical fellow, a safeguarding specialist, a pharmacist, three medical consultants, a consultant in anaesthetics, a consultant obstetrician, a palliative care consultant, a consultant paediatrician, a junior doctor, eight nurses at a variety of levels across the core service specialities and one expert by experience. (Experts by experience have personal experience of using or caring for someone who uses the type of service that we were inspecting.)

Detailed findings

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 08 and 10 March 2016.

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); Monitor; 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 3 March 2016, when people shared their views and experiences of

West Suffolk 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 unannounced inspection visit on 23 March 2016. 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 Suffolk Hospital and Newmarket Community Hospital.

Facts and data about West Suffolk Hospital

Beds: 491

– 443 General and acute

– 31 Maternity

– 11 Critical care (+6 Coronary care beds)

• Staff: 3,063

– 411 Medical

– 975 Nursing

– 1,787 Other

• **Revenue**: £173m

• Full Cost: £178m

• **Surplus (deficit):** (£5m)

Activity summary (Acute)

Inpatient admissions 62,673

Outpatient (total attendances) 389,701

Accident & Emergency 62,106

(attendances)

Newmarket Community Hospital

Beds: 16

Average Length of stay (LoS) – 19 days

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Good	Good
Medical care	Good	☆ Outstanding	☆ Outstanding	Good	Good	☆ Outstanding
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	☆ Outstanding	Good	Requires improvement	☆ Outstanding	Good
Maternity and gynaecology	Good	Good	Good	Good	Requires improvement	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Requires improvement	☆ Outstanding	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	☆ Outstanding	Good	Good	Good

Notes

Urgent and emergency services

Safe	**Requires improvement**	🟠
Effective	**Good**	🟢
Caring	**Good**	🟢
Responsive	**Good**	🟢
Well-led	**Good**	🟢
Overall	**Good**	🟢

Information about the service

The Emergency Department (ED) at West Suffolk NHS Foundation Trust provides a 24-hour, seven days a week service to the local area with a catchment population of 280,000. The ED department sees 63,000 patients annually, with 20% of these being paediatric patients (0-16 years of age). From April 2014 to June 2015 the ED department had 77,994 attendances, 18.4% paediatric (0-16 years of age), and 81.6% aged 17 and over.

Between April 2014 and March 2015 28.7% of attendances resulted in admission, which is above the England average of 22.2%.

Between September 2014 and August 2015, 864 patients left the department before treatment or having refused treatment. Between January 2014 and October 2015 the number of unplanned re-attendance was above the NHS England standard of 5% on the majority of occasions ranging from 4.5% to 5.9%. However this was significantly below the NHS England average of between 7 and 7.5%.

Patients presented to ED by walking in via the reception or arriving by road or air ambulance. The department has facilities for assessment and treatment of minor and major injuries. In the ED there were three resuscitation bays and one high dependency bay, , five major cubicles, 15 minor cubicles, one ear nose and throat (ENT) / ophthalmology cubicle, separate x-ray facilities, and paediatrics and adults waiting areas.

There was a separate clinical decisions unit (CDU), consisting of four reclining chairs, three male beds, three female beds and one psychiatric assessment room.

During our inspection we observed care in the clinical environment and we spoke to 33 members of staff including doctors, nurses, support staff, students, ambulance crew, psychiatric team and the early intervention team. We spoke to seven patients who were using the service. We also met with the leaders of the service and examined the records of 65 patients who used the service.

Urgent and emergency services

Summary of findings

Urgent and emergency care services were rated as good overall, with safe as requiring improvement.

There were clear protocols for the management of stroke and sepsis and care pathways were completed appropriately. There were good examples of multi-disciplinary team working such as the early intervention team and psychiatric liaison team. There was good evidence and robust management of staff training.

Patients and families were positive about the care and service received. Between August 2014 and October 2015 the percentage of patients who would recommend the ED department ranged between 91 and 95% which was significantly higher than the England average.

There was a dedicated fast track process for gynaecology patients, and examinations occurred in a dedicated assessment area which enabled additional privacy and dignity for these patients.

The nursing workforce was a well-established team. There were clear indications of good engagement and staff felt confident in the leadership. The clinical lead and service manager had clear visions for the service and department. There was evidence of information sharing and staff had the opportunity to contribute to the development of the electronic patient records system. Nursing and medical staff worked effectively together and nurses felt well supported by consultant colleagues.

Safety of the service required improvement because the children's emergency waiting area was not fit for purpose and was located within the main waiting area. There was no clear policy or escalation process for observing children for signs of deterioration. The trust told us that the reception staff would inform parents to escalate concerns but we did not see this at our inspection and staff were unaware of this process.

Nursing observations for both adult and paediatric patients was inconsistent. Documentation was inaccurate in 23 sets of notes out of 40 reviewed, and not escalated when observations were outside the recommended range.

Nurse staffing levels were insufficient for both registered nurses (RN) and paediatric nurses. This impacted on the clinical decisions unit, which admitted patients with a predicted length of stay of less than 24 hours. Nursing staff from the emergency department (ED) were often utilised to work in CDU but remained in the overall ED numbers. The current, and proposed increase in paediatric nurses, did not allow for overnight cover.

The department discussed complaints at governance meetings and issued a newsletter but there was no evidence of learning from complaints and implementing and embedding changes to improve patient care.

The policy and practice for admitting patients to CDU had the potential to not be compliant with the Department of Health 2010-2012 guidance on eliminating mixed sex accommodation which includes all admissions and assessment units including clinical decision units. The trust CDU policy states that patients that requiring a stay of less than 24 hours are admitted to CDU.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement ●

Urgent and emergency services were rated as requires improvement for safe because:

- The children's emergency area was not fit for purpose. The location of the waiting area meant that children were not visible and there was no clear policy or process for observing children for signs of deterioration.

- Recording of patient observations was not in line with the Modified Early Warning score (NEWS)

- Registered nursing (RN) staffing levels were not sufficient to ensure safety in the clinical decisions unit (CDU) unit or Emergency Department (ED), particularly overnight.

- There was a shortage of registered nurses (child branch) working in the department which did not fulfill national guidance. However the trust had taken steps to mitigate this risk through additional competency training of adult nursing staff. There was only one nurse with advanced paediatric life support skills in the department.

However:

- Incident reporting was embedded and there was a good learning culture within the department.

- Staff were aware of major incidents protocol and what their requirements would be in the event of an emergency.

- Compliance in safeguarding training was good: safeguarding adults training was 98.7% against trust target of 90%.Safeguarding children levels 1 and 2 were 100% against trust target of 90% and safeguarding children level 3 was 98% against trust target of 90%.

Incidents

- The service followed the trust's incident reporting policy and had reported 161 incidents between August 2015 and November 2015.

- The majority of incidents resulted in no harm or low harm for impact. Between August 2015 and November 2015 161 incidents were reported. The top three reported incidents were: care and treatment 32

incidents reported, medication 19 incidents reported and patients who were identified as having a pre-existing or community acquired pressure ulcer of which 24 were reported.

- Between September 2014 and September 2015 there were no new pressure ulcers, falls with harm or catheter-acquired urinary tract infections reported via the patient safety thermometer (improvement tool for measuring, monitoring and analysing patient harm free care on set day each month, and reported on monthly)

- The ED held monthly governance meetings which discussed all mortality and morbidity within the department. However on two occasions (October 2015 and July 2015) mortality and morbidity was not discussed due to the absence of the lead consultant. Review of the minutes from four meetings demonstrated that information recorded did not provide sufficient detail to learning and actions from reviews.

- Two serious incidents (an incident in which a member of the public experience serious or permanent harm) were reported from October 2014 to August 2015. Both incidents occurred in the CDU. A comprehensive investigation and route cause analysis (RCA) had been undertaken. There were clear action plans, with timelines, completed accordingly. One incident had clearly documented evidence that Duty of Candour (legal duty on NHS trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm) had taken place. The second incident occurred prior to the introduction of Duty of Candour in November 2014.

- One incident related to a patient with dementia sustaining an injury in CDU. The action plan had stated that patients with confirmed diagnosis of dementia would not be suitable to be cared for in CDU. However a patients suffering from dementia was not a documented exclusion criterion for admission to CDU. The notes from the November 2015 CDU governance meeting also demonstrated that clarity surrounding dementia patients in CDU was lacking. This meant that despite recognising the potential risk there was no evidence of actions taken or changes implemented to reduce the risk.

Urgent and emergency services

- We saw three letters showing compliance with Duty of Candour following an incident. The ED had a clear process, which involved the matron meeting with patients and families for moderate harm incidents and most appropriate personnel for major incidents.

Cleanliness, infection control and hygiene

- Throughout the inspection staff displayed good hygiene techniques with frequent hand washing and use of alcohol gels. Staff used the appropriate personal protective equipment (PPE) including gloves and aprons.

- Data from April 2015 to November 2015 showed that the CDU had missed Methicillin-resistant Staphylococcus aureus (MRSA) screening on six occasions in April 2015 rising to 14 in November 2015.This had been escalated to the ward manager and matron to ensure improvement. No updated data was provided at the time of the inspection.

- In quarter 2 (July 2015-September 2015) ED reached 98% compliance in MRSA screening, environmental hygiene and standard principles (hand washing, PPE and uniform compliance), against the trust's target of 90%. In quarter 3 (October 2015 to November 2015) this had reduced to 91% compliance.

- The ED matron performed monthly hand hygiene audits. Audit reports from June 2015 to November 2015 showed out of 64 staff observed there was 100% compliance with hand hygiene practice.

- The paediatric waiting area had a number of toys available. Staff stated that these were cleaned daily by volunteers or staff and this was recorded

- One side room was allocated to manage patients with potential infectious conditions or those requiring reverse barrier nursing (requiring protection from source of infection for example if they are immunocompromised). However this side room did not have an en-suite facility; staff said that a designated commode would be used.

- There were "I am clean" stickers with date and time recorded, used on commodes in the sluice area to indicate that they were clean and ready for use.

- The disposable curtains were changed on a six monthly rota or if contaminated. Curtains were in date and no contaminated curtains were seen.

Environment and equipment

- The Patient Led Assessment of the Care Environment (PLACE) audit was completed in March 2015. ED results for cleanliness were 97%, privacy and dignity 80%, conditions of environment 95% and dementia friendly 51%.There was a clear environment improvement plan which identified areas such as replacement flooring throughout the trust and replacement chairs in ED however there was no evidence on how the department would improve the dementia friendly status.

- The trust had no separate entrance for ambulances, due to the design of the building. This meant that all patients, including those in a critical condition had to enter through the main waiting room. Privacy curtains had been installed by the seated area, which would be drawn if an emergency was expected.

- The designated paediatric room was situated in the main waiting area, which allowed for some segregation of children from adults. However, children had to pass through the main adult waiting area to access the paediatric waiting room. This meant that there was a risk of children being exposed to frightening behaviours or adults who were feeling unwell. The area was not visible to nursing staff and did not have CCTV. Staff had raised this as a concern when the area was built. The clinical lead had proposed ED alterations which included a new paediatric area and a business case had been submitted to the executive team in December 2015. There were no agreements to the plans at the time of the inspection. The trust told us that the receptionist informed parents to escalate concerns if their child's condition was deteriorating however staff we spoke with were unaware of this process and there was no policy in place to advise staff on this.

- There was a designated mental health assessment room within the CDU. The room was ligature free, with non-movable furniture which meant that it was safe for use with patients that may be at risk of self-harm.

- The three resuscitation bays were standardised, with slight modifications in the paediatric area. This was to enable staff to quickly access equipment and medication.

- The emergency resuscitation trolleys in ED were all sealed and there were daily checks of equipment which had been completed. All equipment was found to be in date. Documents showed full compliance for the period between January 2016 and March 2016.

- 12 items of resuscitation equipment were checked and all were compliant with PAT (portable appliance testing).
- Daily fridge temperature recordings were not always completed. There was no indication for staff what the recommended temperature ranges should be. This was escalated to the nurse in charge who said that staffing shortages may have caused the fridges not to be checked and that she would resolve the temperatures range display. However we noted that the fridge recordings that were completed were within the optimal range so that medicines would be effective.
- CCTV in the department was displayed on a screen in the main treatment area. However the screen automatically turned itself off, meaning that continuous visual observation was not displayed. This was escalated to the service manager who rectified this immediately.
- Panic alarms were fitted in the ED reception for use if there was a risk to patient or staff safety. When the alarm is triggered the doors in the department would be locked automatically and the alarm directed through to the police.
- The department had recently purchased a Lucas chest compression system (performs chest compressions at a consistent rate in the event of cardiac arrest, and frees staff of performing this function), through the use of charitable funds.

Medicines

- All medications drug cupboards were checked and medications found to be in date. All cupboards were locked with key code access which was changed on a monthly basis.
- Controlled drugs (CD) were stored securely in controlled drug cabinets. Twice daily checks were made on controlled drugs to ensure records were accurate and up to date. CD records were reviewed for January and February 2016 and were completed accurately.
- If patients were allergic to any medicines this was recorded on their prescription chart. There were reminder posters about penicillin allergies displayed in the medicine storage room.
- Medicine incidents were reported with lessons learnt and positive action taken to prevent them happening

again. The unit manager gave an example where intravenous fluids had been administered incorrectly. There was clear evidence of re-training and counselling for the member of staff.

Records

- The trust was introducing a new patient electronic records system for May 2016 called e-care which would deliver a single integrated electronic patient record. All nursing and medical staff had received training. There was a dedicated room set up with computers for staff to practice using the system. Super users had additional training to support the department, and extra staff had been booked for the weekend in March in which a practice run of "go live" was organised. Staff informed us that they had been involved in the design of the system and felt confident in using the system.
- Forty sets of patient notes were reviewed. There was clear documentation regarding the plan of care and appropriate risk assessments carried out for example pressure area assessment.

Safeguarding

- ED staff compliance figures for safeguarding adults training was 98.7% against trust target of 90%.
- ED staff compliance for safeguarding children levels 1 and 2 was 100% against trust target of 90%.
- ED staff compliance for safeguarding children levels 3 were 98% against trust target of 90%.
- A band 5 nurse was the designated safeguarding champion. They had recently visited another trust to look at safeguarding practice, and they were in the process of developing a domestic violence booklet as a training aide for medical and nursing staff. This was in the early stages of planning and well supported by the chief nurse
- The trust had a designated named children safeguarding nurse. Staff knew how to access the service if required.
- There was a proforma for emergency contraception for under-16s. Staff stated that the GP would be informed of the patient's attendance in these cases and an online safeguarding referral would be made
- Between April 2015 and March 2016 there were 312 children safeguarding alerts (including historic alerts).

Urgent and emergency services

The named nurse reviewed each child attendance to ED. Staff could access the electronic system which enabled them to view relevant records in relation to the safeguarding alert

- The trust was planning to install the CP-IS (child protection information system) which would alert ED if a child was subject to a protection plan and the local authority responsible for them. There was no planned start date provided at the time of the inspection.
- There was an ED mental health assessment form for adolescents (12-17 years). Triage was clear, with reference and escalation in relation to checking child protection register and referral to CAMHS (child and mental health service). The risk assessment matrix provided actions and the timescales in which actions should be completed.
- Minutes from the Safeguarding Children Committee meetings, from September 2015, December 2015 and February 2016, demonstrated regular attendance by a representative from the ED, the ED manager and/or matron and a RN.

Mandatory training

- The trust set a target of 80% completion for all staff groups for mandatory training in the following topics: basic life support, inoculation incidents, transfusion update, conflict resolution, fire, health and safety, infection control MAJAX (Emergency response), medicine management, moving and handling, security and slips trips and falls. Compliance figures for February 2016 ranged between 93 to 100%, with the exception of transfusion update which was at 79.6%. Data provided by the trust was for ED as a whole and not broken down into staff groups.
- The trust set a target of 95% for information governance. ED compliance was at 94.8% for February 2016.
- 100% of registered nurses had attended Paediatric Intensive Life Support training. There was one band 6 nurse who had attended the Advanced Life Support training for children. Medical staff had also attended EPLS (a training for managing urgent situations in children).
- There was a dedicated mandatory training day which meant staff rotas could be arranged to ensure staff attendance.

- Two student nurses confirmed they had a trust handbook which they could refer to for any information regarding safeguarding, pathways, medication procedure and incident reporting. Both students had designated mentors.
- Three RNs had attended the two day Manchester triage training, which enabled them to train staff in ED. RNs who had worked in the department for over one year, were trained by a trainer in the use of the Manchester triage tool. 10 triage reviews were completed and observed, as well as staff completing a competency workbook before they gained competency to triage.
- Out of 41 RNs, 36 had completed the mental health study day, 15 the acute kidney injury training, 40 intermediate life support, 40 paediatric intermediate life support, 32 sepsis study day. All training records were in order within required completion dates. It was clearly recorded if staff had not attended training due to sick leave or maternity leave. If staff had cancelled training due to clinical need, they were rescheduled to a different date.

Assessing and responding to patient risk

- The department used the PEWS (Paediatric Early Warning Score), which is the standardised assessment tool for monitoring observations, recognising patients at risk and ensuring early intervention in children. The trust completed monthly audits that reviewed ten records and the last five sets of observations. The audit consisted of ensuring PEWS had been calculated, escalated and observations increased if required. November 2015 audit data showed 100% compliance.
- We reviewed four sets of paediatric notes, all children were assessed within 15 minutes or arrival to the department
- Between January 2013 and July 2015 the median time to treatment was on average 100 minutes, which is longer than the standard of 60 minutes and the England average of 55 minutes. This had been identified in the quality and performance report December 2015. A business case was submitted to the board in March 2016 outlining three options to ensure that staffing levels were based on current national recommendations and increased demand. It was anticipated that this would improve the median time to treatment.
- Over the winter period from November 2014 to March 2015 there were 840 ambulance handover delays of over 30 minutes.

Urgent and emergency services

- Between April 2015 and November 2015 there have been 18 black breaches (handover time from ambulance arrival to patient off loaded into ED longer than 60 minutes). October 2015 showed 12 black breaches. This amounts to 0.7% of number of conveyances for the month. The trust had not provided a reason for these breaches and they had been described as having "no impact". In October it was noted that the region experienced a high level of demand and a number of trusts in the area experienced black breaches. However, this was comparable with trusts of a similar size and significantly less that some trusts, of similar size, which had between 60 and 90, or around 3-4%of conveyances, black breaches in this month.

- The number of ambulance journeys with turnaround times of 30-60 minutes from June 2014 to May 2015 ranged from 695 to 958. Turnaround time over 60 minutes for the same period ranged between 15 to 116 in January 2015

- The trust performed "about the same" as other trusts in the 2014 CQC A&E survey questions relating to safety. Lowest scores were for the questions relating to the length of time waiting for an examination by a doctor (6.2 out of 10) and the length of time waiting before speaking to a nurse or doctor (6.6 out of 10)

- The trust had implemented the RAT (Rapid Assessment and Triage) for patients in ED in accordance with the Royal College of Emergency Medicine. The RAT is an assessment of patients within 15 minutes of arrival by ambulance. The service operated from 12 midday to 6pm during the weekdays. There was a designated area within ED which is staffed by one doctor, one registered nurse and one health care assistant.

- We reviewed 25 timelines in patient notes over a period of three days. All were consistent in meeting the ED target requirements for 15 minute initial assessment.

- The median time to treatment between January 2015 and January 2016 ranged between 114-124 minutes. This was consistently above the standard of 60 minutes.

- The trust had a policy for the assessment of patients that require enhanced observations for example one to one nursing care. However there was no formal documented evidence of this assessment, or how information was disseminated to admitting wards that may have to request additional staffing. Staff said that if nursing staff were not available, then volunteers would sit with patients who may be confused or distressed.

There was no assurance provided that this was within the scope of the volunteers remit or evidence that this had been risk assessed. It solely relied on opinion of nursing staff at the time.

- Review of 40 sets of notes demonstrated that accurate documentation recording was inconsistent. Eight sets were found not to have nursing observations recorded in line with the required frequency; three had drug charts missing; one had the incorrect patient's drug chart. One set of triage observations were not recorded. 11 sets of observations were not recorded following the initially triage observations. These included only one set of observations completed for an unwell child that had not been followed up. We escalated this immediately to the nurse in charge. We were advised that due to staff shortages, particularly overnight, observations were sometimes missed. We did not feel assured that appropriate observations of MEWS Modified early warning score) were being completed

- Whilst in resus we witnessed a patient brought in following a cardiac arrest. There were seven doctors and two nurses in attendance. There was good clinical leadership from the senior doctor, clear instructions given to the team and clear evidence of teamwork. There was early escalation to organise an intensive care bed.

- During the inspection one of the ED reception staff responded immediately and appropriately to an emergency situation. They summoned help and begin resuscitation on a patient that had collapsed at the reception desk.

- The department recognised that there was an inflexible footprint due to the age and design of the building, and once full capacity was reached there was no flexibility in the movement of patients. The ED redesign project would address this however the trust could not provide a definitive timeline of when refurbishment would commence.

- The Manchester triage tool (a system of identifying the severity of a person's condition based on a flow chart algorithm which are specific for the presenting condition) was used in the assessments of patients and was commenced in 2014.

- Data provided showed that 70% of patients admitted to the ED received antibiotic therapy within the first hour in

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December 2015 when diagnosed with sepsis. In 2013-2014 the average time over the year was 94%. This is against the Royal College of Emergency Medicine standard of 100%.

Nursing staffing

- There were numerous positions currently vacant within the ED. There was one part time Band 6 registered nurse (RN), two Band 5 RN, and one Band 6 and Band 5 registered sick children's nurses (RSCN) either out to advert, or in the process of being recruited to.

- There were two ENPs on each shift until 10pm. Over the summer months this was extended to midnight due to an overall increase in patients presenting. This meant that the department could respond and flex staffing according to patient need.

- In 2014 the clinical decision unit had opened, admitting patients whose length of stay was less than 24 hours. Between April 2014 and March 2015, attendances had increased by 5%, higher than England attendances of 3.88%, and ranged from 4790 to 5737 attendances per month.

- The CDU staffing levels were one RN and one health care assistant (HCA) per shift. Staff confirmed that CDU often only had one RN working in the unit, particularly overnight. Agency staff did not work in CDU. Where there were gaps agency staff were booked but these were assigned to the emergency department and replaced by regular emergency department staff. This added additional pressure to the ED due to potentially inexperienced agency staff diluting the skill mix. This was most prevalent during the night shifts.

- We reviewed the fill rates (fill rates of 100% mean all planned staff are on duty) of RNs and HCA between September 2015 and November 2015. The fill rate for RNs ranged between 89 and 95%, and for HCAs ranged between 88 and 105%, indicating that additional HCA staff may be used if an RN was not available. The unit had dedicated bank (temporary staffing) RNs to cover unfilled shifts. We were told that since October 2015 until March 2016 a block booking for an agency RN had been authorised Bank and agency staff went through local induction

- Data for agency and bank nurses showed a shortfall within the workforce. Between November 2015 and February 2016, 3021 RN hours had been undertaken by agency staff and 2365 hours undertaken by bank staff.

- The department had completed a staffing review over a six week period from November 2015 to January 2016, based on the guidelines from the Royal College of Nursing-Baseline Emergency Staffing Tool (BEST) 2013 and the Royal College of Paediatrics and Child Health 2012.The review has included a review of acuity, rise in number of attendances and the opening of the CDU in March 2014. At the time of inspection the business case was due to be presented to board for the recruitment of a further seven whole time equivalent (WTE) RNs.

- Between January 2015 and March 2016 there had been 40 Datix reports (incident reports) completed relating to inadequate staffing level within the department. We reviewed the risk register and saw that staffing had been identified as a moderate risk.

- There was a shortage of registered nurses (child branch) on the unit. The Royal College of Paediatrics recommend that there are sufficient paediatric nurses employed to provide one nurse per shift in EDs receiving children. The trust had mitigated this risk by having all nurses within the ED having extra training to ensure that they had the competence to care for the acutely unwell child in ED. If there were concerns they would contact the children's ward or the paediatrician. The issue of the shortage of paediatric nurses had been raised in the minutes of September 2015 safeguarding children committee. An action plan was in place to address this.

- The trust could not provide the number of outstanding paediatric shifts for the period of October 2015 to January 2016. This was because there was no set rota due to the limited number of paediatric nurses available.

- There had been an increase in paediatric RN recruitment. One band 6 paediatric RN was due to start in April 2016 with a further band 6 due back following maternity leave. There was one band 5 and one band 6 post advertised.

- A review had been completed in identifying the "peak times" for child attendances and we were told that once all recruitment was completed, two paediatric RNs would be on duty until midnight, as overnight attendances were minimal. This did not fulfil national guidance, however the trust had taken steps to mitigate this risk by training adult nurses to care for children. However there was only one nurse who had EPLS in the department.

- Sickness within the department from January 2016 to March 2016 ranged from 3.17% to 6.18%, against the

trusts target of less than 3.5%. The high level was predominantly due to long term sickness for staff that had undergone recent surgery. The short term sickness was minimal.

Medical staffing

- The department had a clinical lead consultant as well as a clinical director linked to the department.
- The ratio of consultants in the department was 26% compared to the England average of 23%; middle grade staffing 5% against average of 13%; registrar staffing 47% against average of 39%; and junior medical staffing 22% against average of 24%. Junior medical staffing was allocated through the local medical deanery and not within the trust's control.
- The department had three advanced clinical practitioners (registered health professionals who have undergone additional training and encompass an advanced skill set of tasks that were traditionally considered of a doctor).They were on the medical staff rota and covered middle grade shifts.
- There were four paediatric consultants who covered hours between 8am and 10pm seven days per week
- The doctors' rota consisted of six consultants, seven middle grades and 11 juniors. Consultants rotated through shifts during the week. The day shift from 8am to 6pm and 1pm to 10pm working in department, 10pm to 8am on call and weekend cover from 12midday to 10pm.This would not be adequate to provide consultant cover of 16 hours per day.
- We reviewed the training records of locum staff which showed they had received a comprehensive induction to the department. Locum medical staff received a 90-minute induction, led by the consultant.

Major incident awareness and training

- The trust had a generic emergency and business continuity plan to manage major internal incidents and a major incident policy. There were clear action cards relating to the designation of staff within ED, for example the role of the senior ED nurse as area controller for management of majors.
- The trust had an emergency on call and MAJAX rota.
- The trust's self-assessment for EPRR (emergency preparedness, resilience and response) for 2015-2016, showed the trust was fully compliant. This assessment included flu pandemic planning.

- The trust had a clear decontamination policy to manage releases of chemical, biological, radiological, nuclear or explosive (CBRNe) or industrial (HazMat) material. Staff were able to show us the decontamination room and were aware of the process of decontamination in the event of a hazardous substance incident. Clerical and administration staff were taught in the application of protective suits and decontamination.
- The decontamination room was visible clean with MAJAX kit available and designated taped areas for hot and cold zones to prevent absorption of hazardous material.

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

Good ●

Urgent and emergency services were rated as good for effective because:

- There was a clear protocol for staff to follow with regards to the management of stroke and sepsis.
- There were good examples of multi-disciplinary team working for example in the early intervention team and psychiatric liaison team.
- There was good evidence and robust management of staff training, with the role of a dedicated practice development nurse.

However:

- It was unclear how results from local audits were shared amongst staff.
- Medical staff were unsure in the assessment of mental capacity and application of deprivation of liberty safeguards.

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Evidence-based care and treatment

- Learning from national audits was clearly demonstrated. For example the introduction of a mental health assessment proforma and psychiatric liaison service following the National Mental Health Audit 2015, completed by the RCEM (Royal College of Emergency

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Medicine).The trust was also working towards incorporating a mini mental test into the e-care system in response to the Assessment of Cognitive Impairment in Older People 2015.

- The range of local audits undertaken included monitoring of venous blood gas, shoulder dislocation, first seizure and referral management and adherence to admission criteria for the clinical decisions unit (CDU). There was no clear evidence on how results or learning from local audits were shared with staff, despite learning from national audits being shared and owned by staff

- There were named individuals in relation to audits; a designated audit lead; good engagement from staff; and completion dates were on time.

- The department had introduced the "sepsis six" interventions to treat patients. Sepsis six is the name given to a bundle of therapies designed to reduce the mortality of patients with sepsis. The department monitored compliance with the sepsis six pathway and in 2013 -2014 compliance with giving antibiotics within the first hour was 94%. However in November 2015 this had fallen to 70%. There was an action plan in place to encourage greater compliance with the sepsis six pathway. The department was due to complete a sepsis six audit in April 2016.

- We examined the records of a patient with a suspected sepsis. The pathway was completed at every step and the records of the sepsis care for example observations, fluid management and antibiotic therapy were excellent, in regards to the documentation being signed, concise and clearly written.

- The trust had a hyper acute stroke service and a clear pathway for when an patient suffering from an acute stroke would arrive in ED and specialist nurses were available. The acute stroke nurse provided cover from 8am to 9pm seven days a week. After 9pm the registrar would take the stroke bleep to ensure consistent cover.

- During the inspection we witnessed an admission to the department following a pre-alert for a potential stroke. The protocol ran smoothly and followed the correct guidelines and the patient was transferred to the ward via the computed tomography (CT) scan.

- The fracture neck of pathway between ED and the orthopaedic department was good. We examined the records of a patient with a fractured neck of femur

pathway. The pathway had been followed and documentation completed. Nurses can request hip x rays to expedite treatment and reduce delays for patients.

Nutrition and hydration

- CDU had a dedicated kitchen area with fridge and hot drink making facilities. Sandwiches and hot meals were provided to patients.

- There was a dedicated patient fridge in ED. Sandwiches, muffins and bananas were available daily. Water was available at all times.

- The trust scored about the same as other trusts in the question in the national 2014 CQC A&E survey relating to access to suitable food or drinks when they were in the A&E department (6.6 out of 10).

Patient outcomes

- The RCEM (Royal College of Emergency Medicine) audit for management of the fitting child 2014/2015 showed that the trust was in line with the England averages for three areas and better than the England averages for two questions relating to parents/carers provided with written on information on discharge and eye witness history recorded in records.

- The RCEM mental health ED audit for 2014/2015 showed that the trust was in line with the England average for four areas of management of mental health in ED. One area was below the England average in the assessment of patients for alcohol or illicit substance dependency. In the area of liaison with specialist mental health teams, the trust was lower than the England average on the documentation of follow up arrangements. The trust had liaison arrangements with psychiatric services. The ED had a dedicated mental health room for patients. Only 75% of trusts have dedicated rooms.

- The RCEM audit for assessment of cognitive impairment in older people 2014/2015 showed that the trust was above the England average in two areas, documentation of early warning score and communication of finding to carers.

- The RCEM audit for severe sepsis and shock 2013/2014 showed that the trust was above the England average for high flow oxygen initiation and obtaining of blood cultures, but below the England average for vital signs being monitored and recorded and capillary blood glucose measured on arrival.

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- TARN (Trauma Audit and Research Network) data indicated that for 2014/15 there were an additional 0.1 deaths out of every 100 patients. This data was based upon published rate of survival on the 26 November 2015. This was a slight drop from the 2013/14 data. This remained consistently within the middle of the national range of performance.
- TARN data entry completeness for 2014 was 82.4% which was the fourth highest completion rate in the network.
- The trust's unplanned re-attendance rate within seven days was consistently on the 5% standard between July 2014 and October 2015 ranging from 5 to 5.9%. However this was better than the England average which was between 7 and 7.9% for the same period.
- The consultant sign off audit 2013 showed that the trust performed better than the England average on the consultant, associate specialist or the ST4 doctor having seen the patient and discussed the patient and on the England average for the ST4 seeing the patient.

Competent staff

- The ED had a dedicated practice development nurse for 30 hours per week to manage and oversee the training and induction of nursing staff.
- 21 members of qualified nursing staff had completed the ALS (advanced life support) training, which has to be renewed every two years. All staff records checked were in date.
- All health care assistants spent one day on the children's ward to learn the PEWS observation tool.
- There was dedicated weekly medical paediatric training for junior doctors from 2pm to 4pm and middle grades from 4pm to 6pm delivered by the paediatric consultants.
- Senior staff within the department had been enrolled on leadership development programmes such as the NHS Academy Bevan Programme and the Elizabeth Garret Anderson Programme.
- The trust had a dedicated page on the intranet for nurse revalidation, which included example templates of reflective practice. RNs that were due for revalidation were flagged on the trusts electronic staff roster (ERS) system which was monitored by the ED nurse manager.

- The three advanced clinical practitioners were enrolled on the postgraduate certificate for advanced practice through Manchester University with completion date for 2018. The advanced clinical practitioners also received the same in house training provided to medical staff.
- The psychiatric liaison nurse delivered 30 minutes training on the mental capacity act to ED nursing staff every quarter.

Multidisciplinary working

- The early intervention team project consisted of physiotherapy, occupational therapist, dementia specialist nurse, rehabilitation nurse and works alongside 2 external agencies. The team shared one office to ensure an integrated and multidisciplinary approach to admission avoidance
- We were told by staff that there was good multidisciplinary working within the trust, for example linking in with the specialist nurses such as learning disability and safeguarding leads. Staff also stated that they could access support from ward areas for advice for example contacting the paediatric ward.
- The mental health team provided training to ambulance staff in managing patients with mental health problems. This enabled a good working relationship between the mental health team and ambulance crews
- The service had a good working relationship with the ambulance trust that convey patients to the hospital. The HALO (hospital ambulance liaison officer) was positive about the relationship with the ED staff.

Seven-day services

- The ED department for adults and children is open seven days a week and 24 hours per day.
- The early intervention team ran a seven day service, working 8.30am to 9pm Monday to Friday and 10am to 5pm on weekends and bank holidays.
- The psychiatric liaison team were available from 8am to 9pm weekdays and 8am to midday on weekends.
- Diagnostic imaging staff provided a 24 hour service to support the ED department. An x-ray room was located within the ED department which was equipped to carry out plain x-rays.
- Between the hours of 10pm and 8am the trust used a private radiology reporting service. Timescale for review of CT (computed tomography) scans should be 30

minutes. Staff stated that there had been delays in receiving reports back. This was escalated and regular meetings arranged between the clinical lead for ED and radiology which staff felt had improved the situation.

Access to information

- Staff could access patient systems including the administration, radiology and pharmacy systems though a range of computer points in the department.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The majority of consent was implied consent within the department. However 95% of nursing staff had training in obtaining consent.
- Staff were uncertain which age ranges that the Gillick competency (a principle to judge capacity in children to consent to medical treatment), applied to and gave a variety of answers, ranging from 14 to 17 years. Staff were not able to differentiate between Gillick competency and Fraser guidelines. The consent policy states that young people aged between 16 and 17 are presumed to have the capacity to give consent for themselves. However staff did not consider younger children who may be able to consent and understand the implications of consent. Parents would be asked for consent in this instance. This is not in line with national guidance.
- Training was provided to staff on Mental Capacity and Deprivation of Liberty in mandatory training
- Nursing staff appeared unsure of the process of Mental Capacity Assessment (MCA).This was supported by feedback from other health professionals that documentation of MCA was patchy within the department.
- Two medical staff knew how to access the deprivation of liberty safeguarding (DoLS) forms on the trust's intranet. However one said that they were not confident in assessing someone for mental capacity and did not understand the application of DoLS.

Are urgent and emergency services caring?

Good 🟢

Caring within the urgent and emergency services was rated as good because:

- Patients and families in the ED department were positive about the care and service they had received.
- Between January 2015 and January 2016 the percentage of patients who would recommend the ED department ranged between 92% and 93%, significantly higher than the England average.
- Healthwatch responses for 2015-2016 were overwhelmingly positive.

Compassionate care

- During the period of January 2015 to January 2016 the Friends and Family question "would you recommend the department to your friends or family", ranged from 92% to 93%. This was higher than the England average for the same period which ranged from 88% to 92%.
- Between August 2014 and October 2015 the percentage of patients who would recommend the ED department ranged between 91 and 95%. This was higher than the England average for the same period which ranged from 85 to 87%.
- The trust performed about the same as other trusts for all questions relating to compassionate care in the 2014 CQC ED survey. Scores ranged from 3.3 to 9.0, in relation to the question regarding the opportunity for a family or carer wishing to speak to a doctor, above the average trust's score.
- Seven patients and their families discussed their care with inspectors whilst in the ED department. All were overwhelmingly positive about their experience, with comments such as "we are lucky to have this wonderful hospital in our area", "all staff are wonderful and caring" and "we have been given all the information we need ".
- The Healthwatch (the national consumer champion in health care, with statutory powers to ensure the voice of the consumer is heard) responses for 2015 to 2016 were overwhelmingly positive. Feedback related to a number of conditions, including paediatric patients, burn patients and those who had suffered a cerebral vascular

accident (CVA/Stroke). Patients stated that staff were friendly and caring, experienced prompt assessment and had clear plans of care. Negative comments were predominantly around the shortages of staff.

- The trust had a courtyard café feedback service, in which patients, families and carers can leave feedback. Results from November 2015, January 2016 and February 2016 showed six positive responses, praising the staff in both attitude and providing reassurance and only one negative comment relating to ED waiting time.
- A nurse was observed providing comfort and reassurance to a family of a child whilst being taken through to the resuscitation area.
- We spoke with three visiting members of the ambulance service about their experiences of the service and whether they would be happy to be treated at the service, or have any of their family treated at the service. They unanimously responded that they would choose the service and they would have no concerns with their family being treated there as the care was outstanding in their view.

Understanding and involvement of patients and those close to them

- Parents of children within the ED department were positive regarding the information that had been provided. Four sets of parents all confirmed that they had been updated by staff on what was happening and that they had no questions regarding their care.
- Inspectors spoke to three relatives of patients who used the service. All were positive about how they were included in the planning of their relatives' care.

Emotional support

- The trust had a range of clinical nurse specialists within the department that provided support to staff, patients and relatives. These included dementia specialist nurse, acute stroke nurse, learning disability nurse and psychiatric liaison nurse.
- Patients and staff had access to the chaplaincy service that provided support seven days per week.
- Staff had access to counselling services if they had been affected by the cases they had dealt with in the department. Contact details were on the staff intranet and in the staff handbook.

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

	Good ●

Urgent and emergency services were rated as good for responsive because:

- Staff could access translation services through 'language line'.
- Patients were able to access leaflet information for a variety of conditions.
- There was a dedicated fast track process for gynaecology patients, which meant that examinations were completed in a dedicated assessment area and not in the ED department.
- There was a collaborative early intervention team (EIT) which supported early discharge of patients and admission avoidance.
- There was a virtual fracture clinic meaning patients could benefit from shorter waiting times and fewer visits to the hospital, which was the only clinic to which ED can refer patients directly.
- There was a dedicated mental health team in ED to respond to, assess, and plan care for patients aged 13 years and over who attend with mental health problems.

However:

- The department did not have a robust process for, or evidence of, learning from complaints and implementing and embedding changes to improve patient care
- The clinical decisions unit (CDU) policy and practice for admitting patients to the chaired area within CDU was conflicting therefore there was a potential for the trust not to comply with the Department of Health 2010-2011 guidance on eliminating mixed sex accommodation
- Median time to treatment was consistently above the 60 minute target from January 2015 to January 2016.

Service planning and delivery to meet the needs of local people

- The trust operated a virtual fracture clinic in addition to face-to-face clinics. This meant that ED medical staff

could refer directly to the fracture clinic, which is the only clinic to which ED could directly refer. The trust ran three clinics per week. Staff would contact patients the day after attendance at ED once x-ray reports and notes had been reviewed and discuss treatment requirements. This enabled clinicians to manage the patient remotely depending on clinical need. This meant either verbally treating and managing symptoms while the patient remained at home or arranging attendance at the most appropriate clinic.

- Other hospitals had visited the trust to see how the virtual clinic worked, as it has reduced waiting times and received positive patient feedback. Over an 18 month period the service reviewed 6500 patients and reduced new patients and follow up attendances by 25%.

Meeting people's individual needs

- The trust had a dedicated learning disability and an adult and child safeguarding nurse available Monday to Friday. Staff knew how to contact them and found them to be supportive.
- There was a dedicated trust dementia nurse as well as a dementia link health care assistant available Monday to Friday. Patients who had a confirmed diagnosis of living with dementia wore a blue wristband, to help staff identify that they may require additional help or assistance.
- The trust had a dedicated fast track gynaecological protocol for clinical management of women attending the department. The ED department could access the gynaecology on call doctor 24 hours a day. Women attending ED were not examined in the ED department, but admitted to the gynaecology ward where there are two dedicated assessment cubicles. Staff stated that there was a good relationship with the gynaecology team.
- There was a dedicated bariatric wheelchair and trolley available within the department.
- There were a number of patient information leaflets available for a variety of conditions, for example diabetes management, flu and helplines for domestic violence or safeguarding concerns.
- There were signs on the ceiling in the bays to enable patients to orientate themselves whilst lying on a trolley.
- Staff had access to a translation service through the telephone known as 'language line' which was available 24 hours per day seven days a week.

- Mental health liaison services were provided by the trusts psychiatric team and available from Monday through to Sunday. The mental health team provide services to people over the age of 13 years who attend the ED department and require mental health assessment, and provides fast and effective psychiatric advice and assessment.
- The department had a dedicated bereavement room, which joined to a relatives' room. The room was in a quite area; visibly clean with comfortable décor and tea and coffee was available. There was a dedicated bereavement box for children, which included footprint moulds to enable keepsake memories for families
- The department had an electronic waiting times board to keep patients, relatives and carers updated on the length of time it would take before they were seen.

Access and flow

- The Emergency Care Pathway Programme aimed to improve the flow of patients within ED, and had a dedicated work stream for the ED department. This had resulted in the implementation of the early intervention team (EIT), which specifically focused on admission avoidance. The team was multidisciplinary, and worked with two external agencies. The team ensured that the right help was in place once patients have received treatment and clinically fit; for example completing home visits and assessing if equipment is required and starting care packages to enable patients to return home.
- The CDU operated a 24 hour, seven days a week facility for adult patients requiring less than 24 hour admission for ongoing observation or treatment. The unit consisted of six beds (three male and three female with separate en-suite facilities), four recliner chairs and a psychiatric assessment room. The unit had a clear operational policy including admission and exclusion criteria.
- The average length of stay for patients in the CDU between September 2015 and January 2016 was 11.3 hours with the individual months' average hours being 11.1, 12.4, 10.3, 11.8 11.1 respectively.
- In 2014 CDU admitted 3442 patients, averaging 9.4 daily; this had increased in 2015 to 4777 admissions (averaging 13 daily).
- The recliner chairs, within the CDU, were used for both male and female patients where appropriate. This meant that patients were in a mixed sex environment.

Urgent and emergency services

The trust classified these patients as "ward attenders" similar to an outpatient environment however the CDU policy stated that the unit is for "admitting adult patients who require short term admission". The Department of Health guidance on eliminating mixed sex accommodation 2010/2011includes all admissions and assessment units (including clinical decision units), plus day surgery and endoscopy units. Therefore there was a discrepancy between what was happening in practice and what the trusts policy stated which could potentially lead to a mix sexed breach.

- There were no clear criteria in place to identify which patient groups are suitable for the recliner chairs. It had been identified on the CDU governance minutes from November 2015 that some patients may find the recliner chairs difficult to get in and out of.
- The unplanned readmission rate within seven days from January 2015 and January 2016 ranged from 4% and 5.9% against a standard of 5%. This figure was lower than the England average.
- The percentage of patients seen within four hours from January 2015 to January 2016 ranged between 86% and 96%. This was above the England average for the equivalent period which ranged between 88% and 95%
- The number of patients leaving the ED department before being seen between January 2015 to January 2016 ranged between 0.8% and 1.3%This was significantly below the England average of the same period which was 2.5%-3%
- The percentage of emergency admissions via ED waiting four to 12 hours from decision to admit until admission between January 2015 to January 2016 ranged between 0.2% and 3.3%.This was significantly lower than the England average for the same period which ranged from 1.8% to 14.5%.
- Staff did not report patients staying longer than the 24-hour in CDU as incidents and did not record this data. This meant that the department could not monitor or investigate episodes of patients' care if they were in the CDU for longer than 24 hours.

Learning from complaints and concerns

- The ED received 32 complaints between April 2015 and January 2016, an average of 3 per month.
- There was evidence in the governance meeting minutes from July and November 2015 that complaints were discussed. However we were not provided with evidence on learning or any changes in practice directly

relating from complaints at the time of inspection. For example, one complaint was regarding a patient who had been sent from the out-of-hours doctor and left to sit in waiting room following a miscarriage, on a particularly busy day. It was not clear what learning had taken place from this if changes in practice had been made and how this had been communicated to staff.
- Compliments get sent to staff by the unit manager and displayed in the staff room, for example thank you cards.

Are urgent and emergency services well-led?

Good 🟢

Urgent and emergency services were rated as Good for well led because:

- The clinical lead and service manager had clear visions for the service and department, and there was evidence of staff engagement in decisions and information sharing.
- Staff had had the opportunity to contribute to the development of the e-care system.
- The culture of the consultant body received praise with staff complementing on how supported and well led they felt.
- Risks were appropriately assessed and mitigated
- The management team has completed a review of staffing levels and a business case had been submitted
- The management team had identified that the footprint of the department was not conducive to patient experience and flow through the department and plans were in place to address this

However:

- It was not clear from governance minutes how issues highlighted were addressed.

Vision and strategy for this service

- The leadership team for the emergency department had a clear vision for the service and had defined plans for the future development and progression of the adult and children's service, for example the creation of a paediatric assessment point, waiting and treatment area.

- Staff were aware of the vision of the trust and the seven ambitions of the service of the organisation.

Governance, risk management and quality measurement

- Governance meetings were held monthly with key staff and details disseminated to staff. However there was no documented follow up on the issues raised within the governance meetings

- Three sets of ED governance minutes were reviewed (July, November and October 2015). It was not clear from the minutes that items discussed previously had been followed up, actioned or reported back. For example it was noted in the July 2015 minutes under mortality and morbidity that feedback was waiting to be obtained regarding a case. There was no evidence of this in the following minutes for October or November. In October minutes it had been documented that spot checks would be undertaken in response to drug errors, poor documentation and observations. No results or feedback had been provided in the following month's meeting.

- Complaints were discussed at the governance meetings. However it was not clear how learning was recorded and there was no evidence of changes in practice in response.

- The department maintained a local risk register. All risks were rated using a red, amber, green (RAG) rating and had review dates in place. The unit manger reviewed the risk register on a quarterly basis with a band 5 and band 6 nurse. Risks were appropriately mitigated. All the risks identified by the inspection team were already on the risk register

- The management team had completed a full staffing review of the ED department, in line with the increasing activity and the opening of the clinical decisions unit which was staffed from the ED nursing workforce. This had been submitted as a business case for approval

Leadership of service

- There was a clear management structure consisting of a service manager, clinical lead consultant, unit manager and matron.

- Minutes from the staff meeting in August 2015 indicated that an exceptional meeting had been called to discuss concerns staff had regarding the senior management

team. There was evidence of responses to concerns raised, for example staffing levels on night duty. In response to this an agreement was made for a "block" booking of agency staff to ensure adequate cover.

- Feedback from medical staff described how friendly and supportive the ED department was and that there was good leadership and supervision from consultants, including good visibility in the department.

- Staff told us that there was visible presence from board level who were "hands on" when visiting the ED department, for example assisting with the transfer of patients to wards.

- We observed junior doctors asking for instructions on what the consultant wanted them to do. Clear instructions were given and we observed medical staff working in a collaborative manner and with clear leadership from the lead consultant, for example in preparation and the management of a critically unwell patient coming into the resuscitation bay.

Culture within the service

- The nursing and medical staff in the department worked well together. There was noticeable camaraderie.

- There was evidence that the management team listened to staff and responded to concerns raised. Example of this were noted in the staff meeting minutes from August 2015, in which concerns regarding staffing levels had been addressed and the introduction of a staff feedback box in the staff room.

- Medical staff gave praise to the clinical lead and all medical staff commented on how well supported they felt.

- Nursing staff were encouraged to develop and extend their skills. Examples of this included staff being able to attend training courses, becoming link nurses in a specific area and being involved in the management tasks such as the Band 5 and Band 6 RN involved in reviewing incidents.

Public engagement

- Minutes were reviewed from the patient and experience group from August 2015.The matron from ED attended the meeting and was able to provide updates regarding local quality improvement projects.

- The trust undertook its own patient feedback survey which asked question such as did you have enough

privacy at reception and to ensure that information was given to patients when leaving the department, if they were concerned. The department scored 93% and 80% satisfaction respectively

- The department sought feedback from patients through feedback forms, comment cards and the Friends and Family Test

Staff engagement

- Staff were asked to take part in the annual staff survey to provide feedback.
- All the staff said the management team were approachable and engaged with the staff in running the service.
- The department held regular staff meetings and also peer meetings such as the band 6 sisters meeting.

- Staff were able to access management for debriefing sessions, and were aware of the referral pathway for counselling services
- ED staff had been involved in the design of the new e care system and felt confident in using the system.

Innovation, improvement and sustainability

- The team were engaged and involved in the design plans for the renovation and expansion for the ED department to improve it for patients.
- Clinical leaders were recruiting clinical staff through the use of the DRE-EM (defined route of entry to emergency care) programme introduced by the College of Medicine in 2014.This allows medical staff to rotate through the hospital increasing medical staff cover.

Medical care (including older people's care)

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

Information about the service

The medical care services at West Suffolk Hospital covered a wide range of specialities including acute medicine, infectious diseases, respiratory, oncology, cardiac care, stroke, gastrointestinal and older peoples medicine, amongst others.

The trust admitted 25,186 patients between September 2014 and August 2015. 52% were emergency admissions, 1% elective and 47% day case.

Medical care services had a complement of 276 inpatient beds and 12 medical wards. During our announced inspection, we visited all of the medical care areas and wards managed throughout the medical care service including the cardiac care unit (CCU), medical treatment unit (MTU), endoscopy, acute medical unit (AMU) and ambulatory care unit (ACU). We also visited the chapel and multi-faith room, volunteers shop and various storage areas.

The medical departments at West Suffolk Hospital were grouped together under service areas, with each service area supported by a service manager and a senior matron.

We used a variety of information sources to gather evidence in order to assess and rate the medical care services. We spoke with 23 patients and those important to them, two junior doctors, two middle grade doctors and four consultants, 34 registered nurses, nine health care assistants, one student nurse, eight allied healthcare professionals and a number of other support staff, such as discharge coordinators and housekeeping staff.

We interviewed the interim general manager of the medical care service, clinical director, and head of nursing for the medical care services. We observed the care and environment and reviewed 34 sets of records, including written patient care records and the electronic record system. We also looked at a wide range of documents, including policies, minutes of meetings, action plans, risk assessments, and audit results.

Medical care (including older people's care)

Summary of findings

Overall we rated medical services at West Suffolk Hospital as outstanding because patients were protected from avoidable harm and abuse within the medical care service and the concept of 'safe' was embedded in medical care service practice.

Quality improvement strategies were developed and outcomes were monitored and acted upon to ensure patients received harm free care. Standards of hand washing and cleanliness were consistently good and regularly audited. Incident reporting was embedded amongst nursing and allied health care professionals and learning from incidents was promoted. Staffing levels reflected the needs of the patients and the trust was proactive in its recruitment of staff.

Use of NICE guidance was widespread and national and local guidelines were easily accessible on the trust intranet. Trust performance against national audits was outstanding especially in the Sentinel Stroke National Audit Programme (SSNAP) and Myocardial Ischaemia National Audit (MINAP). The trust was able to provide evidence of changes made in response to the feedback received. It was clear that staff and senior leaders saw clinical audit as an effective improvement tool.

Patients received compassionate care and were treated with dignity and respect and their privacy was preserved. Patients and relatives we spoke with said they felt involved in their care and were given adequate information about their care and treatment. Feedback from patients and their relatives was that they felt emotionally supported by hospital staff. Patients felt safe and very happy with how they were looked after and complimented the staff looking after them. The trust had a higher response rate to the friends and family test than the England average. This 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 Friends and Family Test highlights both good and poor patient experience.

Responsiveness of the medical service was good and responsive to patient's needs. Staff worked hard to reduce avoidable admissions and improve early discharges. Whilst out-of-hours transfers still occurred, these were kept to a minimum and reported to senior team members. Complaints were used as a means to improve services and the trust was able to provide evidence of changes made as a direct result of complaints made.

The acute medical unit did not have ring-fenced beds and was regularly used for inpatient beds during periods of escalation. This meant ambulatory care was either restricted or suspended on a regular occasion with patients having to attend the AMU separately or remain in the emergency department.

Leadership within the medical care service was good. Clear accountable governance structures existed and risks were identified and owned by individuals who were appropriately held to account. The culture within the medical care service was one of openness and honesty. The trust wide objectives were well known by all levels of staff and volunteers.

Medical care (including older people's care)

Are medical care services safe?

Good 🟢

Safety in medical care services was rated as good because:

- Incident reporting and learning from incidents was embedded within the staff team, staff felt safe to report incidents.
- Patients were protected from avoidable harm and abuse, quality systems for measuring and responding to risk were well developed.
- Standards of hand washing and cleanliness were consistently good and regularly audited; environments were visibly clean and free from hazards likely to cause harm.
- Safety thermometer data was visible and showed how the trust used data to form action plans for quality improvement.
- Nurse staffing levels met the requirements of patients and recruitment was proactive, patients stated that staff were always available and they felt safe in the care of staff.

However:

- Some of the flooring in ward and corridor areas caused concern for staff due to the deteriorating condition.

Incidents

- The trust reported 25 serious incidents between August 2014 and July 2015 in the medical care service, including older people's care. These included 11 slips, trips and falls, five cases of suboptimal care of the deteriorating patient, four health care associated infections, three pressure ulcers and one medication incident, with a final incident not categorised.

- There had been one Never Event in the medicine medical care service in April 2015. Never Events are serious, largely preventable incidents involving patient safety that can be avoided through adequate safety systems. Records showed that the trust had fully investigated the event and implemented changes to minimise events of this nature occurring in the future. Staff were fully briefed following the event and there had been changes in practice shared across the teams and departments to promote patient welfare.

- Staff reported incidents using an electronic reporting system and staff we spoke with were aware of the reporting system and knew how to raise issues and escalate concerns. Staff were briefed on incidents including details such as what had happened, why it had happened, and learning from incidents were fed back to the wider staff team via emails and team briefings.

- Staff conducted root cause analyses to investigate certain incidents. They also implemented action plans to reduce the risk of the incident happening again. Action plans included evidence of feedback and actions following learning and where necessary identification of where further training for staff was required.

- Mortality and morbidity meetings were held monthly as part of the trust quality and governance processes within clinical governance meetings. Staff stated that they were advised of learning from such analysis through team briefings, team meetings, board rounds, and emails to all staff. Minutes of meetings were detailed and included learning points for each case presented.

- Senior staff were aware of their responsibilities in relation to Duty of Candour and were able to offer examples of when this might apply and how to apply it.

Safety thermometer

- The NHS safety thermometer is a national initiative and local improvement tool for measuring, monitoring, and analysing harm free care. Staff reported the number of falls, urinary tract infections (UTI) and venous thrombolisms (VTE) on a monthly basis. Results were displayed on notice boards and within staff areas.
- The trust reported 15 new pressure ulcers from September 2014 to September 2015.The prevalence of pressure ulcers was increasing towards the end of this period.

- The rate of falls with harm was highest between December 2014, and January 2015, rising again in prevalence in September 2015 with 15 falls in total during this period. The trust monitored the number of falls and carried out investigations into each event. The actions taken to reduce falls included audits of patient records to ensure falls risk assessment were completed.

Cleanliness, infection control and hygiene

Medical care (including older people's care)

- There had been no reported methicillin resistant staphylococcus aureus (MRSA) bacteraemia within the medical core service for over a year. There were six reported cases of methicillin resistant staphylococcus aureus (MSSA) bacteraemia between October 2014 and November 2015. The trust target for screening compliance for MRSA was 90% and achievement against this target was consistently above 95%.

- During our inspection ward G8 was closed due to an outbreak of norovirus. Seven patients and five staff had been infected. The trust had effective staff cover in place to meet the needs of the patients. There were three automated hand washing machines at the entrance to the ward and one in the ward area and staff used these appropriately. Staff were confident the virus was now under control and they had appropriate support from infection control staff. Staff routinely used aprons and gloves and there was sufficient personal protective equipment available on the ward.

- Staff adhered to the trust hand hygiene and 'bare below the elbow' policy, and wore personal protective equipment such as gloves and aprons during care. Staff washed their hands in line with the World Health Organisation's 'Five Moments of Hand Hygiene' guidance between personal care activities with patients.

- Hand hygiene audits took place on all wards with the majority of wards achieving 100% compliance. Ward F12 had only achieved 83% compliance in January 2016. Staff on the ward had identified the reason for the reduction in compliance and offered training and guidance to an individual staff member to improve future performance.

- Patient trolleys, equipment, and privacy curtains were visibly clean in all areas and staff routinely cleaned equipment between use and we saw 'I am clean' stickers were widely used and in date. However the portable screens on the medical treatment unit were made out of cloth and not washable which can increase the risks of spreading infections.

- Staff could explain the protocol for patients with possible infectious disease and demonstrated they had good understanding of infection prevention and control.

- Patients who could pose an infection risk to others were cared for in side rooms. There was a dedicated ward for the isolation, care and treatment of patients with an infectious disease.

- Housekeeping staff were visible throughout our inspection and continually engaged in cleaning activities. Staff frequently emptied waste bins during the course of the day. A member of the house keeping team explained the cleaning regime and cleaning schedules were displayed on walls within all wards. Records of cleaning activities were completed on a daily basis by domestic staff and were sent for approval by senior housekeeping staff on a weekly basis.

- Guidelines for infection prevention and control were accessible to staff via the hospital intranet and on notice boards. Domestic staff stated that they could access these easily from a hospital computer.

- There were four endoscopy rooms situated in the endoscopy unit. These rooms were spacious and well-equipped. There was a clear pathway for clean and contaminated flexible endoscopes. Used scopes were passed via a hatch from the endoscopy room to the decontamination area, which prevented cross contamination.

- Equipment was decontaminated in line with national guidance. Staff maintained an audit of the decontamination process. Custom designed trollies were in place to transport endoscopes between areas such as theatres, clinic and endoscopy. The trolleys ensured clean (processed) and used (contaminated) endoscopes were kept separate and a colour coded cover on each tray (red/green) identified which were clean and which were used.

- Processing machines in the endoscopy suite were serviced in the manufacturer's time frame. The machines were managed under an external service contract and staff understood the process to report issues. Documentation of water testing for legionella, machine testing, servicing and repair records was maintained. There was a standard operating procedure for corrective action if a water test failed.

Environment and equipment

- In order to maintain the security of patients, visitors were required to use the intercom system outside most

Medical care (including older people's care)

wards to identify themselves on arrival. Staff had swipe cards to enable access to ward areas. This meant patients were protected from avoidable harm and patients who may be confused could not exit the ward unchallenged.

- On entering the ward areas all visitors were required to report to a reception area where reception staff checked their identity. On wards F7 and F8 the reception staff were on duty until 2am and on some wards reception staff routinely monitored closed circuit television (CCTV) to ensure security.

- Inspection staff were challenged on a number of occasions within the medical wards by staff and volunteers and asked to show identification. This demonstrated that staff and volunteers took ownership of hospital safety and security.

- All areas inspected were bright and well organised, however in several places, for example the cardiac care unit and main corridors, hazard warning tape had been used to repair flooring that required attention. Staff stated that this had been in place for a long time and reported to the estates team. The tape could be confusing for people with visible impairments and in some places the tape was becoming loose and breaking free which caused a potential trip hazard when the broken floor beneath became exposed.

- Emergency resuscitation equipment was readily available on each ward. A member of staff checked the equipment daily and this was recorded. Equipment records showed daily checks on resuscitation equipment had been completed on all wards and the matron signed these records weekly to ensure staff completed daily checks.

- There were no major environmental hazards or risks identified within the medical care service and the areas were generally well maintained and had sufficient storage. Storage areas were well maintained and equipment was stored safely to prevent trips or falls by staff or patients.

- There were systems in place to maintain and service equipment as required. Hoists were maintained and serviced and electrical items had been labelled with

service and renewal dates. All equipment reviewed during our inspection was up to date with the service schedule, which ensured that equipment was safe, maintained and ready for patient use.

- The environment on the elderly care wards was bright with good natural lighting. However, on some wards, for example F7, the number of beds per bay was high and the trust recognised that environmental space standards did not comply with Department of Health Building Notes 04-09 and 00-01. However, staff made the best use of the space available and were routinely using curtains and screens to promote privacy and dignity for the patients at all times.

Medicines

- We reviewed the prescription and medicine records for 18 patients. The records were clear and accurate however one patient's intravenous (IV) medication had not been signed for or dated. A member of staff was informed about this and they dealt with it immediately.

- Medicines requiring cool storage were stored appropriately and according to manufacturer guidance and staff maintained a daily record of storage temperatures in treatment rooms and medicine refrigerators.

- On the cardiac care unit, although medicines were stored securely, the medication room felt very warm. There was no thermometer available and no room temperature records available to ensure medicines were stored within safe temperature ranges. For example, insulin was stored in the room. It is important that insulin is stored within the advised safe temperature ranges for it to be effective.

- Medicines were stored securely in locked medicine rooms. We reviewed three medicine rooms, both had controlled access, stock control documentation was accurate and all medicines and fluids were in date.

- Controlled drugs (medicines that are required to be stored and recorded separately) were stored and recorded appropriately at the time of our inspection.

- Pharmacists visited wards daily and staff told us stocktake took place weekly. The trust had pharmacy support until 2pm on Saturdays and the pharmacy service was then available via an on-call bleep call system until Monday morning.

Medical care (including older people's care)

- Nurses routinely locked medication cabinets between giving medication to patients. Medicine trolleys were not left unlocked or unattended whilst staff were administering medication. This meant the risk of patients or unauthorised people accessing medication was well managed.

- Nurses asked patients to confirm their personal details prior to administering medication and checked against records to ensure the right patient was getting the correct medication and dose.

- Patients confirmed that staff explained medications to them. One patient on ward G1 said, "my meds are complicated but they explain them well and keep me in the picture." Another patient on ward G5 said, "My meds are very well managed; they explained why they stopped one of them while I was here."

- Medicines for discharge were dispensed and immediately available on the ward. Nurses on the ward reported that having pharmacy on the ward was beneficial and reduced the time taken for patients' medicines to be available for discharge.

- Medication incidents were reported by staff with lessons learnt and positive action taken to prevent them happening again. Safety bulletins as well as patient safety alerts containing details of recent safety incidents and actions taken were clearly displayed on a board in the medicine storage room.

Records

- The trust was in the process of implementing a new electronic patient record system. This system was due to go live in May 2016. Staff had received training on the new system and felt prepared for its implementation. Staff were already using a number of separate electronic record systems and were competent in these processes. Staff felt combining patient information into a single system was a positive move for patients and staff. They said this would promote team working and person centred care through the sharing of information from a single point of recording and access.

- We reviewed 34 patient notes as part of our inspection. Records were kept in two places; at the end of each bed

and in a secured notes trolley, which were closed at all times unless being used by staff. Written records were in good condition and well maintained, signed, legible and dated.

Safeguarding

- The trust's adult protection procedure was up-to-date and reflected current best practice guidance in the safeguarding of adults.

- The trust had a safeguarding lead in place and staff within the medical wards knew who the safeguarding lead was and how to contact them.

- Staff were aware of their safeguarding responsibilities and were clear how to make safeguarding referrals. Information in clinical and ward areas informed staff how to make referrals and who to contact.

- The majority of wards had achieved above 80% completion of safeguarding adults training, against the trust target of 100%. The MTU achieved 91%, stroke services 93%, ward F10 95% and ward F9 97%. However, gastroenterology had only achieved a 77% completion rate and oncology 69%.

Mandatory training

- There was a mandatory training programme for all staff to complete on recruitment and annually thereafter. All staff within the medical care service had completed some mandatory training but not all were up-to date. Ward managers were aware that not all mandatory training was up-to-date and stated that this was a priority.

- The trust policy and procedure on mandatory training set an 80% completion rate for all staff. Mandatory training completion rates for the majority of staff was above the 80% target. The mandatory training also included management of the deteriorating child patients and paediatric basic life support.

- Out of 41 RNs, 36 had completed the mental health study day, 15 the acute kidney injury training, 40 intermediate life support, 40 paediatric intermediate life support, 32 sepsis study day. All training records were in order within required completion dates. It was clearly recorded if staff had not attended training due to sick leave or maternity leave. If staff had cancelled training due to clinical need, they were rescheduled to a different date

Medical care (including older people's care)

- Out of 41 RN's 36 had completed the paediatric intermediate life support (PILS) training, with the remaining five booked onto the next available course. This enabled RN's to respond and treat seriously unwell children, or children in cardiac arrest, until the arrest team arrived
- Two RN's had completed the children's critical care course, with a further two starting in September 2016
- One Band six RN had completed the Advanced Paediatric Life support course.

Assessing and responding to patient risk

- The trust had an up to date operational policy for the prevention and management of the deteriorating patient. Staff knew how to escalate their concerns regarding detreating patients.

- Modified early warning scores (MEWS) were in use across the medical wards, which meant staff could appropriately monitor and escalate deteriorating patients. All records reviewed showed scores were completed correctly and patients identified as requiring clinical review were appropriately escalated and reviewed.

- Nursing handovers occurred at every shift change. Staff used handovers to communicate any changes to patients, staff or the ward environment and to ensure actions were taken to minimise any potential risks to patients or staff.

- Staff routinely completed risk assessments for patients for venous thromboembolism (VTE), pressure ulcers, nutrition, and hydration, urinary tract infections (UTI) and falls. Risk assessments identified the required actions needed to minimise any potential risk to patients and staff completed patient safety management plans to further reduce risks of harm. Staff completed risk assessments accurately and in a timely fashion, and reviewed them frequently during a patients admission.

- On ward G3 staff were utilising the frailty pathway alongside the care of the elderly team guidance to risk assess and monitor patients who may be at risk of falls. This met National Institute for Clinical Excellence (NICE) guidance in relation to Falls in Older People: Assessing Risk and Prevention 2013.

- Patients had access to the anti-coagulatory team as part of their discharge process as well as to telephone guidance on the use of anti-coagulatory medication to reduce the risk of VTE. This reflected guidance published by the British Society of Haematology guidelines on oral anticoagulation with warfarin (2011).

Nursing staffing

- Planned and actual nurse staffing numbers were clearly displayed at the entrance to wards. All of the displays were accurate to actual daily staffing numbers.

- Trust data for November 2015 demonstrated in the main most wards were staffed close to the number of nurses required and were operating safely. However, some wards were understaffed; for example, the actual number of nurses on ward F10 was 102% of the establishment and ward G9 was staffed at 95%. Health care assistant rates were 149% and 121% respectively. Staffing skill mix across the trust was similar to the England average.

- All patients had their individual needs assessed as part of the initial patient assessment process; these were clearly documented by staff and accurately reflected patient needs. This generated a patient acuity and gave staff an accurate number of nurse or health care assistant hours required to maintain the patient's safety and welfare.

- Trust data showed the February 2016 nurse vacancy rate within the medical care service was 3% and that staff turnover rate was 8.6%. This was better than the UK average staff turnover rate of 15%. Employee turnover refers to the proportion of employees who leave an organisation over a set period of time expressed as a percentage of total workforce numbers.

- The use of agency nurses was low; trust data showed that between April 2014 and March 2015 monthly agency usage had ranged between 4.2% and 9.1% within the medical care service. Agency staff had an induction and were supervised at all times by the trust's own staff. The usage of agency staff was low because the trust utilised nurses from its own nursing bank prior to booking agency staff. These staff were generally staff who worked on the medical wards on a permanent basis.

Medical care (including older people's care)

- During inspection the acute medical Unit (AMU) area was being utilised as an escalation area and was staffed at night predominantly by agency staff supported by one qualified substantive nurse. Staff were aware that the situation was not ideal, but staffing the area routinely for a night shift was not financially budgeted for due to the changing number of patients being admitted.

- Sickness absence rates across the trust were variable. During 2014 and 2015, the sickness absence rate in the medical care service was 8.3%. This was the highest sickness absence rate in the trust and was higher than the average NHS staff sickness absence rate, which was 3.98% during July 2015.

Medical staffing

- The trust had a higher proportion of consultants than the England average comprising 43% of the medical workforce compared to the England average 34%. There were slightly fewer middle grade doctors and 14% fewer registrars than the England average, with a 5% higher number of junior doctors than the England average.

- In the majority of clinical areas, consultants reviewed patients on a daily basis from Monday to Friday and all new admissions are seen by a consultant at weekends.

- At the time of our inspection there were no junior doctors on the wards due to industrial action. Medical cover on the ward was provided by consultants and senior doctors to ensure that risk to patient safety was minimised.

- Consultants were supported by medical students during handovers and when assessing the needs of patients. This was due to the lack of junior doctors available to support the staff teams. Staff said consultants were approachable and worked closely with the wider team to ensure patient needs were met.

- Consultants were visible on most of the medical wards and told us team working was effective and they felt the hospital leadership team listened to their views and respected their specialisms. They were proud to be part of the wider team and felt actions taken to stream line services and improve the hospital were having a positive effect on staff morale.

- All medical wards had a dedicated level of medical cover on a daily basis. The junior doctors provided daytime cover from 8.30am to 9pm across all of the medical speciality wards, Monday to Friday. Specialist registrar and middle grade doctor cover was from 8.30am to 9pm Monday to Friday. At weekends an additional specialist registrar was rostered from 9am to 5pm. The trust utilised a physician of the day (POD) on call from 1pm to see new patients. On-call consultants were on site from 9am to 9pm weekdays and 9am to 1pm at weekends. Out of these hours they were available by phone.

- Staff in the stroke service stated there were difficulties recruiting at consultant level, which meant the service may struggle to maintain its level of service going forward. The trust attempted joint appointments with neighbouring trusts without success and senior staff said that recruitment in the area was a priority.

- Locum use within the medical care service fluctuated monthly between 20% and 22% from April 2014 to March 2015 with the highest locum use during October 2014 at 22%.

- During the staff focus group, staff raised concerns regarding patient safety out of hours as junior doctors were asked to cover gaps in the on-call medical registrar rota. The trust provided data showing that between 2 September 2015 and14 February 2016 on two occasions the medical registrar out-of-hours rota was covered by CT2 staff. 'CT2' stands for Core Trainee 2, which means the doctor had completed their undergraduate medical degree, two years of foundation year training (F1 and F2) and one year of specialisation (CT1). On both occasions, the doctor was supported by on call consultant physician. Whilst this situation was not ideal, it is accepted there may be times when cover is unavailable and the trust took mitigating action to ensure patient safety.

Major incident awareness and training

- The trust had a major incident policy last reviewed in October 2016 and the policy comprehensively provided detailed information on how the trust would respond to a major incident.

- Staff on the acute medical unit were aware of the process they should instigate in the event of a major incident being declared. More junior staff were aware they might be called on in the event of a major incident.

Medical care (including older people's care)

Are medical care services effective?

Outstanding ⭐

Effectiveness in medical care was rated as 'outstanding' because:

- The trust submitted data to the Sentinel Stroke National Audit Programme (SSNAP) and between July 2014 and June 2015, the trust was rated 'A' or 'B' for Key indicators in the SSNAP audit.

- The National Diabetes Inpatient Audit (NaDIA) 2013 participation showed the trust performed better than the England median for all measures within the audit framework.
- Care given was consistently in line with national guidance and best practice. Staff adhered to local policy and procedures and the trust performance in national and local audits was outstanding.
- Pain relief was given in a timely way and patients assessed for the effectiveness of the pain relief given. Patients were very satisfied with how their pain and medication was manged.
- Patient pathways were embedded in the medical care service to standardise patient care, meeting NICE guidance.
- Patients received appropriate nutrition and fluids and were supported with other forms of nutrition. Meal times were well managed and specialist therapeutic support enabled patients to benefit from comprehensive eating and drinking guidance and dietetic support.
- Staff were competent to carry out their roles and there was effective multidisciplinary working within medical services. The trust had invested significantly in specialist roles to support individuals with complex needs and some staff had developed extended roles to benefit patient care and safety.
- Multidisciplinary working was a core theme within the medical care service and contributed significantly towards patient care and wellbeing.

However,:

- Staff appraisals were not universally completed and on the majority of wards performance was below the trust 90% completion target.

- Staff did not always complete patient assessment documentation in relation to mental capacity appropriately.

Evidence-based care and treatment

- Medical specialities provided care and treatment in line with guidelines from the National Institute of Health and Care Excellence (NICE) and Royal College guidelines. Local policies were written in line with these guidelines. Staff would use this guidance at handovers when discussing patients and when directing care.

- Staff delivered care to patients with specific conditions using appropriate care pathways. This meant care was standardised to best practice while meeting individual needs. Examples included stroke pathways, sepsis, pulmonary embolus and chronic obstructive pulmonary disease (COPD) pathways. Patient care pathways followed NICE guidance.

- Staff carried out assessments, which covered most health needs such as clinical needs, mental health, physical health, and nutrition and hydration needs.

- The endoscopy department had been awarded Joint Advisory Group (JAG) accreditation. The accreditation process assesses the unit infrastructure policies, operating procedures and audit arrangements to ensure they meet best practice guidelines. This meant the endoscopy department was operating within this guidance. The pride and enthusiasm of staff for the service they provided was evident.

- Wards carried out local quality audits that alternated in focus; recent examples included nutrition and hydration, dignity and respect, complaints and use of equipment, MRSA, and hand hygiene. Other audits being undertaken included the National Audit of Cardiac Rehabilitation (NACR), Deteriorating Patient - MEWS Audit (Monthly), Medical Record Keeping Audit (Ward Audit programme) and Falls Audit (Monthly).

- The Endoscopy Global Ratings Scale (GRS) is a quality improvement system designed to provide a framework for continuous improvement for endoscopy services to achieve and maintain accreditation. The endoscopy unit at the trust had received Joint Advisory Group (JAG) accreditation, incorporating the GRS global rating scale, in 2012, which was due for renewal in February 2017.

Pain relief

Medical care (including older people's care)

- Pain scores were checked and recorded for patients requiring analgesia, both before and after administration. We reviewed 18 medicines charts and found pain relief had been given in a timely way and in line with the prescription.

- Most patients stated their pain was well managed.

Nutrition and hydration

- Patients had their nutritional status assessed and were referred to a dietician where necessary. Where required patients were prescribed nutritional supplements to promote their wellbeing.

- Protected meal times were in place on all the wards we visited. Staff assisted patients to eat and drink and enabled choices to be made about suitable positions to eat. Staff also promoted patient food choices based on their nutrition and hydration needs. Meal times were social but quiet and well organised.

- Specialist eating and drink aids including cups, beakers and lipped plates were used effectively to promote eating and drinking. Where patients had not finished their meal or drink staff fully established the reason why and ensured the patients were given alternative options.

- Staff used food and fluid charts to monitor the intake of people who were at risk of malnutrition or dehydration.

- On the AMU housekeepers completed intentional rounding charts to ensure patients had been offered food and hydration. Intentional rounding is used to ensure patients receive care and treatments at set times to improve their wellbeing. Staff maintained a fridge with a wide range of food and drink choices including soft options like yoghurt. Staff offered drinks and food to patients waiting to be seen and patients said that the food was always nice and tasty.

- Ward G8 scored 100% feedback in the local patient survey for supporting patients who required support with their eating.

Patient outcomes

- The trust contributed to the Sentinel Stroke National Audit Programme (SSNAP). The national programme aims to improve the quality of care to patients by auditing stroke services against evidence based

standards and national and local benchmarks. Between July 2014 and June 2015, the trust was mostly rated 'A' or 'B' for key indicators in the SSNAP audit, on a scale of A to E, with A the highest rating.

- The trust participated in the Myocardial Ischaemia National Audit (MINAP). This is a national clinical audit of the management of patients who have experienced a heart attack. The trust admitted 16.7% of patients to its cardiac unit or ward during the 2013/14 year. This was a smaller percentage of nSTEMI (Non ST-segment Elevation Myocardial Infarction) patients being admitted than the England average of 55.6%. However, the percentage of nSTEMI patients seen by a cardiologist or a member of the cardiology team increased from 90.8% during 2012/13 to 94.2% during 2013/14. The number of nSTEMI patients that were referred for or had angiography (including after discharge) had also increased from 90% during 2012/13 to 93.9% during 2013/14 and showed an improvement over time.

- The trust performed worse than expected in the Heart Failure Audit 2013-14, scoring lower than the national average for the majority of measures. The trust had an action plan in place to address any issues that led to the short fall monitored by the Resuscitation and Outreach Services Manager.

- The National Diabetes Inpatient Audit (NaDIA) 2013 participation showed the trust had performed better than the England median for all measures within the audit framework.

- Standardised readmission rates between August 2014 and July 2015 were within the expected range and mostly similar to the England averages for elective and non-elective patients.

Competent staff

- All new staff attended an induction when starting employment at the trust and staff confirmed they had received adequate induction. Staff also stated that they would receive orientation to a new ward, including common practices or policies.

- There was an induction process for agency staff and this covered key areas to ensure they were oriented into the trust including handovers, ward equipment, ward

routines, escalation, patient notes, policies and procedures. The induction process clearly stated agency staff were not allowed to administer blood or blood products.

- There were formal systems in place for staff to have regular supervision sessions with their line managers. Some staff said they did not have routine supervision but they could approach their line manager for support as required.

- Staff said that they received annual appraisals and we reviewed staff personal development portfolios (PDP) where records of appraisal and supervision were kept. The majority of medical wards did not meet the trust 90% appraisal completion target for example, ward G9 55.5%, ward G8 76.9%, ward G4 83.3%, ward G3 70%, ward G1 34.7% and ward F10 87.5%. Ward F12 and F9 achieved1000% completion rate in January 2016.

- Nursing staff stated that there were opportunities to undertake additional study and professional development.

- There was a wide range of specialist nurses, for example there was a specialist nurse identified for care of the frail and elderly team, and palliative care team. There was an identified Parkinson's nurse, dementia practitioner and safeguarding leads and their role was to provide presence on the wards supporting patients and staff. Staff knew how to contact these specialists and felt supported by them.

- Some nurses had taken on extra responsibility by becoming leads for infection control, end of life care, diabetes and other specialist areas. Staff had to achieve set competencies and training days to achieve this status and PDPs reviewed showed extra certification and study days for staff carrying out these extended roles.

- There had been a skill mix review during 2015 to ensure staff competencies matched the roles and areas in which they worked.

Multidisciplinary working

- Ward teams had access to a range of allied health professionals and team members described excellent collaborative working practices between the teams.

There was a joined-up and thorough approach to assessing the range of people's needs and a consistent approach to ensuring assessments were regularly reviewed and kept up to date.

- Each ward had a dietitian allocated who visited daily. The dietetic department provided a service Monday-Friday between 8.30am and 4.30pm. The dietician team had assistants who worked under the direct supervision of qualified staff to provide direct support to patients. The dietetic department operated with an adult in-patient team lead and a paediatric in-patient team lead, who co-ordinated cover as required if there were instances of unplanned leave.

- Consultants stated that they found the input of other clinical teams and specialist nurses to be very good and that it was patient focused.

- Therapy staff stated that they felt part of a strong MDT and their views and opinions were valued by staff across various professional teams. All staff described teams working well together and sharing best practice to improve patient outcomes.

- Interactions observed between members of the MDT were noted to be positive and clearly showed mutual respect for each other's roles.

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

- Doctors led daily medical handovers efficiently, with effective verbal and written communication regarding the location of patients and their conditions. Consultants and multiple specialist nurses attended handovers and all of the medical specialities were represented. At this meeting, every admitted patient was discussed and patients who had not already been seen by a consultant were assigned to the most appropriate specialist. Staff discussed each patient that had been discharged to ensure appropriate plans and follow-up had been arranged.

- Records showed multidisciplinary care and treatment took place. For example, occupational therapists,

Medical care (including older people's care)

physiotherapists, and speech and language therapists routinely used patient records to update staff on patient wellbeing and achievements toward individual therapy targets.

Seven-day services

- The early intervention team covered the emergency department and the acute medical unit from 8.30am to 9pm Monday to Friday and 10am to 5pm weekends and bank holidays. The team provided a flexible service and covered various hospital areas to meet patient demand. Staffing numbers varied due to the need to cover a seven-day rota.

- Physiotherapy historically covered two orthopaedic wards on a volunteer rota for cover at weekends. Since January 2014, physiotherapy for elective orthopaedics was funded for a six day service, with a volunteer rota covering Sundays. In addition, volunteers continued to cover trauma orthopaedics on Saturdays and Sundays to provide additional support to patients towards discharge.

- The occupational therapists and physiotherapists on the stroke unit worked a seven-day rota to ensure NICE standards were met. Physiotherapy staff worked weekends including on the stroke unit where new patients and patients for discharge were reviewed. There was an on call chest physiotherapist available at all times.

- The endoscopy unit was open 8am to 9.30pm Monday to Thursday and 8am to 6pm Friday. Saturday endoscopy sessions did take place with an on call service provided out of hours and on Sundays. On call in endoscopy was from 6pm to 8am Monday to Friday and 6pm Friday to 8am Monday morning. There was a general colorectal surgeon consultant on call out of hours and at weekends, but there was not a separate consultant for emergency gastric bleeds. The trust was developing a separate "on-call bleed rota." Staff knew who the on-call team were and this was updated daily on the departmental notice board. Staff said the on-call team were easy to reach and readily available.

Access to information

- Staff could routinely and easily access information relevant to their roles and responsibilities via the hospital electronic intranet system. We observed staff using the system to access the internet, patient records, care pathways and policies / procedures.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Where people were able to give their consent to care and treatment their consent had been recorded appropriately and correctly.

- Staff were clear on their responsibilities in relation to the Mental Capacity Act (2005) (MCA) and could explain the process to us.

- The requirements for lawfully depriving a person of their liberty under the Deprivation of Liberty Safeguards (DoLS) was understood and appropriately recorded by staff. We reviewed the records of a patient who was being deprived of their liberty and were able to establish that appropriate steps had been followed to ensure the authorisation was lawful and appropriate.

- Staff were able to locate information relating to MCA forms on the trust's electronic recording system and there were care plans in place to support people who did not have capacity to make decisions.

- One patient that lacked capacity had been on a ward for a long period of time while tests were carried out to establish the cause of their illness. The patient had their own security guard 24 hours per day seven days per week provided by an external security company. Staff explained the MCA had identified risks to the patient and others. Staff had appropriately applied for a DoLS authorisation. In the interim whilst waiting for a DoLS authorisation, staff followed a detailed safety and care plan to promote the patient's wellbeing and others on the ward.

- However staff were expected to record on assessment if the patient had mental capacity. We found this part of the assessment documentation was not always completed. Staff we spoke with were aware of this issue and said the record should be completed at initial assessment not after a patient's transfer to another ward. We also saw that this information was passed between staff at handover. This mitigated the risk of incomplete documentation.

Medical care (including older people's care)

Are medical care services caring?

Outstanding ☆

Caring within the medical care service was rated as 'outstanding' because:

- NHS Friends and Family Test (FFT) scores were high for medical wards and individual wards regularly scored 100%.
- Patient and relatives feedback was consistently positive. Patients said that staff promoted their privacy and dignity at all times and compassionate and respectful care was observed on all the wards visited.
- Staff routinely went the extra mile for patients for example, shopping in their own time to bring in patient requests.
- The local patient survey, undertaken by the trust, showed all medicine wards scored 98% or above when patients were asked if they were treated with respect and dignity by staff.

- Families and relatives were actively involved in patient care. Individual needs and choices were respected and patients said that staff provided excellent emotional support.
- Patient religion and beliefs were catered for and the hospital had a dedicated chaplaincy services with a multi-faith room and a dedicated group of volunteers who support patients at appointments or bed side visits.

Compassionate care

- Results of the Friends and Family Test (FFT) were displayed on every ward, and there were posters displayed encouraging patients to feed back to improve the care provided. The FFT response rates from July 2014 to June 2015 were 36.5%, which was slightly higher than the national average of 33.7% and individual wards regularly scored 100%.

- Twenty-three patients all expressed a high level of satisfaction with the care and treatment provided. One patient said, "My, they are well trained", another patient told us "It took about an hour from getting here by ambulance to getting to the ward and being seen by a

doctor, they are on the ball with everything". A relative said, "They are angels here, if ever I was ill, I would want to be here; there is plenty of staff to help mum; I see them all the time."

- Feedback was universally positive about the way staff treated patients receiving care in medical wards. One patient told us, "The care is excellent in this hospital." Another patient said, "The nurses come quickly when I call the call bell." A patient on the coronary care unit said "Staff are very caring; they stayed with me when I was frightened."

- Patients stated that staff routinely go the extra mile to make their stay a positive experience. Patients gave examples of staff going shopping for them in their own personal time, bringing in specific items such as decaffeinated tea bags, newspapers, drinks and food.

- Volunteers were highly respected by patients who told us they were always willing to help and made a big difference to their stay in hospital, often stopping for chats and collecting items or passing on messages to friends and relatives.

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

- Throughout our inspection, staff were observed treating patients with compassion, dignity, and respect. Curtains were drawn and privacy was respected when staff were supporting patients with personal care. Staff routinely reminded patients about privacy, by asking them to "please cover up." Staff also used privacy curtains during personal care and assessments.

- The local patient survey showed all medicine wards scored 98% or above when patients were asked if they were treated with respect and dignity by staff.

- Patients stated that they felt safe in the hospital care and treatment at all times.

- Staff had access to a bespoke mobile patient cleaning system, which could be moved from room to room to provide washing facilities to patients who were too ill to leave the room. Staff provided an example of a terminally ill patient who had been unable to have their hair washed prior to entering the ward. The equipment

Medical care (including older people's care)

had enabled the staff to support the patient with their request prior to dying, respecting their individual choices and promoting their dignity at a time of significant need.

Understanding and involvement of patients and those close to them

- There were initiatives in the medical wards to ensure staff maintained appropriate involvement with patients, their carers and family. Patients and relatives said they felt involved in their care. Patients and relatives had been given the opportunity to speak with their allocated consultant.

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

- Family or carers could stay with patients who were nursed in a side room and visiting times were flexible. This was to promote the patients welfare by a familiar person aiding them to access nutrition and hydration, for example a confused patient or a patient not having appetite following treatment.

- The Macmillan Cancer Information and Support Centre was based in the Macmillan outpatients area on ward G1. The centre offered support, advice and information for anyone affected by cancer and was staffed by a Macmillan information and support specialist and trained volunteers. Staff were thoughtful and considerate in discussions with patients following diagnosis. Literature on cancer including specific treatments, side effects and the emotional impact of a cancer diagnosis was provided and readily available.

- A relative on ward G5 said, "They always tell me what's going on with my mum, I haven't had to ask a question yet." Another relative on ward G4 stated, "The doctors went out of their way to talk to us and go through things".

- Local patient surveys on medical wards showed generally over 87% of patients felt they were involved as much as they wanted to be in decisions about their care and treatment, with ward G1 achieving 100%.

- Patients on the AMU and ACU said s that the care received was excellent, that staff had been supportive and understanding of their needs and nothing was too much trouble.

Emotional support

- A patient on ward G1 said, "All brilliant people, everything is explained so you understand and my emotional support is great".

- In the local patient survey, patients were asked if they found someone in the hospital staff to talk about their worries and fears. Ward G1 scored 100% feedback, ward G9 scored 98%, ward F10 scored 94 % and ward F9 scored 92%. A patient stated, "They are all super staff, the emotional support, they've been grand, especially the Macmillan, they are wonderful".

- The medical team had taken time to explain to the relatives of a loved one that the care being given to a patient had ended. Staff gave them a very honest appraisal of the poor prognosis. The family were fully involved in discussions about the end of treatment, which was explained in a professional, compassionate, and caring manner and the family felt able to ask questions. The family had been encouraged to stay and visit anytime.

- The hospital chapel and multi-faith room was in constant use by various members of the hospital population. The chaplain explained how services were arranged. People could pop in to pray, or just have a quiet space for peaceful reflection time and the chaplain often supported patients, families, and staff in very difficult situations. The chaplaincy supported people of all faiths and beliefs and specialist support for various faiths was available.

Are medical care services responsive?

Good 🟢

Medical care services were rated as good for responsive because:

- Referral to treatment times (RTT) from September 2014 to August 2015 were consistently better than expected and the trust was meeting or exceeding standards for all specialties.

Medical care (including older people's care)

- The trust was working in partnership with a specialist charity to provide mobile chemotherapy services to patients in rural areas in order to offer treatment to patients closer to home and reduce pressure on the hospital services.
- Patients had their needs comprehensively assessed by both medical and nursing staff and where required input was provided from other members of the multidisciplinary team.
- There was a wide range of patient literature displayed on the wards including information on dementia care, care after having a stroke, diabetes and patients caring for patients with Parkinson's disease.
- The trust had a designated learning disabilities specialist nurse who could provide support for staff should a person with a learning disability be admitted to any of the medical wards.

However:

- The ambulatory care service on the Acute Medical Unit did not have ring-fenced beds and was regularly used by medical inpatients. This meant ambulatory care was either restricted or suspended on a regular basis with patients diverted to the emergency department instead. At times patients had to use alternative facilities, for example, rooms on other wards.
- Directional signage around the hospital was not always clear.
- Length of stay and delayed transfers of care and discharges affected access and flow. At the time of our inspection, bed occupancy across the trust was at almost 100% and ward records showed the occupancy rate to be 100%.

Service planning and delivery to meet the needs of local people

- The trust provided a mobile chemotherapy service in partnership a national charity supporting patients to have treatment for cancer closer to home. Staff and patients called this service the 'Chemo Bus'. Patients in rural areas could access treatment on board the bus, which parks in supermarket car parks, GP surgeries, and other spaces, rather than patients traveling into hospital. This reflected the UK government's 2014 'Five Year Forward' strategy that encouraged treatment closer to home in order to improve patient outcomes and reduce pressures on hospitals.

- Due to escalation at the hospital and lack of space, some patients were cared for by staff in a separate room which was about 50 metres down the corridor from the AMU and ACU area. This meant patients had to walk from the AMU and ACU to be seen in a room that was not specifically designed for their use. The room was shared with another service, which meant that staff could not use it once per week, making it difficult at times for staff to see patients. Staff stated that there could be patients who did not receive assessment or treatment because of this issue.
- The trust had a designated ambulatory care unit, which enabled staff to deliver care closer to home and avoid unnecessary admission to hospital. However, during the first two days of our inspection this area was in escalation and 100% occupied by inpatients. However on our last day of inspection this area was relatively unoccupied by patients and was ready to see new patient referrals.

Access and flow

- Admission for medical care were from a variety of routes. The majority were referred via the emergency department, however, some patients passed straight through to the ambulatory care unit, to a specialist service or via a GP referral. Once assessed by staff in the emergency department patients were then admitted to a ward area.
- Referral to treatment times (RTT) from September 2014 to August 2015, consistently exceeded the NHS standard and the trust was meeting or exceeding standards for all specialties. Operational standards were that 90 % of admitted patients should start consultant-led treatment within 18 weeks of referral.
- Length of stay and delayed transfers of care and discharges impacted the flow of patients through the hospital. Bed occupancy across the trust was at almost 100%. This was worse than the NHS average.
- The average length of stay between September 2014 and August 2015 for elective patients was 3.9 days, which was marginally higher than the England average of 3.8 days. The average length of stay for non-elective patients during the same period was 7.1 days which was higher than the England average of 6.8 days. Staff said

Medical care (including older people's care)

that discharge could be affected by the lack of community care beds available locally and due to patients waiting long periods for doctors to prescribe patients medicine to take home.

- Ward F7 was a short stay unit used to provide care for patients for up to 72 hours. Patients should then be moved to the most appropriate ward to have their medical needs met. This was a very busy area of the hospital and bed occupancy at the time of our inspection was at 100%. Staff said that bed capacity issues throughout the hospital affected their ability to transfer patients to other wards and had a knock on effect on the unit being able to accept patients from the emergency department or AMU.

- The ambulatory care unit was a day unit with the aim of avoiding hospital admission. Patients attended the unit either from the emergency department or via their GP. The unit was open from 0800 to 2300 Monday to Friday and was open for a shorter amount of hours at the weekend. Patients could undergo investigations and go home if this was appropriate.

- During the period July 2014 to June 2015, 17% of patients experienced one ward move per admission, 6% were moved twice, 1% three times and a further 1% were moved four or more times. The trust monitored the reason for moving patients between wards and could therefore clarify whether the moves were made for clinical or non clinical reasons.

- Meetings on bed availability were held four times a day, to determine priorities, capacity and demand for all specialities, the MDT played a crucial role in these meetings to help identify patients who may through early intervention, be discharged earlier.

- Bed availability meeting, were held four times a day to determine priorities, capacity, and demand for all specialities. Staff told us these meetings would reduce or increase based on patient flow.

Meeting people's individual needs

- There was a wide range of patient literature displayed on the wards including information on dementia care, care after having a stroke, diabetes and patients caring for patients with Parkinson's disease. There was also health advice and general information relating to health

and social care services available locally. Patient information leaflets were not displayed in languages other than English however, staff said that these could be made available if required.

- Patients had their needs comprehensively assessed by both medical and nursing staff and where required input was available from other members of the multidisciplinary team, for example physiotherapists, speech and language therapists, and specialist link nurses.

- Staff used a system of 'intentional rounding' to ensure patients' fundamental needs were being met. Records were made of these intentional care rounds and that they were being carried out at the specified frequencies.

- Staff were able to access interpreting services by using a telephone based language line that was available 24 hours a day for people who did not speak English as their first language. A Polish speaking nurse on a ward provided care to a patient whose first language was Polish and interpreting their needs to the rest of the staff team. This meant staff were able to provide effective care and support without any delay due to language and showed staff were making best use of the skill mix inwards to meet individual needs.

- The trust had a designated learning disabilities specialist nurse who could provide support for staff. Should a person with a learning disability be admitted to any of the medical wards, they could be bleeped 24 hrs a day seven days a week. Staff said that patients who had a learning disability would come into the hospital with a 'my health' hospital passport.

- Patient assessments identified when patients had sensory deficits and staff were aware of these. Staff supported a patient with a learning disability by using basic Makaton to promote and respect their individual needs. Makaton uses signs and symbols to help people communicate.

- Bathrooms and lavatories were suitable for those with limited mobility. There were adequate supplies of mobility aids and lifting equipment such as hoist to enable staff to care for patients who were unable to mobilise without the use of such equipment.

Medical care (including older people's care)

- There were arrangements to ensure patients were cared for in single sex facilities with access to single sex washing and toilet facilities.

- Clinical areas displayed printed health-education literature produced by national bodies. Some of this information was general in nature whilst some was specific to the speciality of the ward. For example, literature about alcohol use and guidance was available on ward F9.

- The trust had a team of diabetes specialist nurses covering all adult inpatient areas. This team received their referrals via the electronic patient record system or telephone. The team did not see every inpatient with diabetes but could offer guidance regarding patients with specific needs when required.

- The trust had a dementia specialist nurse and ward areas had dementia leads to support patients and their respective families. Patients with dementia were identified on the electronic patient record system and staff used a forget-me-not symbol above a patient's bed so clinicians could discreetly identify the needs associated with dementia. Staff also used a blue wrist band, and 'This is me' or 'Getting to know me' personal history documents to aid their communication with patients living with dementia. Staff had access to the psychiatric liaison team for complex assessment and medication review for patients with dementia.

- On ward G4, the trust had utilised different coloured bays and colour contrast in the environment to support patients with dementia and help them identify the area where their bed was. There were 'twiddle blankets' and 'twiddle muffs' made by volunteers at the trust to provide sensory stimulation and comfort to patients who may be agitated.

- The hospital nurse responsible for supporting patients with Parkinson's disease had been in post for 12 months prior to our inspection to support patients with Parkinson's disease and offer guidance and support to family members. This post had been influential in supporting patients with Parkinson's and the post had been essential as part of a multidisciplinary approach towards meeting individual patient needs.

Learning from complaints and concerns

- The head of nursing was responsible for coordinating complaints in the medicine medical care service. The trust board received data about complaints as part of the quality assurance processes and quality board meetings. In addition, complaints were discussed at the monthly ward governance meetings, and on general and emergency medicine boards.

- Learning from complaints took place at a ward level and was shared across the medical care services in relation to the medical wards.

- Staff tried to deal with people's complaints at ward level, before they escalated into complaints that were more serious. However staff knew they must escalate any safeguarding concerns immediately, and who to seek guidance from in the case of a safeguarding issue.

- The total number of complaints received by each medical ward was monitored through the ward governance meetings and fed back to senior staff. Between December 2015 and January 2016, the medical care service received 86 complaints in relation to its services. The general medicine area received 45% of complaints, with 29% from cardiology and 9% from gastroenterology. The highest percentage of complaints (22%) were in relation to clinical treatment within medicine, 10% related to admissions, discharge and transfers and communications, 9% to staff behaviour and 9% to values.

- Whiteboards and notices in various ward areas displayed comments in relation to 'you said, we did,' which demonstrated services encouraged patients and relatives to give feedback and make complaints, and that services responded to comments made.

- Posters were displayed around the hospital explaining how to make a complaint. Comments boxes where patients and those close to them could leave feedback on their experience anonymously were also in place.

- Staff on ward F10 had received anonymous feedback that the ward was not welcoming. Staff responded to this by offering information and advice for patients on entering the ward and installing a new 'Welcome to the ward sign'. Staff knew they had to respond professionally and not personally to complaints and the actions taken demonstrated that staff were listening and responding to complaints.

Medical care (including older people's care)

- A patient on ward G1 said that, "I have been given a couple of surveys over the months; it's a good chance to say why this ward is so good."

Are medical care services well-led?

Good 🟢

'Well led' was rated as good because:

- Staff were aware of the trust's vision and the trust vision and priorities were openly displayed on posters and banners in prominent areas across the hospital, in corridors, ward areas and on notice boards.

- Staff knew how to escalate concerns relating to risk and clinical governance.

- The trust won three awards at the NHS East of England Leadership Awards 2015, in the Innovation (hip and knee pathway), collaboration (Care Homes), and board of the year (West Suffolk FT) categories.

However, we also found:

- Changes in the clinical governance structure had only recently been implemented and senior staff felt more time was needed to engage staff in the quality processes that were being developed.

Vision and strategy for this service

- There was no specific strategy for medical services in the trust. However, the trust had a vision that aimed to deliver the best quality and safest care for the local community. The trust aimed to focus on three priorities: 'Deliver for today, invest in quality, staff, and clinical leadership, and build a joined up future'.

- The vision demonstrated the trust wanted staff to provide the highest standard of care and support through how they offered care to patients and the local community, how they wanted to work with each other and with external professionals. Most of the staff were aware of the trust's vision.

- The trust vision and priorities were openly displayed on posters and banners in prominent areas such as in corridors, ward areas and on notice boards.

Governance, risk management and quality measurement

- Staff knew how to escalate concerns relating to risk and clinical governance. Initially concerns would be raised with ward managers who would then escalate the concern to clinical leads for the medical care service. Ward governance meetings took place feeding into monthly quality board meetings, alongside medical care services operational meetings and trust strategic operational meetings to share developments and discuss risks.

- Governance was very much focused on a 'ward to board' and 'board to ward' methodology where senior staff and operational staff could effectively communicate through the various levels of management within the trust. A quality board meet monthly alongside trust operational meetings and medical care service operational meetings to feedback details on performance including complaints, incidents, and innovation, to the trust senior leadership team.

- Senior staff stated that changes in the clinical governance structure had only recently been implemented and they felt more time was needed to engage staff in the quality processes being developed. However, there were regular monthly governance meetings throughout the directorates relating to acute medicine, specialist medicine and care of the elderly. We reviewed the minutes of meetings and discussions about complaints, audit outcome, risk, and incident analysis were occurring.

Leadership of service

- Staff were universally supportive of both the local and senior hospital leadership teams and said they felt managers were working hard to make the hospital a better place. Staff said the chief executive was visible and told us he would routinely visit various areas of the hospital including at weekends. .

- Staff spoke very highly of the head of nursing and clinical director. They were approachable and listened to staff concerns and the changes they had made to shift working patterns and workloads were beneficial for staff and the patients alike.

- The leadership team were still relatively new at the time of our inspection and much of their developments were

yet to be embedded in the service. However it was clear to see that the team worked exceptionally well together and were clearly focused on service improvements for the patients and the staff they served.

- A patient on ward G5 told us, "I find all the senior people very approachable, I can't fault it."

Culture within the service

- The trust promoted an open and honest culture within it staff team with regard to incident reporting and complaints and developed its own policy, 'Being Open – The Duty of Candour' and reference to this policy was available through the incident reporting policy.

- All patients we spoke with acknowledged a caring and positive culture and were happy with their experience of care and treatment.

- The trust had recently launched its pledge to "never walk by" encouraging its staff team to speak up and have the freedom to speak about the trust and give feedback without fear of reprisal.

Public engagement & Staff engagement

- The trust was in the top 20% of trusts for staff engagement and recommendation as a place to work or

receive treatment in the last NHS staff survey. It was also one of only 41 trusts nominated for HSJ 100 best places to work during 2015. The HSJ 100 is an annual list of the most influential people in UK health service.

- During Spring 2015 the trust ran a consultation to engage staff, patients and the local community for views on its proposed vision, priorities and ambition, 'Our patients, Our hospital, Our future, together'.

Innovation, improvement and sustainability

- The trust won three awards at the NHS East of England Leadership Awards 2015, in the Innovation (hip and knee pathway), collaboration (Care Homes), and board of the year (West Suffolk FT) categories.

- The trust was awarded top hospital for quality of care 2015 by CHKS and more recently 'NHS Board of the Year' in recognition of effective leadership and commitment to high quality care, with consistently good performance including cancer targets, low mortality rates, and one of the best trusts in the UK for stroke and hip fracture care. CHKS is a provider of healthcare intelligence and quality improvement services.

Surgery

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

Information about the service

West Suffolk Hospital provided surgery services to the local population. The service consists of two emergency wards, two elective wards, nine theatres, one day surgery unit, and an eye treatment centre.

There were 22,947 surgical spells in the period from September 2014 to August 2015 which places the trust in the lower half of all trusts nationally. 63% of all surgical cases were day case surgeries, 14% were elective cases and 23% were emergency cases. Most types of surgery were general surgery and least types performed were ophthalmic surgery.

Ward F3 is an emergency ward, primarily taking trauma and orthopaedic and taking ear, nose and throat (ENT) emergencies. There are 33 beds split between bays and side rooms and a trauma assessment room that can be used as a side room for infectious patients.

Ward F4 is an elective surgical ward. Orthopaedic cases are prioritised in the first two bays, with other surgical specialities including gynaecology and ENT cases being placed onto the rest of the ward. There are 33 beds on the ward.

Ward F5 is an elective ward. The ward acts as a step down from the emergency surgical wards. There are 33 beds on the ward.

Ward F6 is an emergency surgical ward with 33 beds. The ward includes the surgical assessment unit that has six assessment and six short stay beds.

There are nine operating theatres at this trust, six main theatres, one emergency theatre, one obstetric theatre, and one theatre used for storage.

During the inspection we visited wards F3, F4, F5, F6, the surgical assessment unit, a theatre scheduling meeting, theatres, recovery and the day surgery unit. We looked at 22 sets of medical records, and spoke to 10 patients.

We spoke with four administrative staff, 15 surgical staff or doctors, nine managerial staff, three porters, one housekeeper, 32 nursing staff, one pharmacist, one occupational therapist, and a member of staff from sterile services.

Surgery

Summary of findings

Surgery services at West Suffolk Hospital were good overall.

Incident reporting and management was robust, with evidence of investigation, scrutiny and learning at both ward level and in governance meetings. Harm Free Care is a national programme that helps services reduce or eliminate patient harm in four common conditions; pressure ulcers, falls, urinary tract infections (UTI's) in patients with a catheter, and venous thromboembolism (VTE).There wards had a focus on the four harms. Risk assessments and checks were in place for all four harms and were part of a regular audit and learning cycle. Incidents of surgical site infections (SSI's) were below the England average for knee and hip surgeries.

Ward equipment and resuscitation equipment was regularly safety checked, with detailed logs of repairs, replacement and servicing. Medicines management was effective and drugs were stored securely and checked appropriately. Learnings from medicine related incidents shared throughout the whole service to all staff. There was a proactive approach to the implementation of processes to increase clinical safety, such as the safer surgery action plan. An independent review from the Royal College of Surgeons, to look at never event incidences, had resulted in an action plan based on recommendations.

There was good local management of surgical and nursing staffing throughout the service with low sickness and vacancy rates. However we found the recording of morbidity and mortality, and associated learning, in governance meetings required further development.

Patient care was in accordance with national guidelines and best practice recommendations. National, regional and local clinical audits were completed. Compliance with National Institute for Health and Care Excellence (NICE) and Royal Colleges' guidelines (RSC) was managed and learnt from. The trust had a range of clinical governance groups who were responsible for reviewing best practice guidelines and changes to legislation, with information shared from these groups to ward level.

National and local guidelines were accessible to staff through the trust's intranet. The trust performed local and national audits regularly. The service performed better than the England average in the Hip Fracture audit and was performance was good in the 2014 Lung Cancer Audit. However locum and agency surgical staff did not always have timely access to requesting patient tests or results and had to rely on permanent staff to undertake this.

Patients were treated with dignity and respect and had their care needs met by caring and compassionate staff. Friends and Family test results and patient survey results were consistently positive, although the response rate was lower than the England average. Staff treated patients in a professional and considerate manner by staff. Patients reported feeling involved in planning their care and told us they received enough information about their conditions. Specialist nurses provided emotional support to patients.

Overall, lengths of stay were better than the England average and surgical outliers rarely occurred. The surgical wards worked together to ensure they could admit as many patients as required. Discharge planning was effective and involved a multidisciplinary team and the patient. Discharge planning was effective and involved a multidisciplinary team and the patient. Patients requiring additional support at home had their discharge facilitated by a dedicated complex discharge planning team.

The service was proactive in planning for known events such as industrial action. There was a high focus on meeting the needs of people living with dementia, including the use of hospital passports and bespoke knitted items. There had been a reduction in complaints received from the previous year and there was evidence of learning from complaints.

However, the service did not meet referral to treatment time in most surgical specialities. Theatre utilisation was below the England average and was impacted by late starts.

Surgery

Local leadership was good with staff feeling able to raise concerns. However risks management was not consistent. Not all risks were recorded appropriately and we could not be assured that they had received the appropriate attention.

Are surgery services safe?

Good ●

Safe was rated as good in surgery services because:

- The use of the incident reporting system was embedded amongst staff. Staff knew how to report incidents. Incidents were investigated and received appropriate scrutiny and staff received feedback.
- All four surgical wards consistently performed well in safety thermometer audits reviewing pressure areas, urinary tract infections, falls and venous embolisms. Incidents of surgical site infections (SSI's) were below the England average.
- Ward equipment and resuscitation equipment was regularly safety checked.
- Medicines, including controlled drugs, were regularly checked and stored securely. Medicines related incidents were learned from.
- Patient risk assessments and checklists were thoroughly completed in medical records.
- Surgery services were proactive in implementing processes to increase clinical safety. There was a safer surgery action plan in place and an independent review invited from the Royal College of Surgeons to look at never event incidences.
- Surgical and nursing staffing was well managed throughout the service with low sickness and vacancy rates.

However;

- Mortality and morbidity review was not well documented at meetings.
- Visual infusion phlebitis scores were consistently low across the service.
- Safeguarding vulnerable adults training compliance was consistently not met amongst the surgical staffing group. Mandatory training amongst medical staff was not well attended.

Incidents

- There had been four never events in surgery between November 2014 and February 2016. Each never event was investigated and the trust board had invited an external review by the royal college of surgeons in July 2015. Recommendations were made in this report. The

report stated that the Royal College of Surgeons had no significant concerns regarding the safety of surgery services at this trust. Root cause analyses (RCA's) had been completed for all never events in a thorough and transparent manner.

- Learning from never events was shared with staff. For example, a junior doctor confirmed that they received emails with learning from never events as well as a pharmacy newsletter with learning from prescription errors. A surgical care practitioner demonstrated awareness of three of the five never events and was clearly informed of the actions and practice changes from the relevant investigations.

- Staff understood how and when they should report incidents and near misses. Incidents were appropriately investigated and managed. Incidents and near misses were recorded onto an electronic system for active management and monitoring. This system was accessible to all staff and was found on the desktops of all trust computers. No log in was required to report an incident this meant that anyone working in the trust could log an incident.

- Staff reporting incidents received electronic feedback when the appropriate person has investigated the incident. Managers completed investigations for incidents and had permissions to amend the report as appropriate. For example if an incident had been inappropriately categorised. Analysis of incidents for trends occurred at governance meetings. Minutes of these meetings show a discussion occurring around each new incident graded as red and amber in a traffic light scoring system of severity. An example was given of a historical trend of drug errors being detected. This was discussed between the matron, ward sister and general manager and changes for implementation were decided and actioned.

- Between February 2015 and January 2016 there had been Root Cause Analysis (RCA's) undertaken for three serious incidents (SI's), and one SI was still under investigation. All three RCA's contained a detailed, chronological investigation into the incident and had associated action plans. There was evidence of updates to those action plans up to completion of the action.

- Root cause analyses (RCA's) for serious incidents (SI's) were cascaded to all wards including any practice changes. This was observed in newsletters created by

ward managers for their staff. This sharing of learning included learning from incidents. The matron also distributed a newsletter to communicate learning from incidents with staff.

- Individual wards cascaded and implemented learning from incidents. A folder was held on ward F4 for staff to refer to. This detailed incidents that had occurred and how practice had changed due to learning from these things. For example, the development of a pressure ulcer on the ward had led to the ward manager joining a pressure prevention group for education and disseminating learning to their staff. Learning had taken place on ward F5 from two similar incidents. One of the cases was anonymised and put in the ward manager's newsletter for learning all of the nurses.

- Mortality indicators were lower than the national benchmark. Out of 16 other trusts, this trust's mortality indicator was approximately the same or better than 10, and worse than six of the other trusts. According to the trust's quality dashboard, the standardised mortality rate for surgery was 92.5 in March 2016. This was below the target set by the trust.

- The reporting of mortality and morbidity (M&M) discussions and learning was inconsistent in surgery. For example, M&M was a standard agenda item in the surgery clinical governance meetings as well as the urology audit and multidisciplinary meetings. The depth of discussion varied between each meeting, with actions to be taken and discussion around urological cases, and only a mention of a discussion in the clinical governance meetings for the remaining cases.

- Duty of candour was understood amongst staff. There were duty of candour-specific stickers available for staff to use in patient records. These enabled staff to clearly record that they had had a duty of candour discussion with the patient, and to record what had been said. An example was given where the matron had discussed the development of a pressure ulcer with the patient.

Safety thermometer

- The NHS safety thermometer is a national initiative and local improvement tool for measuring, monitoring, and analysing harm free care. Staff reported the number of falls, urinary tract infections (UTI) and venous thromboembolisms (VTE) on a monthly basis. Results were displayed on notice boards and within staff areas.

- There was a focus on driving improvements to avoid harm to patients in these areas from the chief nurse that

was also reflected in ward managers. The four surgical wards monitored their performance relating to the patient safety thermometer, and consistently performance well.

- Ward F6 had not reported any pressure ulcers since May 2015 and achieved 100% compliance in the areas of the safety thermometer over time. Ward F5 reported one fall in February 2016 and none in March 2016. There had been no pressure ulcers reported since April 2015 on F5. Ward F4 had reported no pressure ulcers and three falls in February 2016.

- Wards were proactive in ensuring their compliance to the patient safety thermometer. Completed plans of care indicated patient requirements for reducing the risk of pressure ulcers, falls, UTI, and VTE. Whiteboards and internal newsletters communicated results of the patient safety thermometer to all staff.

- Falls and pressure ulcer charts were completed daily. Any concerns from daily checks for pressure ulcers, removal of anti-embolism stockings, and visual inspections were escalated to trained staff by health care assistants. These were documented on an electronic system which was updated after every 12 hour shift. VTE assessments were completed on admission and kept with medications charts. Weekly audits were performed to check VTE assessment completion, along with monthly audits performed by clinicians on prescribed treatment.

- Staff were able to demonstrate action taken as a result of auditing compliance with the safety thermometer. An example of this was that following a rise in UTIs, a review of the length of time catheters were used was conducted. An action to increase staff awareness had recently begun.

- The Visual Infusion Phlebitis (VIP) score is a tool for monitoring infusion sites. It is a valid and reliable measure for determining when a peripheral intravenous catheter should be removed. The trust target for compliance to VIP checks is 90%. In March 2016 the overall score for surgery was 77%. This was communicated to all surgery staff through the monthly newsletter, and discussed at the ward managers meeting. A new electronic system, once fully implemented, would not allow nurses to proceed with entering patient information without entering VIP data. This had recently been implemented at the time of inspection and was too early to have a realised impact.

Cleanliness, infection control and hygiene

- The trust had ceilings set of zero cases of methicillin resistant staphylococcus aureus (MRSA) per year and under 25 cases of Clostridium difficile (C. Diff) per year. For the period April 2015 to March 2016, the trust's quality dashboard reported zero cases of both MRSA and two cases of C Diff.

- Elective surgical cases were screened in advance of admission for MRSA. If patients tested positive surgery was cancelled whilst patients received treatment. MRSA screening compliance was set at 90%, with all four wards consistently exceeding the target. This meant that the trust was proactive in identifying and managing MRSA.

- Uniform, hand hygiene and environmental audits were completed weekly with results being emailed to staff.

- MRSA positive patients were cared for in dedicated side rooms. Two side rooms were noted to have isolation charts on the doors for MRSA positive patients during our inspection. However a surgical staff member was observed leaving a side room of an MRSA positive patient and discarding their apron in the clinical waste bin opposite. This could potentially spread the infection. We raised this with the ward manager who addressed this lapse in infection control.

- Surgery services consistently scored highly in hand hygiene and cleanliness audits. This meant that most staff were proficient at preventing the spreading of infection in their wards and areas.

- Disposable curtains and blinds were in use throughout the surgery services to prevent the spread of infections.

- In the theatre department we saw that sterile and, aseptic techniques were adhered to. However one member of the surgical team was seen removing their mask during an operation. Sharps bins in the theatre department were not consistently labelled or dated. We raised this with the senior manager who took action to address.

- Hand gel dispensers were available throughout each ward and in bays for staff and visitors, helping to prevent any spread of infection.

Environment and equipment

- There was a management of medical equipment policy in place that set out the responsibilities of all staff, in particular the electro-biomedical engineering (EBME) staff, in their role in ensuring all medical equipment was

tracked, tested, repaired and maintained in a timely manner. This policy was supported by an EBME business continuity plan. This plan set out key processes to follow in the event of particular failure such as equipment failure, denial of access and significant staff absence.

- Equipment was regularly safety checked. We reviewed 15 pieces of equipment across all four surgical wards and all were within the safety checking date.
- Requests for repairs, replacements and other estates related jobs were logged and recorded appropriately. The job log included details such as the date and time a request was made, where and what the job was, and the date and time the job was completed. This meant that it was easy to track the status of all job requests at any given time.
- Resuscitation trolleys were checked regularly. Logs were kept on the trolleys for staff to record daily checks of the equipment and emergency medicines. These logs were observed to be fully completed with no dates where equipment had not been checked.
- Oxygen and suction equipment was available on all wards. We checked four sets of equipment were checked and all were functioning as required.
- There was insufficient bladder scanning equipment available to the surgical wards. During the inspection, one bladder scanner was observed to be shared between the four wards on two separate occasions. This meant that surgery services could not be certain to provide bladder scanning to inpatients at the time it would be required.
- We could not be assured that anaesthetic machines were checked prior to use in theatres. Checking logs for three anaesthetic machines were observed to have several gaps in checks prior to use.

Medicines

- We found that medicines were stored securely with secure access limited to nursing staff. Controlled Drugs which require special storage and recording were stored following good guidance procedures including daily checks by two nurses on quantities and records. Medicines requiring cool storage were stored appropriately in locked medicine refrigerators. Daily temperature records for the medicine storage room and for the medicine refrigerator documented that medicines were stored within safe temperature ranges.
- A clinical pharmacist visited the surgical wards five days a week. They were involved in discussions with doctors

and nurses about patients' individual medicine requirements and helped identify medicine issues which could be dealt with immediately. A nurse told us that there was a good relationship with pharmacy with access to a pharmacist out of hours if needed.
- Learning from medicine incidents was shared. A 'safety bulletin' was e-mailed to the ward manager which was printed out and displayed on a staff noticeboard. Knowledge of medicine incidents was consistent between the surgical wards.

Records

- Patient records were thorough, legible and of a good standard. Twenty sets of records were reviewed. There was evidence of multidisciplinary team input into patient care. Consent forms were completed and stored in patient records. Patient observations were consistently recorded with no omissions, and drug and care rounding checks were recorded.
- Appropriate risk assessments were recorded in patient records. In the 20 records observed, there were consistent pressure area assessments, falls assessments and five steps to safer surgery checklists commenced on the wards.
- Patient records were paper based on the wards and were transported with the patients throughout the hospital. Historical records were accessible on an electronic system once they had been scanned and archived.
- Ward managers took ownership of the completion of nursing records on their wards and encouraged their staff to record accurately. For example, the ward manager of the day surgery unit checked the completion of venous thromboembolism assessments on a weekly basis. This was reflected in a compliance score of 98% at the time of inspection.
- One set of notes reviewed had an illegible prescription chart. This meant that it was difficult to ascertain when medication was due for administration. This issue was escalated to a member of nursing staff who took action to have the chart amended.

Safeguarding

- Safeguarding vulnerable adults training was available to all staff. This training advised staff how to recognise signs of abuse, and how escalate any concerns. Safeguarding training and safeguarding guides on the wards equipped staff to complete safeguarding forms

when required. Posters with the contact details for the safeguarding team were available on all surgical wards. Safeguarding booklets were given to staff, these guided staff if they had concerns. Completed safeguarding forms were sent to both the matron and social care.

- Safeguarding vulnerable adults training compliance for the period October 2015 to March 2016 was 64% for surgical staff and 97% for nursing staff. This showed a large difference in up-to-date safeguarding knowledge between doctors and nurses, meaning that there was limited assurance that surgical staff knew how to recognise signs of abuse.

Mandatory training

- There was a mandatory training programme in place for all staff to complete on recruitment and then annually thereafter. All staff within the surgical service had completed some mandatory training but not all were up to date. Ward managers were aware that not all mandatory training was up to date and stated that this was a priority. There was an action plan in place to address shortfalls in training.

- Compliance to mandatory training in surgery services was variable between nursing and surgical staff. From April 2015 to March 2016, nursing staff achieved green ratings (compliance between 80% and 100%) 90% of the time, amber ratings (compliance between 60% and 80%) 9% of the time, and red ratings (compliance below 60%) 1% of the time. This meant that over 80% of nursing staff had undertaken mandatory training. Surgical staff achieved green ratings 10% of the time, amber ratings 40% of the time and red ratings 50% of the time. This meant that less than 60% of medical staff had received mandatory training.

Assessing and responding to patient risk

- A safer surgery policy and action plan was in place within the surgery service. The safer surgery approach focused on effective teamwork and communication in providing safe care in surgery. The action plan was implemented as a response to the rise of never event reporting. The action plan was referenced as a positive step, from an independent Royal College of Surgeons review that was conducted to look into never events in surgery. The action plan was on-going at the time of inspection so impact of the action plan was not assessed.

- The Five Steps to Safer Surgery surgical checklists were re-launched in surgery services in December 2015 in response to the series of never events. The surgical checklists were observed being completed before general anaesthetic administration with direct questioning of patient name, DOB and which operation and site, with site labels being noted. Checklists were also completed before any incisions were made by the surgical team. This was observed in two separate theatres.

- The Five Steps to Safer Surgery surgical checklists were audited on a quarterly basis. Each element of the checklist was audited and scored. Scores below 95% had associated action plans in place with a responsible staff member and expected end date detailed. Review of quarterly audits demonstrated increasing compliance in particular area of the audit.

- A modified early warning scoring system (MEWS) was in place to detect patient deterioration. Health care assistants received training to calculate MEWS scores, and conducted the majority of observations on the surgical wards. An escalation pathway was included in the MEWS score chart. A MEWS score of more than 3 required escalation to the outreach team. The outreach team's contact telephone number was visible at nurses' stations on the surgical wards.

- In the event of escalation to the outreach team, doctors would arrive on the wards 45 to 60 minutes after being contacted by a member of the ward staff, registrars arrived within four hours of being contacted. Consultant ward rounds take place twice daily on the surgical wards.

- Two incidences of MEWS scores being 6 occurred during the inspection. Staff gave analgesia to the patients but did not recheck the MEWS score afterwards. One of these cases was escalated to ward staff, who took action and re-evaluated the patient's MEWS score. One MEWS score was observed to be recorded as 4 but no escalation had taken place. This meant that we could not be assured that all patients in the early stages of deterioration were detected in a timely manner.

Nursing staffing

- A staffing review had completed in January and February 2016 looking at acuity and staffing levels on each ward. The review was due to go to the board in April 2016. This meant that we were unable to review the results of the review at the time of the inspection.

Surgery

- The fill rate, which is how many of requested nursing shift were filled, for day shifts in November 2015 averaged across all four wards at 124% for registered nurses, and 101% for unregistered nursing staff. Night shifts saw a fill rate of 99% for registered nurses and 106% for unregistered nursing staff. This meant that in general the levels of nursing staff required were achieved.
- Levels of nursing staff on the emergency surgical wards was set at five registered nurses and three healthcare assistants on day shifts, and three registered nurses and three healthcare assistants on night shifts.
- In recovery, levels of staffing were set at one manager, nine sisters or nurses in charge, and 11.3 staff nurses. Flexible rostering was used to cover early, late, mid-shifts, twilight and night shifts.
- Staffing establishments and skill mix were set according to the Association of United Kingdom University Hospitals dependency tool. This tool enabled managers to determine patients' dependency, or acuity, and calculate the appropriate skill mix and numbers of staff required to care for them safely. The senior matron reviewed staffing on a daily basis.
- Ward managers from all four surgical wards worked closely together and flexed staffing to cover any shortages as much as possible. If existing staff were unable to cover any shortages, then agency staff would be requested.
- Shifts covered 12 hours, plus handover time, between 7am to 7:30pm and 7pm to 7:30am.
- There was always a ward sister on all shifts. This meant that there was always support for more junior nurses.
- In the period between December 2015 and February 2016, the average bank use for all surgical wards was just less than 2% for registered nurses and just less than 2% for non-registered nursing staff. Agency use of registered nurses averaged at just less than 1% for all four wards for the same time period. No agency staff were used in theatres. The hospital bank provided cover for any gaps. Theatres used bank staff on average 12-15 hours each week.
- Collectively, all four surgical wards carried on average 2.8 whole time equivalents (WTE) vacancies in staff for the period August 2015 to January 2016.
- Registered nursing vacancies across all of the surgical wards were 4.59 WTE. Unregistered vacancies across all four surgical wards were 2.2 WTE in February 2016.

Surgical staffing

- A slightly greater proportion of consultants (45%) and junior doctors (15%) were employed than the national average (41% and 12%). There were a total of eight consultants in the surgical service which had a vacancy for a further consultant. Three speciality doctor fixed term vacancies had been met within the period August 2015 to September 2015.
- A rota was observed on the trust intranet that showed there to be 10 foundation year one (FY1)doctors, eight foundation year two (FY2) doctors, two consultants, two trainee general practitioners, and nine specialist registrars.
- Between December 2015 and February 2016 there had been 64 bank shifts and 57 locum shifts undertaken.
- A daily trauma meeting and ward round took place daily at 8am. A registrar was present at ward rounds in the morning. This meant that a senior member of the surgical staff was available for each meeting and ward round.
- A consultant of the week scheme was in place. A post-take ward round was observed. A registrar, FY1, consultant and healthcare assistant were present. The same FY1, registrar and consultant were on call for the week which promoted continuity of care.
- A consultant geriatrician and team performed daily ward rounds to consider the comorbidities of patients, particularly those who were not operated on for fractured neck of femur within 24 hours.
- At the time of our inspection there were no junior doctors on the wards due to industrial action. Medical cover on the ward was provided by consultants and senior doctors to ensure that risk to patient safety was minimised.

Major incident awareness and training

- There was a major incident policy available on the staff intranet and was accessible to all staff. Staff were able to find and demonstrate this policy during the inspection. This policy advised staff on processes in the event of a major incident and management structures.
- In preparedness for surgical staffing strikes, full emergency care was scheduled to be provided as usual. Ward cover was allocated out to consultants who provided cover in the mornings and afternoons. 26 operations were cancelled, with the exception of cancer operations, and rebooked. Surgical nurse practitioners

and outreach nurses were assisting consultants on the wards. British Medical Association representatives were on hand to review the trust's plans for preparedness and support any escalation issues to NHS England although this had not occurred.

Are surgery services effective?

Good 🟢

Effective was rated as good in the surgery services because;

- Throughout our inspection, we observed patient care carried out in accordance with national guidelines and best practice recommendations.
- National, regional and local clinical audits were completed, monitoring compliance with National Institute for Health and Care Excellence (NICE) and Royal Colleges' guidelines (RSC).
- The trust had a range of clinical governance groups who were responsible for reviewing best practice guidelines and changes to legislation.
- Staff were able to access national and local guidelines through the trust's intranet, which was readily available to all staff.
- The service participated in local and national audits. The service performed better than the England average in the Hip Fracture audit and performance was good in the 2014 Lung Cancer Audit.

However;

- Performance for knee replacements was just below the England average as per PROMS data April - December 2015

Evidence-based care and treatment

- National Institute for Health and Clinical Care Excellence (NICE) guidance on falls prevention, the management of patients with a fractured neck of femur, pressure area care, and venous thromboembolism (VTE) were being followed. For example, anti-coagulant therapy was prescribed for patients at risk and anti-embolism stockings were measured and fitted to relevant patients.
- Patient care was observed to be carried out in accordance with national guidelines and best practice

recommendations. For example, patients attending for pre-admission clinics had pre-operative investigations and assessments carried out in accordance with NICE clinical guidelines

- The Trust was awarded the Anaesthesia Clinical Services Accreditation (ACSA) by the Royal College of Anaesthetists in May 2015. The ACSA is a voluntary scheme that offers quality improvement through peer review, benchmarking against standards and anonymised local, regional and national performance. 73 anaesthetic departments across the United Kingdom have registered for the scheme with 13 accredited departments.
- Staff in theatres adhered to the NICE guidelines CG74 related to surgical site infection prevention and staff followed recommended practice.
- Care was provided via care bundles, which adhered to national guidance. Training on the use in these was provided to staff.
- A harm free care bundle was developed and implemented by the team on ward F3 for patients undergoing specific orthopaedic surgery. This incorporated current national guidelines. Care bundles were completed appropriately in medical records.
- Surgical and nursing staff were aware of audits that had been undertaken and actions taken to improve service.
- National clinical audits were completed, such as the National Hip Fracture Database. The trust's performance was better than the England average or rated as "good" for all measures in the 2015 Hip Fracture audit. The percentage of patients undergoing surgery for a fractured neck of femur within 48 hours was 94% between January 2015 and December 2015, this was better than the national average of 72% in 2015 (National Hip Fracture Database).
- Data from the National Joint Registry (NJR) showed the number of knee and hip surgery performed at this trust was similar to other trusts. The trust received a quality award from the NJR for data completeness for the period April 2014 to March 2015.
- There was clear evidence of ongoing local audit activity within the trust. Audit programmes identified nominated audit leads, rationale, methodology, results, associated action plans, improvements, and a re-audit cycle.

Surgery

- Patient pathways were in place in the surgery services. These included; an enhanced recovery pathway for major bowel and nephrectomy patients; emergency admission pathway; delirium pathway for the over 65s; fractured NOF pathway; and a trauma pathway.
- Elective patients had a face-to-face pre-assessment at a centralised clinic. A patient questionnaire was completed in clinic and screened along with the medical notes to determine the type of clinic required for that patient. Patients were placed in one of three separate clinics (red, amber and green). The red clinic was led by a nurse practitioner and consultant anaesthetist, the amber clinic was led by a nurse practitioner and either a foundation year one (FY1) or foundation year two (FY2) doctor, and the green clinic was staff nurse led. This meant that patients saw the most appropriate clinician during pre-assessment.
- Theatre recovery was in alignment with the Royal College of Anaesthetists guidance. The recovery had the capability to take emergency surgery out of hours. Recovery aligned to the critical care report 'Without Walls', which stated that in times of crisis, recovery would take level two intensive care patients.

Pain relief

- West Suffolk Hospital pain management service was nurse led with support from consultant anaesthetists with an interest in pain management.
- The pain team worked in collaboration with both medical and surgical teams to help manage the patients' experience. Referrals to the team were via an online system and via a bleep system for urgent requests. The team had a single point of contact. Pain nurses proactively visited wards looking for patients in pain and supported both staff and patients to manage their pain better, through information and education.
- The pain team were available between Monday and Friday 8am to 4pm, and out of hours cover was provided by an on-call anaesthetist.
- The pain team worked with the practice development nurses to produce two study days for nursing staff to attend on a quarterly basis.
- There was a proactive approach to managing patients' pain on the day surgery unit. A new protocol in place meant that patients could be given loading doses of 800mg ibuprofen and one gram paracetamol pre operatively. This was seen as best practice by the British Association of Day Surgery (BADS).

- A World Health Organisation (WHO) pain ladder was used to assess adult pain levels, as well as a neuropathic pain ladder. For patients lacking mental capacity the pain team used The Abbey Pain scale as an assessment tool. Pain scoring tools were completed appropriately and pain relief was given when needed.
- Patients who had recently undergone surgery stated that there were no problems in obtaining adequate pain relief. One patient explained that their pain medication made them feel sick and staff had it changed within an hour. Another patient explained that they had been visited by the pain team as well as the nurses checking their pain levels every time they passed their bed.
- In the 2013-2014 Cancer Experience Survey (CES) 88% of patients said that the hospital staff did everything to control pain all of the time, placing the trust in the top 20% of all hospitals.
- Specialist nurses were able to prescribe analgesia.

Nutrition and hydration

- All wards used a 'risk assessment trigger tool' as part of the admission process. This detailed tissue viability, falls and nutrition, using questions that asked for a 'yes' or 'no' answer. If any questions answer 'yes' then all other risk assessments must be completed, including a nutrition risk assessment and actions. Examples of appropriately completed forms were observed.
- Dieticians were accessible on a daily basis on the wards for patients requiring nutritional support.
- Two patients stated that staff offered them a variety of food and drink and did not highlight any concerns about the food and drink provided.
- Nutritional needs were indicated above patients' beds on laminated sheets that had a cutlery sign ticked indicating that assistance was required at mealtimes.
- The malnutrition-screening tool (MUST) is a five-step screening tool to identify adults at risk of malnutrition. Compliance with the care plan was monitored on the patient dashboard. From April 2015 –March 2016 data for the surgical directorate demonstrated that all wards achieved a green rating.
- Diet and fluids required post operatively were ordered in the pre-operative phase. This meant that patients' nutrition and hydration needs were being planned for in advance.

Patient outcomes

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- The trust performed better than the England average for all of the 10 measures in the Hip Fracture Audit in 2015 with 90% of patients receiving surgery within 36 hours of admission against an England average of 78% and received a good rating.
- Elective and non-elective patients had a lower risk of readmission than the England average although it was slightly higher for elective ear nose and throat (ENT) surgery and non-elective urology surgery.
- The service had a good performance in the National Bowel Cancer Audit in 2014 with 100% of all cases discussed at multidisciplinary meetings (MDT), 94% of patients were seen by a clinical nurse specialist and 99% of patients had a reported computed tomography (CT) scan. The trust also had high case ascertainment rates and data completeness.
- Trust performance was good in the 2014 Lung Cancer Audit, with 94% of patients receiving a CT scan before bronchoscopy compared to the England average of 91%. 98 percent of patients had their cases discussed at an MDT meeting compared to an England average of 91%.
- In the 2015 National Emergency Laparotomy Audit (NELA), the trust received a green rating (between 80 and 100%) for meeting nine out of the 11 standards. The Trust was identified by NELA in April 2015 as being within the top ten sites for five of the 11 standards. The trust had been asked by NELA for information on their approach to enable better understanding of achieving and maintaining targets consistently.
- The trust received a red rating (0 to 49%) for two of the 11 standards. Less than half of the patients were reviewed by a Consultant Surgeon within 12 hours of admission and no patients over the age of 70 received an assessment from a specialist physician in medicine for the care of older people (MCOP) as seen in the NELA baseline assessment for June 2015. The trust was proactive in addressing one of the two standards not met. A consultant geriatrician had been appointed to ensure that older people received appropriate care.
- Results from the Patient Outcomes Reporting Measures (PROMS) from April 2014 to May 2015 for hip replacements and varicose veins were similar to the England average.
- Performance for knee replacements was just below the England average as per PROMS data April - December 2015."

Competent staff

- New members of staff received induction packs. These included department information, skills requirements, and preceptorship documentation. These were observed on wards and in theatres.
- Induction and competency assessments were in place for new, temporary and agency staff across all areas. Regular agency staff were booked for competency assessment as they were familiar with the areas, paperwork and systems at the trust. This improved the effectiveness of care given to patients.
- Existing competency assessments and highlighting of required competence was identified on annual staff appraisal. One nurse gave the example that they completed the aseptic non touch technique competency once every two years and has received approved to undertake acute kidney injury and chronic pain control competencies.
- The overall appraisal rate for both surgical and nursing staff at the end of February 2016 was in line with the England average of 84%.
- There were 20 different equipment competencies between the four surgical wards. Competence was recorded on a monthly basis for monitoring. This provided insight as to which staff had gained competence and been assessed, each month.
- Annual band 5 development days were set up by the senior matron.
- Nurses were supported in their revalidation by the trust. The education team held revalidation workshops.
- Junior doctors were allocated one hour bleep-free each week to receive teaching.

Multidisciplinary working

- Surgery services had multidisciplinary team (MDT) input from nursing, surgical, pharmacy, physiotherapy, occupational therapy and dietetic staff. The trust had conducted a multidisciplinary scoping review as a recommendation from a root cause analysis of a never event. This scoping review led to the development of an action plan to strengthen and improve multidisciplinary team working. The action plan was on-going at the time of inspection so no impact could be ascertained.

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- There were no concerns regarding staffing levels of dietetics, occupational therapy and physiotherapy staff for the period from September 2015 to December 2015, with excepted staffing levels being met the majority of the time.
- Daily board rounds took place on surgical wards between the nursing staff and the physiotherapy and occupational therapy, or allied health professional (AHP) staff. The whiteboards on the wards gave AHPs quick access to information. For example, if patients were highlighted as medically fit, this prompted an alert to the AHP to see the patient as quickly as possible before discharge.
- There were set MDT meetings for surgical specialisms such as cancer and colorectal care, led by specialist nurses.
- Enhanced recovery meetings were held quarterly. Review of minutes of these meetings showed that themes were reviewed and feedback was given for each element of the MDT. These meetings had representation from the colorectal specialist nurse, a surgeon, an anaesthetist, a dietician, an occupational therapist, a physiotherapist, the pain team, a ward manager, and pharmacy.
- There was MDT representation at the theatre scheduling meeting. Attendance included; the matron, two consultants, pharmacy, sterile services, a clinical team manager, admissions and bed management.
- A complex discharge planning team worked closely with social care and the medically fit team. The team was nurse led and therapy led for links to community rehabilitation beds.
- The community dental team provided a surgical service with support of the day surgery unit. The team consisted of a dentist and theatre nurse, with a second year dental nurse to support patients in the ward area. The second year dental nurse was supported by ward staff. The community team liaised with the trust link nurse to plan hospital treatment for community patients.

Seven-day services

- Acute and emergency surgery services were available seven days a week. There was out-of-hours cover by surgical staff and nursing staff told us they felt well supported outside normal working hours. This included 24-hour, seven days a week anaesthetic support and cover.

- The outreach team provide a 24 hour service seven days a week. Staff could bleep the outreach team directly for support.
- Elective surgery was carried out either five or six days per week depending on demand.
- Junior doctors were on a rota of one in every nine weeks of being on call. Along with middle grade doctors, they provided out of hour's care to patients on the surgical wards. There were seven consultants on an on-call rota, who provided cover to the surgical wards and theatres.
- A team of one two junior doctors, one registrar and one consultant provided care at the weekends. The workflow consisted of the consultant seeing newly admitted patients, and the ward-based doctors saw existing patients on the surgical wards.
- There was a 24-hour emergency service with dedicated theatres. This meant that any patients admitted out of hours or over the weekend could have emergency surgery if required.
- Microbiology, imaging, for example x-rays and scans, physiotherapy and pharmacy support was available outside of normal working hours.
- Multidisciplinary care was mostly available seven days a week. There was orthopaedic occupational therapy cover at the weekends between 8.30am and 4.30pm, although there was no general surgical occupational therapy weekend cover. There was physiotherapy cover for surgery six days a week between 8.30am and 4.30pm.On-call pharmacy support was available 24 hours a day, seven days a week.
- The complex discharge planning team was available between the hours of 8am and 4pm seven days a week.

Access to information

- An electronic system was used by all staff in the admission, transfers, and discharges of all patients. This system was accessible throughout the hospital.
- Individual patient risk assessments could be completed on the electronic system for any inpatient. The system used data inputted to calculate the risk score for a particular assessment. Risk assessments were reassessed weekly or as clinical need determined, for example, if a patient fell or deteriorated.
- Electronic white boards were in use and were linked to the bed management team. Patients due for admission the following day were identified on the white board for ward staff to plan care provision in advance. The white boards were used to convey messages such as MRSA

results that required a medication regime to be commenced. On the wards, the whiteboards were located behind the nurses' station away from patient and visitor view. This maintained confidentiality.

- The theatre management system was electronic. A live screen of current theatre activity was on display for staff to plan and prepare their work.
- Substantive nursing and surgical staff had access to documentation and medical records for patients to ensure continuity of care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had appropriate support and knowledge around consent. There was a consent policy in place, which was based on guidance issued by the Department of Health (2001). This included guidance for staff on obtaining valid consent, and details on the Mental Capacity Act 2005 (MCA) guidance. Flow charts of the MCA process were on display in staff areas.
- Consent forms were consistently completed in patient records, with evidence of patient involvement. Patients received copies of consent forms. There was a standardised consent form that was discussed at a patient's outpatient clinic if they were elective patients. This form was taken home so that the patient could take their time reading the form and information provided, and brought back to be signed on the day of surgery. Verbal consent was observed to be obtained in the anaesthetic room prior to anaesthetic being administered.
- Patients confirmed that they had been given clear information about the benefits and risks of their surgery prior to signing the consent form. They also confirmed that they were given the opportunity to ask questions if they were not clear about any aspect of their treatment.
- Results from the December 2015 consent audit showed that performance was variable. Performance was good for using the correct consent form, explaining the risks and benefits of the surgery and recording of the patients' details, but performance was low for documenting provision of an information leaflet, with 16% of 150 patients having this documented.
- A trust-wide safeguarding team provided support and guidance for staff in relation to any issues regarding mental capacity assessments and DoLS.
- Mental capacity was reassessed every 72 hours on the surgical wards to ensure that patients with fluctuating

mental capacity received the most appropriate care at any given time. Evidence of this was seen of this in a patient's medical records which showed a difference in capacity due to the patient's needs at the time.

- Ward staff were aware of what to do if a patient's mental capacity required them to be deprived of their liberty to receive appropriate care. If a patient still lacked mental capacity after six days, a DoLS application was completed using a guide on the wards. One of these applications was observed and was completed appropriately.

Are surgery services caring?

Good ●

Surgery services were rated as good for caring because;

- Patients confirmed they were treated with dignity and respect and had their care needs met by caring and compassionate staff.
- Family and Friends test results and patient survey results were consistently positive.
- Patients were observed to be being treated in a professional and considerate manner by staff.
- Patients reported feeling involved in planning their care and told us they received enough information about their conditions.
- Specialist nurses provided emotional support to patients.

Compassionate care

- The Friends and Family Test (FFT) is a feedback tool that gives people who use NHS services the opportunity to provide feedback on their experience. We saw that Friends and Family information was displayed on notice boards around the wards and departments.
- The FFT scores for surgery were in line or above the England average of 96%. The majority of patients who used the surgery services at this trust recommended the service. From August 2014 to February 2016 scores were regularly 100% and did not fall below 93%. The surgical ward F4 had been nominated by the trust for the FFT 2016 awards, for consistently achieving 100% patient recommendation from September 2013 until January 2016.
- Response rates for the four surgical wards and the day surgery unit (DSU) were variable. Ward F4 was only ward

with response rate above England average at 52%, the remaining three wards response rates ranged between 26% and 32%, and DSU at only 5%. The response rate overall was 24%, which was in line with the England average

- The patient advice and liaison manager had nominated ward F4 for an award for their friends and family results. The ward manager printed the test for elderly patients who struggled using the electronic devices. They were offered a drink and snack whilst completing the form. Response rates for this ward F3 between April 2015 and December 2015 ranged between 47.4% and 71.5%. Results were 100% since April 2013 (exception of 4 months at 98%).

- Results from a local patient survey from June 2015 to November 2015 were positive overall. For example, staff being caring and compassionate scored 100%, patients treated with dignity and respect scored 98%, and patients' privacy being respected when receiving treatment scored 98%.

- Surgical inpatient areas were compliant with same-sex accommodation guidelines. In all ward areas staff pulled curtains around each patients' bay and closed doors to maintain patients' privacy and dignity.

- In the Cancer Patient Experience Survey 2013/14, performance at the trust was within the top 20% of trusts in answers to nine out of 34 questions. These included; patient had confidence and trust in all ward nurses, patients' family definitely had time to talk to the doctors and possible side effects of treatment explained in an understandable way. The trust was in the bottom 20% of trusts for one question, the lack of information given to patients' on support groups. The trust performed about the same as other trusts for the remaining 24 questions.

- We spoke with 14 patients currently receiving care, and some of their relatives, who told us "the care here is really good" and "the staff are amazing". Another patient said, "They [the staff] all seem to work as a team – nothing is too much trouble".

- Nurses and surgical staff on the wards, anaesthetic room and recovery were observed to be talking with patients in a respectful and caring manner, taking time to explain options and interventions to patients.

- Surgery services achieved consistently better scores than the England average for all four categories of patient led assessments of the care environment (PLACE).

- Board rounds were observed to maintain patients' privacy and dignity, with consultants and their teams discussing patients away from patients and visitors.

Understanding and involvement of patients and those close to them

- Patients at all stages of their surgical journey through the hospital felt involved in their care and in decision making about their treatment.

- Patients confirmed that they were given adequate information about the specific surgical procedure that applied to them. Risks, benefits and alternatives were explained to them.

- The trust performed about the same as other trusts for all of the questions of the 2014 CQC Inpatient Survey.

- An established patient and carer experience group was in place and was attended by the surgical ward senior matron. This meant that senior nurses ensured they were aware of patient and carer experiences in their service.

- One patient stated they had been treated in the surgery services three times for their specific condition. The patient felt that staff were competent and caring, that staff answered all of their questions and went the extra mile. After emergency surgery, the patient was given a programme of care to expect, and had been asked to give feedback on the service.

- A patient's wishes being sought was observed in the anaesthetic room, with the patient being given the opportunity to express any concerns and these being addressed prior to undergoing a general anaesthetic.

Emotional support

- Arrangements were in place to provide emotional support to patients and their families when needed. Clinical staff carried out behavioural assessments and assessments of individual psychological and emotional needs either at the pre-assessment appointment or on admission where possible. These were also completed where patients had needs associated with living with dementia.

- Staff on the day surgery unit arranged extra support before admission and discussed care with the multidisciplinary team when it was identified that patients required extra support.

- The worries and fears of patients were monitored through patient experience feedback. The most recent

figures showed that that the surgery services achieved a range of scores between 78% and 100% across all surgery services between June 2015 and November 2015.

- There was access to clinical nurse specialists, such as the enhanced recovery nurse, and stoma care nurses, as well as the colorectal nurse, breast care nurse and the palliative care team who all provided emotional support and help relating to the patient's clinical condition when required.

- There was access to the chaplaincy 24 hours a day, seven days a week for staff, patients and visitors. There was an on call system in place to ensure that a chaplain was available at all times. The availability of other faith leaders was variable and the trust was currently looking to address this. The bereavement team worked office hours between Monday and Friday.

Are surgery services responsive?

Good 🟢

Responsiveness was rated as good for surgery services because;

- Overall, lengths of stay were better than the England average.
- Surgical outliers rarely occurred.
- The surgical wards worked in tandem with each other to ensure they could admit as many patients as required.
- Theatre lists were appropriately prioritised.
- Discharge planning was effective, involving a multidisciplinary team and the patient.
- A complex discharge planning team was dedicated to facilitating discharge for patients requiring additional support at home.
- Surgery services were proactive in planning for known events such as industrial action.
- There was a high focus on meeting the needs of people living with dementia.
- There was a reduction in complaint numbers from the previous year and evidenced learning from complaints.

However;

- Referral to treatment times (RTT), for admitted patients, was below the national indicator of 90% but was better than the England average.

- There were no single sex bathrooms on surgical wards. However, given the constraints of the physical building, it had been agreed with Commissioners that this was being appropriately managed within the circumstances
- Theatre utilisation was below the England average. This was affected by late starts to operations were often due to the lateness or delay of surgeons and anaesthetists.
- Patients placed in recovery as a step-down facility from the intensive care unit had to eat, drink and use toileting facilities in recovery.

Service planning and delivery to meet the needs of local people

- Every patient waiting for treatment has the right to expect that treatment within 18 weeks of being referred, known as referral to treatment time (RTT). The national operational indicators to ensure that patients receive their treatment within 18 weeks are 90% for admitted, 95% for non-admitted and 92% for incomplete (patients still waiting for treatment but timeframe remains within the 18-week indicator)
- The trust performed well against the non-admitted and incomplete indicators. Data for September 2015 to February 2016 demonstrated that non-admitted patients received their treatment between 95.2% and 96.8% of the time. Incomplete data results were between 94.6% and 95.4%. Therefore both were within target indicators and better than the England average.
- Admitted patients results for the same period ranged between 75.9% and 83.4%. this was below the target indicator however was better than the England average which ranged between 75.8% and 79.6%
- Beds on surgical wards were within bays. These bays were used as single sex bays for patients. There were no single sex bathrooms on the wards. This was a known issue and was acknowledged on the surgery services risk register. It had been agreed with Commissioners that this was being appropriately managed within the circumstances and the trust was in the planning stages of converting a bathroom with a bath into a wet room.
- Patients were not inappropriately moved between wards in the surgery services. Bed moves were monitored monthly with night time bed moves noted to mainly take place when patients required a higher intensity of care than they were receiving on the surgical wards. For example, patients were moved from surgical wards to the critical care unit as appropriate if they deteriorated. In January 2016 there were four overnight

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bed moves within surgical services, two of these moves were to the critical care unit, one move was to recovery (which acted to stabilise patients requiring intra-hospital transfer), and one move was to the stroke unit.

- Risk of falls, dementia and mealtime assistance was indicated to staff on laminated sheets above all beds. A medium risk of falls was indicated by an amber leaf and a high risk of falls was indicated by a red leaf above the patient's bed. Patients living with dementia were indicated by a blue flower, and patients requiring assistance at mealtimes were indicated by a cutlery picture being placed above the patient's bed. This picture indication allowed staff to quickly assess and provide appropriate care whilst maintaining the privacy and dignity of patients.
- Lengths of stay had consistently been the same as, or better than, the England average for all specialities.
- An enhanced recovery pathway was implemented in 2007 and had reduced the average length of stay for patients from 11 days to five days.

Access and flow

- There were rarely surgical outliers in the trust. Female surgical outliers would be placed on ward F14, a gynaecology ward, and male surgical outliers would be placed on the acute medical unit.
- There were two routes into the emergency wards. Patients were either transferred from the emergency department (ED) or from the seven days a week general practitioner hotline to the surgical assessment unit (SAU). If there was no capacity on SAU, then patients were sent to the ED. SAU could see ED surgical patients as ward attenders, which meant they were not to be admitted at that moment in time. Patients from ED that were awaiting senior review and reaching breach times in ED would arrive on SAU and be seen there which increased capacity in ED. This allowed patients to be more comfortable in the day room on the ward whilst waiting for their review. These patients, whilst treated as ward attenders, were still reported as breaches for ED if their wait extended beyond four hours.
- Bed meetings were routinely held daily at 8am, 12 noon, 3pm and 5.30-6pm. This meant that the bed status and flow of admitted patients through the trust was understood and managed by the trust.
- Ward managers from the two elective wards, F5 and F4 liaised closely to manage the placements of patients.

This method of planning enabled elective orthopaedic cases to be mainly kept together on ward F4, and major bowel and urology cases to be mainly kept together on ward F5.

- Surgical inpatient forecasts were printed three to four days in advance. The lists detailed how many cancellations patients had previously had. It also detailed if they were rapid access patients, for example on a cancer pathway, urgent cases or routine cases. This enabled staff to manage patient flow appropriately and take into consideration previous experience and current condition.
- Elective operations were performed in all-day lists starting at 8am and finishing at 5.30pm. The lists were split into two, between 8.30am and 12.30pm, and 1.15pm and 5.15pm. Patients returned to the wards from recovery as soon as it was safe and appropriate to do so
- Theatre priorities were determined by surgeons and confirmed by 4pm the previous day on the electronic system. Children and diabetic patients were prioritised for treatment.
- If patients needed to have their operations cancelled, the waiting list team contacted patients the day before where possible and kept them informed. Cancellations were usually anticipated so patient expectations were well managed.
- Cancellations on day of surgery were identified at bed meetings. Patients would be contacted by telephone and offered new dates within 28 days of their cancellation. The process was similar for cancellations made a week in advance, new dates were confirmed with both the ward and theatre and the chief operating officer was informed. As a percentage of admissions, cancelled operations have remained below the England average since quarter one of 2014-2015. Since quarter one of 2014-2015 the England average has ranged between just under 1% to just over 1%. For the same period, this trust has ranged between just under 0.5% to just less than 1%.
- Patients who have their operations cancelled on the day were informed by the ward manager as the surgeon would be in theatre. Diet and fluids would be offered to the patient and the surgeon would see the patient as soon as possible. The trust tried to rebook the patients' surgery at the time of cancellation.
- Theatre scheduling meetings took place and reviewed all gaps, clinics and theatre and kit requirements. For

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example, some theatre lists, consisting of 24 operations, were cancelled in anticipation of planned industrial action. This increased the capacity of consultants to cover wards.

- Extra clinic and theatre lists were put in place to mitigate high ears, nose and throat (ENT) treatment waiting list.
- Dedicated trauma lists took place Monday through to Friday afternoons.
- Discharge planning started at the point of admission. The care coordinator planned discharges in liaison with social care when required, and the multidisciplinary team. One patient confirmed that the physiotherapist had spoken to them regarding their home arrangements for discharge.
- Surgical staff produced discharge summaries from the electronic patient system and sent them to the patient's general practitioner (GP) in a timely way. This meant that the patient's GP would be aware of their treatment in hospital and could arrange any follow up appointments they might need. A copy was also given to the patient along with an information leaflet with contact details if patients become concerned post discharge.
- A complex discharge planning team was in place. This consisted of one manager, seven specialist nurses, and five discharge planning practitioners. The aim of the team was to arrange discharge of patients to a safe environment with appropriate support. The team completed the NHS continuing healthcare checklist electronically. This is an assessment of the patient looking and grading mobility, behaviour, and breathing. This would be submitted for review by specialist nurses and to go through a 'decision support tool' which gave a rating on a ladder. This was then submitted to the clinical commissioning group (CCG) for ratification.
- The target for internal completion of complex discharge checklists was 10 days although this was usually completed within seven days.
- Two separate weekly reports were created regarding referral to treatment time and cancelled operations. The cancelled operations report fed into the weekly internal surgical waiting list meeting, where each cancelled operation was considered. This fed into a monthly focus group on theatre productivity. An example of an output from this meeting was the implementation of a 'call out system' that had seen a 50% decrease in dermatology and maxillo-facial call out in the first month.

- An independent review took place in July 2015 on theatre utilisation and effectiveness. The new call out system had reduced the rate of operations cancelled on the day, which was at 12% at the time of the inspection. This action was currently being audited for effectiveness.
- A dedicated lead was looking at theatre over runs and late starts on a weekly basis to see if there were themes apparent. This information was fed back to the clinical leads to take forward. The focus was on getting booking correct. Booking is now at 85%, which is in line with the trust target of theatre utilisation of 85%. Data for the period December 2015 to February 2016 shows that of 797 late starts, 255 (32%) of these were due to the surgeon or anaesthetist being late or delayed.
- Elective surgery wards had two admission intakes, the first intake being at 7am and the second at 11.30am. The day room was used as a waiting area for the 11.30am admissions. Despite this arrangement, on one of the inspection days, 10 patients were all admitted at 7am and starved for an all-day urology list. This was because the surgeon liked to see all of their patients in the morning before surgery. Patients were given a glass of water and informed they could have sips until they went to theatre. The day surgery unit also had two intakes of admission, one at 7.45am and the other at 12.30pm. This meant that flow through the unit was planned so that patients would not wait too long for their surgery.
- Theatre utilisation information was on display in theatres and was observed on the surgical dashboard. From July 2015 to February 2016, the day surgery theatre utilisation rate was 63% and the main theatre utilisation rate was 74%, below the England average of 85%.
- For the period 15 August 2015 to 31 December 2015, 101 out of 153 patients stayed over 12 hours in recovery. Fifteen of those patients stayed over 24 hours. Recovery was used 24 hours a day, and used as a step down facility from the intensive care unit to the wards. Overnight patients were placed in three bays that had monitors linked to the central monitor for ease of assessment for nurses. Recovery staffing was sufficient to take stepped down intensive care patients.
- Visitors attended recovery to see step down patients whilst other patients were in recovery post-operatively. Patients requiring toileting facilities had screens placed around their beds and commodes were used. Patients

that were ambulatory were required to walk to the nearby intensive care unit to use the toilet. Step down patients were offered food and drinks whilst in recovery which increased the risk of contamination of post-operative patients.

Meeting people's individual needs

- Family and carers of people living with dementia were granted open visiting to the wards. They were offered discounted meals whilst visiting the hospital and dedicated identification for out of hours visiting.
- A hospital passport system was in use for patients living with dementia. This meant that staff were aware of the needs of patients and the care that was provided to them in their own homes.
- There was a link nurse for dementia as well as dementia champions on the surgical wards that received extra dementia training. This meant that surgery services had staff who could share best practice and support their colleagues through additional knowledge and skills.
- Family members of staff voluntarily knitted hand muffs with small toys and items sewn into the inside, named 'twiddle muffs', as a calming method for people living with dementia on ward F3. A new twiddle muff was given to each patient and was taken home with them or disposed of on the ward. These complemented the existing selection of puzzles and distraction equipment. Music therapy was also used on ward F3 to calm and distract patients with an altered mental state.
- Patients with a learning disability were identified on the ward's white boards. This made staff aware when they needed to provide care for these patients.
- The surgery services had the use of translators when required. However a Polish speaking nurse was observed speaking to a patient who was confirmed to be receiving a poor prognosis. Patient information leaflets were observed on the ward in Polish and were available on the trust's intranet in other languages.
- Information regarding venous thromboembolism and anti-embolism stockings was given to patients at their pre-operative assessment. Personalised procedure leaflets, pain advice leaflets and a bleep number for the site coordinator were provided to patients discharged from the day surgery unit with post-operative advice, as well as a pain leaflet. This meant that patients were given the information and advice to manage their post-operative experience at home, with additional support if required.

Learning from complaints and concerns

- For the period October 2015 to December 2015, surgery services had received 18 complaints which was a reduction by 12 complaints compared to the previous three months. The main trend identified in these complaints was around communication with patients. A quarterly report was produced by the senior matron that identified numbers of complaints according to departments and locations within surgery, trends identified, and actions taken in response to those complaints.
- Staff were aware of the complaints process and what to do if they received a complaint. Written complaints were sent to the complaints department. A request would be made from the appropriate ward or location within surgery to provide a response to the complaint within 10 days. The response would then be overseen by the chief executive who would personally reply to the complainant. Where complaints were face to face, complainants were offered a form for completion by either a member of staff or the complainant, to be sent to the complaints department. The complainant would also be offered the opportunity to speak to the patient advice and liaison department (PALS).
- Learning from complaints was observed in ward manager's newsletters and staff communication folders.

Are surgery services well-led?

Good ●

Well-led was rated as good in surgery services because;

- There were structured meetings between ward and board level where governance issues were discussed and followed an assurance pathway.
- Information and learning was shared with all staff through various methods of communication, and staff felt informed.
- Ward managers had an understanding of incidents, complaints and risks for the areas they managed.
- Leadership was strong. Staff felt that the chief executive was visible and available to them.
- Ward managers were active in recruiting and developing their own staff.

Surgery

- There was a strong culture of teamwork and collaboration amongst all staff groups within surgery services.
- Innovative ideas were developed by front line staff and were celebrated as successes.

However;

- Although risks were discussed in governance meetings, recording of this was poor and we could not be assured that risks received appropriate scrutiny.
- Some members of staff were not aware of risk registers for the areas they worked in.

Vision and strategy for this service

- The trust vision consisted of one vision to deliver the best quality and safest care for the community. There were three priorities relating to this vision, to deliver for today, to invest in staff and leadership and to build a joined-up future. Seven associated ambitions were derived from these priorities around delivering personal, safe and joined up care, and supporting healthy starts, healthy lives, aging, and staff. When asked about the trust's vision, staff referred to putting patients first. Staff also referred to the seven ambitions although they could not name them.

Governance, risk management and quality measurement

- A quarterly clinical safety and executive committee was fed into by monthly surgical clinical governance steering group meetings, a monthly audit meeting and monthly divisional performance meetings. Quality, safety and patient experience were overseen by both the junior and senior matron in surgery, and a performance review was completed by the matrons monthly.
- The surgical clinical governance group reviewed; incidents and root cause analysis reports, audit and survey results and updates on guidelines. They also reviewed all complaints, and national recommendations and specialist reports. Minutes from these meetings showed that discussions took place concerning pharmacy and infection prevention and control reports.
- Dissemination of information and sharing of learning occurred via monthly newsletters created by each ward

manager. These included audit results. Newsletters were observed on wards, information on notice boards in theatres and communication folders throughout the service for staff.
- Live risks were a standing agenda item at the monthly surgical governance steering group meetings. Minutes of these meetings showed that brief discussion of the risk register took place but did not provide assurance that individual risks were scrutinised.
- Ward managers were aware of their ward's current risks. For example, one ward manager referred to only nine beds having piped oxygen on their ward and the rest having cylinder oxygen, stating that this had been entered onto the risk register. Upon checking the risk register this item was observed to be present. Theatre managers were able to demonstrate their risk registers and what actions were being taken against any live risks. However, not all staff knew what the risk register was. Three staff nurses and one health care assistant did not know that risks were entered onto a register for monitoring.

Leadership of service

- Staff, inclusive of health care assistants and nurses, felt that the chief executive of the trust was visible, approachable and involved in the surgery directorate.
- Five members of staff from across the service stated that senior managers have an open door policy.
- Managers and nurses in charge were informed and supported by the senior matron, who had set up regular meetings. Ward managers also received monthly one to one meetings with the senior matron. Due to the success of the nurse in charge meeting staff nurse level meetings with the matron were planned.
- Ward managers were actively involved in recruiting their own teams and expressed pride in their staff. Staff felt supported by their ward managers in their development.
- The trust had engaged with staff ahead of the implementation of a new electronic care record was taken. This system was not implemented at the time of the inspection; however some staff concerns centred on the time allowed for decreased productivity as staff got used to the new system.

Culture within the service

- There was a positive culture between all staff groups in the surgery services.

Surgery

- A range of staff inclusive of health care assistants, nurses, doctors and managerial staff highlighted collaborative working, feeling appreciated and enjoying work.
- Senior nurses felt able to highlight concerns and one ward manager gave an example of raising concerns in the past that were listened to and actioned.

Public engagement

- There was consistent patient representation at the monthly surgical clinical governance steering group meetings. This meant that patients' voice was heard when reviewing issues within the surgical service. During Spring 2015 the trust ran a consultation to engage staff, patients and the local community for views on its proposed vision, priorities and ambition, 'Our patients, Our hospital, Our future, together'.

Staff engagement

- The chief executive undertook regular walk arounds to ensure that staff felt engaged in proposed changes and published a regular blog.
- The trust was in the top 20% of trusts for staff engagement and recommendation as a place to work or receive treatment in the last NHS staff survey. It was also one of only 41 trusts nominated for HSJ 100 best places to work during 2015.

Innovation, improvement and sustainability

- A trend of comments regarding noise at night on ward F4 led to the development of a tray by a healthcare assistant. The tray, named a Rosevital tray, contained sanitising wipes and a pair of earplugs, and had led to a decrease in noise at night complaints. The trust had rolled out this initiative and had received an award from the patient experience network for this initiative. There were plans to start including an eye mask to the tray. This initiative has led to an ongoing project to replace bins with soft closing devices to reduce noise at night.
- A service for patients wearing hard collars, following neck injuries, had been set up on ward F3. Patients could attend as ward attenders to have their collars removed safely and receive checks for pressure sores, washes and shaves (for men) and have their collars refitted. Staff told us that this service was not available in the community due to the competencies required when caring for patients in hard collars. The service took place in the discussion room on F3 and staff recorded this on a daily whiteboard however there was no funding or formal monitoring of it.

Critical care

Safe	**Good**	🟢
Effective	**Outstanding**	☆
Caring	**Good**	🟢
Responsive	**Requires improvement**	🟠
Well-led	**Outstanding**	☆
Overall	**Good**	🟢

Information about the service

The critical care unit at West Suffolk Hospital is a bright and well-equipped unit with capacity for nine patients in six bed bays and three side rooms. The unit is funded to provide care for six intensive care, level three patients and two high dependency level patients. There is a fully equipped paediatric stabilisation bay in the unit, including paediatric resuscitation equipment. Each bed bay or side room can be configured to provide 'barrier nursing' for highly infectious patients. A post-anaesthetic care unit has two bed spaces, which can be used to care for critical care patients when the main unit is full.

Between April 2014 and May 2015, 533 patients were admitted to critical care. The unit had an average occupancy rate of 84% between January 2015 and January 2016. There is 24-hour, seven-day cover from a team of consultant intensivists who provide on-site cover from 8am to 5pm daily and until 8pm on weekdays.

The unit receives both elective and emergency patient admissions, from all wards, theatre and the emergency department. There are two beds in the post anaesthetic care unit (PACU) used for critical care patients when the main unit is full to capacity.

During the inspection we spoke with seven doctors, 10 nurses, professional development nurses, the senior leadership team and the physiotherapist, pharmacist and dietician assigned to the unit. We also spoke with five relatives and three patients. We looked at the results of patient surveys and staff research, incident reports, minutes from governance meetings, 12 patient records and 38 other unique pieces of evidence to come to our rating.

Critical care

Summary of findings

Overall we rated critical care as 'good'. Safe and caring were rated as good, effective and well led rated as outstanding and responsive rated as requires improvement.

This reflects consistently good staffing levels of doctors and nurses, which met the safe standards established by the Faculty of Intensive Care Medicine, the Royal College of Physicians and the Royal College of Nursing. Two dedicated professional development nurses managed mandatory training in the unit and provided substantial development support and opportunities to nursing staff.

There was consistent, seven-day input from a multidisciplinary team of specialists. This included a consultant microbiologist, dietician, physiotherapists and occupational therapists. The standard of medicine management was very high and the unit had a dedicated full time pharmacist. A follow-up nurse, audit nurse and technologist significantly extended the scope and effectiveness of the critical care service.

Staff practiced evidence-based care and treatment based on the best practice guidance of the National Institute for Health and Care Excellence and developed plans to improve the service by using the results of local and national audits.

There was a demonstrable focus on providing individualised care based on feedback from patients and their relatives and from the outcomes of pilot projects conducted by critical care staff. Additional support for critical care patients was provided by a follow-up nurse and a critical care outreach team, who also provided a cross-department education programme.

Staff were encouraged and supported to undertake novel research projects, which they were able to present at national conferences as a knowledge-sharing strategy. Senior staff had developed a robust five-year service plan in collaboration with unit staff, which was further evidence of the cohesive and supportive work culture we found.

Dedicated housekeeping staff maintained a very high level of cleanliness and hygiene and infection control evidence reflected this.

There were a number of areas within the service we judged to require improvement. For example, staff did not always understand or use incident reporting processes and investigations did not always result in demonstrable learning. There was a lack of governance in relation to incident reporting and how the senior directorate team acted on these. This included failing bedside computer equipment, which staff had escalated as a risk through a business case for new equipment.

The principles of infection control were not always evident in the unit for a patient who was potentially infectious. Staff did not always provide continuous and appropriate supervision for high dependency level two and level one patients when they were cared for in side rooms.

Critical care

Are critical care services safe?

Good ●

We rated critical care at West Suffolk Hospital as good for safe:

- The number of doctors and nurses allocated per shift met the requirements of national critical care organisations and ensured patients were appropriately reviewed.
- Staff knowledge of the principles of safeguarding was good and this was embedded in their practice and documentation.
- Medicine management was particularly robust and was led by a dedicated full time pharmacist.
- Mandatory training was monitored and kept up to date by two professional development nurses, who also provided additional specialist and ad-hoc training for staff.
- Cleanliness and hygiene standards were consistently maintained by a dedicated housekeeping team.
- Staff adhered to trust guidance on the care of deteriorating patients and used appropriate tools to assess this. Escalation strategies relating to deteriorating patients were in place and we observed staff use them appropriately. The critical care outreach team provided rapid reviews of deteriorating patients and support to ward staff.
- The unit was a paperless environment and professional development nurses and a pharmacist had built an electronic patients record and clinical information system to meet the complex recording and diagnostic requirements of critical care patients.
- An established major incident and emergency plan was in place, which staff demonstrated awareness of.

However we also found,

- There was not a consistent or robust approach to reporting and investigating incidents. Learning from incidents was not always clear or disseminated appropriately.
- Patients were not always protected from risks associated with infectious conditions because a robust policy was not in place to proactively manage infection risks.

Incidents

- Staff reported 103 incidents between December 2014 and November 2015. 86 incidents resulted in no harm to patients. Senior staff tracked incidents to help identify patterns. The most common incidents related to pressure ulcers, clinical care and treatment and medication. There were no serious incidents (SIs) or Never Events between October 2014 and November 2015. Never Events are serious, largely preventable incidents involving patient safety that can be avoided through adequate safety systems.
- Staff did not always have an understanding of the need for incident reporting in the event of clinical complications or unplanned events. For example, during our inspection a patient deteriorated suddenly and required emergency ear, nose and throat (ENT) specialist support to stop a bleed and support intubation. Staff reacted to the situation appropriately to stabilise the patient but did not record this as an incident. We spoke with nurses about this and found a lack of appreciation that whilst the bleed was a known complication of the patient's treatment, harm was caused and needed to be investigated to identify possible improvements in practice and learning. This meant staff could miss opportunities to learn and develop because incidents were not always reported.
- We asked staff about the incident-reporting culture. A nurse told us incident reporting was not covered in their induction or supernumerary period. They said, "I hadn't heard of the electronic incident reporting system until my second month working here. The computer screen of a patient failed and another nurse said we should report it. That was the first time anyone had mentioned it. The incident reporting seems subjective, it's up to the doctor or nurse and whether they want to report it." Three members of staff said they were not aware of a formal policy regarding the reporting of incidents. This meant we could not be sure staff reported incidents consistently or senior staff had an awareness of how many reportable incidents occurred.
- Staff had implemented learning from an investigation relating to a pressure ulcer. For example, one patient developed a pressure ulcer on their nose as a result of an oxygen mask. To reduce the risk in future, staff trialled and then implemented the use of a mask with a gel rim, which reduced pressure on the nose. This

represented substantive learning from an incident but not there was a lack of consistency in how involved individual members of staff felt they were included in communication about this.

- Senior staff shared learning from incidents or unexpected events reactively rather than proactively. For example, although managers and the clinical lead discussed outcomes of incidents, this did not form part of scheduled routine safety briefings or a structured way to obtain staff feedback on safety related policies and procedures. This meant although the working culture was based on safety, senior staff did not actively seek to improve or develop this in the absence of incidents or problems. Nursing staff were not able to tell us how feedback from incident investigations was disseminated and could not provide examples of learning from previous incidents.

- Where an SI had occurred, the clinical lead and clinical service manager adhered to the National Patient Safety Agency (NPSA) National Framework for Reporting and Learning from Serious Incidents Requiring Investigation and appointed an appropriate investigator. This individual was responsible for the creation of a multidisciplinary team to ensure learning took place. For example, following an SI involving a paediatric patient, senior critical care staff had engaged paediatric specialists from another hospital in the critical care network who provided staff with simulation training based on the incident. This was used to scrutinise staff skills and highlight learning opportunities from the incident. Following this, professional development nurses provided a series of in-house training sessions on learning from the incident.

- Senior staff focused on the awareness and response of nurses following a serious incident involving the death of a patient. The learning provided to staff was appropriate based on the investigation of the incident and led to a greater awareness of risks associated with unpredictable patients. For example, nurses considered risks associated with bed rails and unpredictable behaviour during risk assessments to keep people safe.

- We spoke with the clinical director about incident reporting. They told us incidents were discussed as part of monthly morbidity and mortality (M&M) meetings and results were disseminated by e-mail and said improved reporting to the National Reporting and Learning System was an area for development.

- The electronic incident reporting system included a prompt for staff to use the Duty of Candour to ensure they discussed incidents with patients and relatives. Senior staff had a good understanding of the time scales involved in the Duty of Candour process.

- Clinical staff and managers attended a mortality and morbidity meeting (M&M) every six weeks, which was used to discuss all deaths in the previous month. Nurses and doctors identified morbidities to be discussed at M&M meetings as part of the discharge process. For example, one M&M meeting was used to discuss any gaps in care, which may have contributed to the need to transfer a patient to another hospital. Staff recorded this discussion and identified no omissions in care. Nurses, doctors, the critical care pharmacist and technologist and other specialists routinely attended the meetings.

- Staff used M&M meetings to assess practice and identify areas for improvement. For example, staff introduced new catheterisation equipment and updated the chest drain insertion guidelines and checklist for use out of hours following an M&M review.

- Senior staff used unit meetings to encourage more consistent M&M representation from nurses. Learning from incidents was also discussed during M&M meetings and staff identified opportunities for improvements in practice as a result.

- A monthly staff newsletter included details of incidents and investigating staff used this as a method disseminating learning. Although this represented part of a number of opportunities for staff to learn about the outcomes of incident investigations, our conversations with staff indicated dissemination of this information could be improved.

- The clinical services manager or clinical lead always followed up a Duty of Candour discussion with a letter outlining this to the people concerned.

Safety thermometer

- The service reported one new pressure ulcer and one fall with harm between September 2014 and October 2015. There were no catheter-acquired urinary tract infections.

- From April 2015 to January 2016, 100% of new patients received harm-free care.

Critical care

- Staff assessed each patient's level of risk for venous thromboembolism (VTE) assessed within 12 hours of admission. The audit nurse conducted a monthly audit of this. Between April 2015 and January 2016, 100% of new patients had a complete VTE assessment.
- Safety thermometer data was displayed in the unit but was not easily visible.

Cleanliness, infection control and hygiene

- Housekeeping staff and nurses used brightly-coloured 'I am clean' stickers to indicate when an item of equipment had been cleaned and was ready for use. The team also completed a 32-item 'clean and green' check every 48hours, which included a check of the expiry dates of alcohol gels and hand wash and the condition of the sluice room.
- The unit was visibly clean and tidy and housekeeping staff attended quickly to risks posed by spillages. The sluice room and toilets were visibly clean and tidy and commodes were disinfected and labelled as ready for use. Staff consistently used personal protective equipment.
- Two housekeeping staff provided a dedicated service to the critical care unit. Both staff were trained in infection control procedures and we saw they adhered to these stringently. For example, staff cleaned uninfected areas before the barrier nursing rooms. This reduced the risk of cross-infection. The housekeeping team demonstrated an excellent awareness of the need for thorough cleaning of equipment and adherence to trust cleaning protocols. One housekeeper said, "I feel part of the critical care team and think we communicate very well with each other. I'm proud of the job we do here and we look at the quality audits to make sure we obtain 100% every time." Staff completed electronic records of daily damp dusting and of weekend cleaning tasks.
- Staff completed and recorded daily flushing of taps according to legionella prevention methods. Daily checks had identified the growth of pseudomonas in some taps and staff had taken action by fitting appropriate filters to the affected taps.
- During the inspection one patient who presented a potential infection risk to others was cared for in an open bed space despite a private side room being available. We asked the nurse in charge about this. Their approach to the situation was reactive rather than proactive and they told us they were waiting for test

results to be returned before making a decision about moving the patient. We were not confident from our discussion or observation of this patient that staff adhered to best practice in infection control.

- The unit did not have a policy or risk assessment process for the management of patients with diarrhoea, which meant staff did not always respond to infection control risks consistently. For example, we found staff had taken a stool sample from a potentially infectious patient but had not sent it for analysis immediately. They were not able to explain this or to identify the potential risks in the delay. Although the sample sent for testing indicated good practice, this represented a reactive approach to infection control. A proactive approach to reducing infection risks could have been achieved if staff had been more responsive to the situation and moved the patient into a side room as a precaution.
- Doctors used the aseptic no touch technique (ANTT) whenever they accessed lines to reduce the likelihood of cross-infection.
- An audit nurse led nine monthly audits of infection control patient safety indicators. This included high impact interventions and the results were disseminated widely to praise good work and to indicate where improvements could be made. Audit results from April 2015 to January 2016 indicated staff consistently adhered to trust best practice guidance. For example, the audit nurse found 100% compliance in every month in central venous catheter insertion and ongoing care; Clostridium difficile (C.Diff) prevention measures and peripheral cannula insertion and ongoing care. They found 100% compliance with ventilator associated pneumonia care in every month except May 2015 where compliance was 90%.
- Hand hygiene audit results from April 2015 to January 2016 showed the trust target of 95% had been exceeded in every month except July 2015, where compliance was 91%.
- The unit reported no MRSA infections and no unit-acquired C.Diff infections in the 12 months prior to our inspection.
- The audit nurse monitored monthly feedback on the environment and cleanliness on a monthly basis, which could be provided by patients and their visitors. From May 2015 to January 2016, patient and visitor feedback indicated an average of 95% satisfaction.

Critical care

Environment and equipment

- A dedicated equipment technologist was based in the unit five days a week, provided support to staff and maintained clinical equipment to manufacturer standards. This member of staff worked closely with the electro-biomedical engineering department (EBME) to ensure business continuity in the event of equipment failure and to ensure the unit adhered to the trust's medical equipment management policy. The technologist had previously worked in the unit as a nurse assistant, which meant they had sufficient clinical context and understanding to develop equipment protocols and training.

- The technologist worked collaboratively with nurses to introduce practices based on developmental evidence. For example, to improve the management of blood glucose in patients with sepsis, equipment had been modified to switch off if a nurse had not confirmed a check of blood sugar every 20 minutes. This member of staff worked with professional development nurses to provide one-to-one training and support for staff on the use of equipment and accompanied staff and patients to CT scans on request.

- The EBME team conducted an audit in 2015 to check the unit's adherence to trust equipment management policies and to check the levels of maintenance, asset control and staff training. The outcome of this audit was rated 'good' and there were no corrective actions for the critical care team.

- The technologist completed portable appliance testing (PAT) on electrical items. We checked 32 items of equipment and found all but one item to have an up to date PAT test label.

- We looked at the equipment and environment of a vacant level three bed space and saw staff had completed equipment readiness checklists, including cleaning.

- An airway trolley, resuscitation trolley, emergency transfer trolley and grab bag were available on the unit. We looked at documentation relating to these and found the technologist documented daily checks of their serviceability and equipment and drugs stock. The technologist documented corrective action where a problem was found.

- A paediatric bay was available in the critical care unit. This bay was equipped with specialist paediatric equipment, included resuscitation equipment. The equipment technician documented daily and weekly functional equipment checks which were all up to date with no gaps in recording for the previous six months.

- Oxygen cylinders were stored on the unit safely, with documented checks and appropriate cylinder holsters intact.

- Senior staff had identified the casing of the bedside computer monitors as a significant governance and safety risk. The monitors had passed their warranty date and staff noted they had begun to fail. Although the clinical services manager had prepared a business case for their replacement, the trust had not yet acted on this.

- The critical care unit predated the Department of Health Building Notes (HBN) and the high dependency unit bed bays did not comply with HBN 04-02 or HBN 00-09 in relation to available space and infection control standards. Staff mitigated this risk by complying with the principles of the HBNs whenever reconfiguring bed spaces and side rooms and had prepared a business case for the expansion of the unit. The clinical services manager had completed a scoping and consultancy exercise to consider novel methods of using the space available in a way that would comply with current HBNs, such as the use of isolation pods. As part of the mitigating strategies, staff were reminded to identify trip hazards regularly and were required to maintain tidy workspaces, which we observed in practice.

- Staff demonstrated a quick response to information released from the central alerting system. For example, when an alert was issued about the use of a type of face mask, the unit's PDNs and technologist initiated new competency-based training for all staff.

Medicines

- Medicines were stored securely with access limited to nursing staff. Controlled Drugs which require special storage and recording were stored following best practice procedures including daily checks by two nurses on quantities and records. Medicines requiring cool storage were stored appropriately in locked medicine refrigerators. Daily temperature records for the medicine storage room and for the medicine refrigerator documented medicines were stored within safe temperature ranges.

- A dedicated critical care pharmacist who was also a Non-Medical Prescriber (NMP) was based full time on

the ward five days a week. They were involved in ward rounds, clinical decision making and discussions with doctors and nurses about patients' individual medicine requirements. They helped identify medicine issues which could be dealt with immediately.

- Learning from medicine incidents was discussed, shared and communicated by the critical care pharmacist to unit staff.
- The pharmacist was highly regarded by clinical staff and provided out of hours on-call support when needed. They also provided ad-hoc supervision and training for staff and supported investigations and training following medication errors. For example, if a member of staff was involved in a drugs error, the pharmacist and a professional development nurse offered a one-to-one discussion with the individual involved and facilitated a reflective exercise to identify what might have contributed to the error. The pharmacist disseminated learning from this.
- Between April 2015 and January 2016, staff reported 13 medication errors.

Records

- Staff used an electronic clinical and patients records system as the result of a period of transition to make the unit paperless. The unit's pharmacist and professional development nurses had built the system to the specific needs of critical care patients. These individuals used protected time to actively maintain the system, update existing information and add new policies.
- The electronic records included links to treatment algorithms, a drug library, and links to national guidance and trust policies.
- We reviewed 12 patient records. In all cases staff had completed appropriate risk assessments and care bundles, which were updated according to individual need.
- Staff involved in patient treatment were encouraged to document conversations with relatives, including when staff had started a patient diary. We found this to be the case in all but one of the records we looked at.

Safeguarding

- All new staff undertook a mandatory initial training course in safeguarding and 95% of critical care staff had up to date mandatory training in adult safeguarding. Ninety-three percent of critical care staff had up to date child safeguarding training and 100% of the critical care

outreach team had up to date training in both child and adult safeguarding. All of the staff who provided care for critical care patients in the post-anaesthetic care unit (PACU) had up to date training in both child and adult safeguarding.

- Staff had a demonstrable understanding of the principles of safeguarding and gave numerous examples of how they adhered to these in practice. For example, a nurse explained how they had worked with senior staff, the police and the psychiatric liaison team to establish if a patient found bruised at home had been assaulted or had injured themselves due to deteriorated mental state. The nurse had completed a safeguarding and vulnerable person's assessment but felt disappointed they had not received feedback from their safeguarding report.
- A nurse had liaised with the local safeguarding team after becoming concerned about the welfare of the relative of a critical care patient, particularly in relation to their housing situation.
- Advice on safeguarding issues and how to obtain a referral to the trust or local authority social care safeguarding team was readily available through the clinical information system. Staff demonstrated they could access this rapidly when needed.

Mandatory training

- Critical care staff, the critical care outreach team and PACU staff had a mandatory training target of 90% for each team. Mandatory training included infection prevention, basic life support, moving and handling, medicines management and fire safety. Each team met this target for every course, with the exception of classroom infection prevention (80%), classroom fire safety (80%) and moving and handling (70%) training for the outreach team. The figures had been impacted by recent staff changes in the team and refresher training was scheduled imminently.
- Two dedicated professional development nurses (PDNs) were responsible for the mandatory training programme of critical care staff. They supplemented the basic initial training provided by the trust with practical specialist training in the unit. This included manual handling training delivered by a trainer who used the critical care unit's own equipment to provide instruction.
- PDNs supported critical care outreach (CCOT) nurses with degree modules and provided practical assessments as part of this support.

Critical care

- The CCOT team offered regular critical care outreach study days for ward nurses and junior doctors. Although this was not mandatory, the CCOT team had presented this as a recommendation to the matron team. They told us this had been successful in part and an increased number of new staff began attending the study days.

- All nursing staff had completed basic life support training and conflict resolution training. This included breakaway training to protect themselves, without harming the patient, if they were attacked. The training also included guidance on how to diffuse situations through the use of effective posture and body language.

Assessing and responding to patient risk

- Staff across the hospital used the Modified Early Warning Scores (MEWS) and Situation Background Assessment Recommendations (SBAR) to identify deteriorating patients and escalate them to CCOT for review. Staff readily used both tools during our observations of bedside handovers.

- Consultants, doctors and CCOT discussed deteriorating patients during daily morning handovers. During handover staff from different specialties contributed to the sick patient list held by CCOT nurses, which they prioritised for review based on their MEWS. CCOT nurses used this meeting to escalate deteriorating patients to the critical care consultant for review.

- Admitting doctors used the SBAR tool to contribute to the daily plan and to identify patients who were at risk of deteriorating. This multidisciplinary approach to treatment planning meant patients who were very sick or deteriorating were seen by a critical care nurse or doctor rapidly.

- Out of hours, ward staff used a graded response strategy (GRS) to help them assess deteriorating patients in conjunction with assessing the MEWS. Outreach nurses had identified a gap in knowledge amongst agency nurses with regards to GRS and MEWS and visited wards overnight staffed largely by agency nurses to make sure they were monitoring sick patients appropriately.

- A nurse handover took place twice daily. This consisted of an overall handover for the whole unit, including the resuscitation status of each patient and a discussion of any patients being cared for under barrier nursing. Staff also discussed a brief overview of patient conditions, which was supplemented by a more detailed handover at each patient bedside. This included a check of baseline observations including safety checks of infusion pumps and oxygen. Staff also checked the patient had up to date risk assessments for falls, pressure ulcers and nutrition.

- Staff treated patients with delirium according to best practice guidance, using guidelines specific to ventilated and non-ventilated patients

Nursing staffing

- A team of 52 nurses worked in the unit and were led by three senior band seven nurses and a band eight dual-role matron and clinical service manager. The number of nurses represented a very small shortfall of 0.8 whole time equivalent (WTE) staff identified as the ideal established number. The recovery unit was staffed by 21 nurses and had a shortfall of 0.5WTE. This meant there were always sufficient nurses to provide care and treatment for patients based on safe recommended levels in the main critical care unit and when patients were cared for in the post-anaesthetic care unit (PACU).

- Nurse staffing levels were allocated based on the acuity of patients and adhered to the guidance of the Royal College of Nursing and Intensive Care Society. This included a nurse to patient ratio of 1:1 care for level three patients and a nurse to patient ratio of 1:2 care for level two and level one patients. If a level two patient had a tracheostomy tube fitted, the senior nurse in charge ensured the patient received 1:1 nurse support.

- A healthcare assistant was available in the unit three days per week and assisted with stock-taking duties and moving and turning of patients.

- Nurses worked within a robust team system, which included lines of accountability and support. For example, band five nurses were mentored by band six nurses who in turn had supervision and appraisals with band seven nurses. This system ensured nurses were able to access timely support and guidance when needed.

- A patient who was being nursed according to a barrier model in a side room for infection control purposes told us it was more difficult to attract staff attention at certain times of the day. They said as they needed the support of three staff to be mobilised between their bed and a chair, they sometimes had to wait a while for staff to help them.

Critical care

- Nurses were allocated specific patients for their shift based on their knowledge of the individual, their treatment and the competency and skill set of the nurse.

Medical staffing

- A team of 12 consultant intensivists worked in the unit, led by the clinical lead. Some of the consultants acted as the clinical lead for specific areas such as critical care outreach, clinical tutoring and research.
- Consultants were available in the unit between 8am and 5.30pm seven days a week, with on-call consultant cover provided overnight. On weekdays, one junior doctor was available from 8am to 8pm and two to three junior doctors worked 8am to 5.30pm. On a weekend one consultant was in the unit from 8am to 5.30pm, one junior doctor worked 8am to 5.30pm and another from 8am to 8.30pm. Overnight up to three junior doctors were available in the unit.
- A consultant was available 24 hours, seven days a week in the unit within 30 minutes of being called. This meant the unit met the requirements of the Faculty of Intensive Care Medicine.
- A consultant led a ward round daily at 10.30am, which was attended by staff appropriate to each patient's individual care including junior doctors and nurses.
- A consultant reviewed each patient within 12 hours of admission, after which time care and treatment was led by a consultant intensivist.
- The junior doctors' induction and orientation pack included details of the escalation procedure when they needed consultant support as well as examples of treatment pathways and protocols and care bundles.
- A clinician with advanced airways skills was always immediately available on site.
- A consultant intensivist dedicated time to the CCOT team when they needed specialist medical advice. Although this role was unfunded, the consultant attended CCOT meetings and was supported by the critical care clinical lead. Out of hours, the senior nurse available as part of this service said they referred to the site medical registrar or the on-call critical care consultant.

Major incident awareness and training

- The induction programme for new staff included a briefing on the fire exits and emergency procedures.

- Senior staff in charge of shifts were clear of their roles in the event of a major incident. Rapid-access information cards were posted in the unit, which staff could refer to during an emergency to help ensure continuity of care and patient safety were maintained. Staff were aware of their responsibilities in an emergency and could explain their actions and primary evacuation routes.
- The critical care unit was secured with swipe-card access for hospital staff. Access to visitors was controlled by staff in the unit who only granted access after verifying the identity of the visitor. Staff said that out of hours security provision was very responsive. There were no recorded incidents relating to the security of the unit in the 12 months prior to our inspection.

Are critical care services effective?

Outstanding ☆

We rated critical care at West Suffolk Hospital as outstanding for effective because:

- Staff demonstrated a consistent approach to evidence-based care through the use of a comprehensive range of local audits used to assess and improve services.
- A dedicated audit nurse was based in the unit who ensured audits were timely and consistent. The audit programme resulted in a sustained and focused improvement in practice.
- Staff benchmarked care and treatment against national care and treatment standards established by the National Institute for Health and Care Excellence, the National Dietetics Association and the British Thoracic Society.
- Dedicated professional development nurses worked closely with the critical care team to support and encourage on-going progression in skill competencies. A wide range of specialist training was available to nursing staff, who were able to establish special interest groups based on areas of professional practice they were interested in developing. The work of the groups contributed significantly to the development of policies and practices.
- Multidisciplinary working was clearly embedded into the work of the unit. A range of services were available on a 24-hours, seven days basis including

physiotherapy, occupational therapy and microbiology and liaison teams were accessible for patients with alcohol or drug-related needs. This contributed significantly to patient care and treatment.

- Staff had established a robust approach to meeting the requirements of the Mental Capacity Act (2005) when assessing patients for capacity. Professional development nurses ensured guidance for staff in relation to this was readily accessible, electronically, using the clinical information system.

However we also found,

- The unit experienced an increase in reported mortality rate in the previous 12 months, influenced by a rise in unplanned surgical admissions.
- Ward rounds did not always have a dietician in attendance.
- A consultant was available to support the critical care outreach team but this was an informal arrangement as the team was not funded for a doctor.

Evidence-based care and treatment

- The Critical Care Outreach Team (CCOT) and the critical medical and nursing teams adhered to guidance from the National Institute for Health and Care Excellence (NICE) relating to the care of deteriorating patients according to NICE 50. The CCOT team had developed a risk assessment tool for the transfer of sick patients, such as when they needed to be moved for a CT scan. They shared this tool with their medical colleagues across the hospital, who were able to request a CCOT escort during such transfers.
- The follow-up nurse and physiotherapists ensured the unit adhered to NICE clinical guidance 83 relating to the provision of a rehabilitation prescription to each patient on discharge. A senior occupational therapist (OT) led an 18 month audit to assess if the OT team met the requirements of NICE 83 in relation to the rehabilitation of the critically ill patient. This audit was due to be completed in March 2016 and demonstrated the commitment of specialist staff to ensure work practices were evidence-based and focused on patient-centred outcomes. The audit involved a review of the notes of 50 patients and was over 50% complete at the time of our inspection. The OT team attended a weekly critical care board round and patient reviews contributed to the audit.

- Professional development nurses, the unit's pharmacist and teams of special interest nurses ensured the availability of policies and procedures through the unit's electronic patient records system, including the maintenance of policies in line with trust and national guidance. One nurse said this worked well and that they found policies and protocols to be readily accessible. They said they recently needed rapid access to the total parental nutrition and renal protocol and found this very quickly, noting it had been recently updated.
- Dietetic support was provided by a dietician who was a member of the National Dietetics Association, which meant dietary support was in line with national best practice guidance. This individual also audited the nutrition care bundle audit and assessed outcomes in patients where feeds had been started or increased.
- Senior staff presented and discussed the results of 19 local audits during monthly governance meetings. From looking at the minutes of six meetings, we saw the audits included hand hygiene, safety thermometer, falls, complaints, and medication errors and ventilator care bundles.
- Staff were actively engaged with the East of England Critical Care Operational Delivery Network. They monitored the unit's compliance with the critical care national service specification standards adhered to by the network. The criteria consisted of 105 standards of service provision, which focused on distinct areas of critical care including admissions and discharge processes, medical staffing cover and the availability of multidisciplinary specialist staff. The senior team monitored the unit's performance against the criteria and in 2015 they achieved 96% compliance.
- The unit adhered to the guidance set out in regulation 9 and regulation 12 of the Public Health England microbiology audits, in relation to patient-centred care and safe care and treatment. Staff met the regulations through daily input from a consultant microbiologist, engagement of a home intravenous antibiotic team on discharge and the sharing of incidents using the trust-wide incident reporting system.
- A consultant intensivist was leading a local audit in lung protective ventilation and another consultant recently completed an audit of methylene blue treatment for septic shock. Staff used local audits such as these to contribute to best practice and to explore strategies to improve patient outcomes through leading-edge treatment.

Critical care

- The critical care outreach team supported ward staff to conduct local audits in their use of the modified early warning scores (MEWS) system with deteriorating patients. CCOT nurses were able to conduct ad-hoc audits as a method of exploring and improving practice. For example, they conducted an audit of a patient with their own non-invasive ventilation machine to ascertain if the patient could manage alone. They also conducted oxygen audits in line with British Thoracic Society guidance and sepsis audits.
- Nurses followed the diabetic ketoacidosis protocol and use innovative practice in space glucose control. This had been developed in the unit by staff as a method of glycaemic control in patients with sepsis and the unit was the only site in the critical care network to have this.
- Nurses were organised into special interests groups, such as diabetes, renal care, pain, paediatrics, and organ donation and infection control. 14 special interest groups were in place and nurses were able to establish groups based on their own professional interests. The special interest group members were responsible for developing new policies in their interest area and disseminating these through established communication channels and ad-hoc training sessions.
- The work of the groups had resulted in improved care and treatment processes. For example, the spinal care group launched a new care bundle for the initial phases of spine function and the tracheostomy group launched a new care bundle for tracheostomy care. The tissue viability group revised the assessment process for pressure area care and implemented a new care bundle.
- Staff in the unit demonstrated a proactive approach to trialling new care and treatment processes. For example, the PDNs and technologist liaised with an equipment manufacturer to pilot the use of closed suction non-invasive ventilation circuits, which the unit did not usually use. Following the successful trial period, this had been implemented as a standard care protocol.

Pain relief

- Staff were developing a pain agitation delirium bundle, which would enable them to streamline care and treatment for patients who experienced pain-induced delirium. This care bundle was also intended to support staff in caring for patients whose delirium resulted in violence and aggression.

- Clinical staff had implemented the Faculty of Pain Medicine's core standards for pain management, which we saw used in practice.
- Each patient had a pain score in their electronic notes, which staff updated regularly.
- Staff had access to a chronic pain management team on an on-call basis.
- A nurse-led pain management special interest group had been established to ensure patients had access to appropriate and effective pain relief.

Nutrition and hydration

- Patients in the unit were offered regular drinks and meals at appropriate times. All of the patients we spoke with told us they were pleased with the quality of food.
- Staff ensured patients had easy access to fresh water and checked this was within reach at regular intervals.
- A dietician risk assessed each person for nutritional need. Where they found someone was at risk of malnutrition, nurses used a food chart as a preventative tool. The dietician provided staff with a standard algorithm and guidance for feeding out of hours or in their absence, which was used as part of a nutrition care bundle.
- The unit's audit nurse conducted a monthly audit of the nutrition care bundle. This included a check of five components: patients are weighed within 24 hours of admission and at seven days; patients receive a nutritional screening within 24 hours of admission; patients are reweighed at seven days; a dietician conducts a nutritional reassessment every seven days and a food diary is commenced for patients with an elevated risk of malnutrition. From April 2015 to February 2016, nutrition care bundles met the criteria 100% of the time during seven months and 90% of the time during four months.

Patient outcomes

- The unit contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide.
- Between April 2014 and May 2015, the unit mortality rate was 19.5%. This was better than the national average however represented an increase of 24% from the previous year. This figure was disproportionately

influenced by an unexpected increase in the number of emergency surgical admissions between April and June 2014 and did not reflect the overall better than expected outcomes highlighted by the national ICNARC audit.

- The numbers of unplanned readmissions, out-of-hours transfers and discharges and non-clinical transfers were significantly better than expected in line with national averages. Between March 2014 and March 2015, 34 patients had been discharged between 10pm and 7am. However, a peer review from the critical care network identified this figure included patients who were transferred to the post anaesthetic care unit (PACU) and had been highlighted as an area for improved clarity of data collection.
- Clinical staff used seven key care bundles to plan and deliver treatment. The care bundles included sepsis, ventilator, central venous catheter, sepsis and peripheral cannula. An audit nurse worked with doctors to conduct local regular audits on the care bundles.

Competent staff

- Nursing staff received one month of protected supernumerary time when they began working in the unit. We asked a nurse about this. They said, "The supernumerary month is fixed; it never falters. It's a very directed time in that you get so much direction and support, there is lots and lots of support from the more experienced nurses."
- Four nurses were positive about their induction experience. This was a two week initial period directed by professional development nurses (PDNs) who helped new staff to be orientated in the environment. The induction programme included time with the critical care outreach team, technologist, pharmacist, follow-up sister and audit nurses. New staff received initial training on moving and handling, fire safety, the principles of safeguarding, chemical sedation, intermediate life support, echocardiogram interpretation and support to adapt to the unique critical care environment.
- We looked at completed induction records and saw the programme was specific to the critical care environment. It included checks of the individual's critical care competencies in intravenous medication and blood transfusion.
- The technologist gave new staff competency checks in the use of critical care equipment.

- During the induction period, new nurses, medical students, physiotherapists and occupational therapy staff spent time shadowing CCOT as part of their introduction to the department.
- PDNs ran a programme of in-house workshops for existing staff designed to complement basic mandatory training with specialist knowledge. Recent workshops included invasive ventilation, haemodynamics, patient transfers, temporal artery thermometers and organ donation. The unit's pharmacist contributed to the study days and other specialist teams, such as the respiratory team, delivered workshops.
- PDNs supported senior nurses to develop their leadership roles. This included a six week period as a supernumerary coordinator followed by a secondment to a team leader role. Staff providing support and developmental training for this used the National Competency Framework for Critical Care Nurses.
- The technologist maintained a record of staff training and competencies in the use of specific items of equipment. The record included where a member of staff was trained in an item of equipment but needed further support in its use. It was immediately clear who was competent in the use of paediatric equipment. This meant senior nurses and doctors were rapidly able to check the most appropriate member of staff to support them based on the individual needs of each patient. Ninety-four percent of nurses in the unit had up to date competencies in the use of critical care equipment.
- Sixty-three percent of nurses held a post-registration qualification in critical care. This exceeded the Royal College of Nursing standard of 50% of nurses. PDNs supported nurses to undertaken a mentorship programme following their critical care certification and subsequently progress to a nursing degree.
- A small group of critical care nurses completed a project to improve the transitional experience of nurses moving into critical care from other hospital wards. The results of the project resulted in a more responsive supernumerary period, more robust mentoring from senior nurses and the use of the staff newsletter as a forum for nurses to discuss their experiences. The nurses presented the results at a national critical care conference. PDNs also set up a buddy system for transitioning nurses as a result of the project.
- The care and management of deteriorating patients was a mandatory training subject and the CCOT team offered weekly training sessions for this. This team also

supported ward nurses in the development of their skills in caring for sick patients and supported staff to achieve the certificate of fundamental care. Other training offered by the CCOT team included non-invasive ventilation and blood gas monitoring.

- CCOT nurses took part in professional development days focused on their outreach function. This enabled them to continue to provide specialist up to date advice for ward-based staff caring for sick patients. This team demonstrated a focus on professional and clinical development as a strategy to embed the skills of each nurse with the sustainability of the service. For example, two nurses were developing an advanced nurse practitioner course, which would be offered to nurses who wished to further develop.

- Each nurse received an annual appraisal from a senior member of the team, usually a PDN. PDNs used appraisals to offer staff the opportunity to request additional or specialist training in any areas they felt were highlighted by patients they had cared for in the previous 12 months. Eighty percent of the CCOT team and 88% of the critical care team had an appraisal in the previous 12 months. Ninety percent of the staff in the PACU, who could provide care for critical care patients, had undergone an appraisal in the previous 12 months.

- PDNs used a bed bay in critical care for simulation training, using a 'simulation man' for live training scenarios. Simulation sessions took place in real time using past patient conditions and scenarios. The electronic patient records system was live during the exercises and staff were assessed for their ability to respond according to patient need, including the contact of specialists, use of intravenous fluids and drugs. Equipment was also live and the bed bay was equipped in the same way as patient bed bays. The technologist contributed to simulations by feeding live information to the patient monitoring system and PDNs observed the simulation remotely using digital video cameras to assess clinical competency, teamwork, leadership and communication skills. Following a simulation, a PDN offered a group and one-to-one debrief and the video recording was stored for use as future training. We looked at an example of a previously recorded live simulation exercise. PDNs showed us how beneficial the process was to provide staff with a safe but challenging space in which they could assess and

develop their skills. Staff were very positive about the simulation exercises and PDNs said it had proved to be an invaluable tool to 'teach experience' to nurses and doctors.

- As part of the training and development programme, band five nurses who were working towards their critical care certification undertook intermediate life support training. Senior staff nurses took paediatric intermediate life support training every two years and staff who had post-registration certification in critical care undertook intermediate life support training every two years.

- Nurses recruited from outside of the UK were offered English language study and exams in-house if required.

Multidisciplinary working

- A dedicated critical care dietician was available on the unit on a 0.5 whole time equivalent (WTE) basis. The dietician conducted a handover with ward-based dieticians as part of the patient discharge process. They also met with nurses and a consultant to give feedback on nutritional care as part of the nutrition care bundle. Dietetic students were supported to gain experience in critical care by performing audits for the dietetics department.

- The dietician did not routinely attend ward rounds unless this was requested by a nurse or doctor. However, the dietician liaised with consultants and nurses after each ward round and attended a weekly multidisciplinary rehabilitation meeting to discuss individual patient progress.

- The Speech and Language Therapy (SaLT) team worked closely with critical care staff, including the dietician, and helped to maintain individual treatment assessments and plans. One plan we looked at included the need for long-term monitoring of fluid intake, which staff had documented and maintained appropriately. A senior member of the SaLT team had undertaken tracheostomy care training, which meant they were able to provide more comprehensive support to ventilated patients.

- The trust physiotherapy team was not required to adhere to any specific published guidance relating to staffing levels. However, the team established 2.1WTE physiotherapists were required to provide safe and consistent care and review to critical care patients. From looking at physiotherapy rotas, it was evident that this internal standard was routinely maintained. Physiotherapists were available in critical care Monday

to Friday and were available 24-hours, seven days a week on call. Occupational therapists were available on the unit at the same time and their established staffing figure of five WTE was shared between critical care and surgery. The cover provided by physiotherapists and occupational therapists meant the teams could provide appropriate care, support and review to critical care patients.

- A multidisciplinary team attended a weekly board round of all patients. This included consultants, junior doctors, nurses, the unit's pharmacist, dietitian, microbiologist and input from the physiotherapy and SaLT teams. The follow-up nurse identified the lack of funding for routine OT attendance at the weekly board meeting, which meant the continuity of care required by NICE 83 was not always met. However, the OT team was well staffed and they attended the meeting whenever possible.

- CCOT was available 24 hours, seven days a week and staffed by nine senior nurses. This team provided urgent reviews to ward-based patients who were deteriorating, assisted with the transfer of sick patients between critical care and wards and helped ward staff conduct reviews of sick patients. CCOT also provided an educational role and provided ward staff with specialist training sessions to help them care for critically ill patients. The team also offered regular trust wide study days on the care of patients with acute kidney injury and sepsis, as well as the acute illness management (AIM) course, acute life-threatening events recognition and treatment (ALERT) course and advanced life support and intermediate life support instruction.

- A CCOT consultant was not funded and a named consultant provided ad-hoc support as needed. CCOT nurses worked closely with junior doctors, including during their induction and by running a 'survival day' for new doctors.

- CCOT nurses maintained continuity of care for deteriorating and sick patients by attending twice daily medical handover meetings. This team maintained a work ethos of being friendly and approachable. For example, one senior nurse said it was important to build positive working relationships with ward staff because, "…we are guests in their area."

- A senior nurse led a follow-up service for patients who had been discharged from critical care and who had spent four days or more in the unit. A physiotherapist and nursing assistant were part of this team and provided patients and their relatives with physical and

psychological rehabilitation support for up to one year after discharge. The follow-up nurse invited patients to a meeting immediately after discharge and then at two, six and 12 months after this. The follow-up nurse offered patients the opportunity to enrol on a six week gym-based rehabilitation programme, which adhered to the principles of the following intensive therapy (FIT) programme. This meant follow-up care adhered to the principles of the rehabilitation after critical illness clinical guidance NICE 83.

- The follow-up nurse conducted a research project about the patient journey in critical care, from admission to discharge. They had published a poster of their research findings, which was displayed in the unit to help nurses and doctors understand the critical care experience from the patient's perspective. This project helped to influence how the follow-up service operated. For example, patients involved in feedback on the project indicated how useful they found patient diaries. As a result the follow-up nurse made sure each patient in the unit for four days or more had a patient diary and this was bound and given to them on discharge to help them make sense of their experience. Multidisciplinary staff were able to contribute to the diaries and physiotherapists and occupational therapists were involved in this. Patients had given very positive, constructive feedback as part of this project. One patient said, "It was good to be able to talk and identify causes of nightmares and to understand what happened to me…and to feel respected as an individual with feelings and fears I could express openly."

- A consultant microbiologist reviewed patients between 12am and 2pm seven days a week and provided medical staff with individual support on antibiotic therapy.

- Nurse-led research projects involved multidisciplinary feedback wherever possible. For example, a project to develop a patient profiles tool resulted in positive responses from allied health professionals (AHPs). One AHP said, "The profiles are a great innovation, families love them, they're a great tool to help me feel closer to my patients." The nurses responsible for the project presented the findings at the hospital AHP board meeting to senior staff. After the patient profiles were implemented, nurses visited ward-based colleagues to show them the tool and offer them support to implement them in their own areas.

Critical care

Seven-day services

- Staff had on-call access 24-hours, seven days a week to specialists in internal medicine, endoscopy, radiology, echocardiography, biochemistry, transfusion, informatics support, physiotherapy, pharmacy and medical engineering services, obstetrics and organ donation services.
- Additional seven-day services were available from liaison teams in psychiatry, alcohol, drugs and counselling.

Access to information

- The electronic patient records and clinical information system enabled staff to obtain past patient notes and diagnostics, which helped them plan appropriate treatment. For example, staff could access historical information for patients who were admitted for treatment relating to a drugs overdose. This meant they could check if the person had overdosed previously and make an appropriate referral to the drugs liaison team.
- A dedicated ward clerk worked full time Monday to Friday and facilitated the timely dispatch of discharge letters to GPs and community services.

Consent and Mental Capacity Act

- Staff conducted a mental capacity assessment on each patient within 12 hours of admission and a CAM-ICU (confusion assessment method for intensive care units) assessment within two hours of admission, followed by regular re-assessments. The electronic patient records system automatically reminded staff to update the CAM-ICU assessment.
- The clinical information system included detailed information on the Mental Capacity Act (2005), which staff could access readily. The information was up to date and included clear instructions for staff on the steps they needed to take with regards to assessing mental capacity. This included a decision flowchart and information on how staff could obtain the support of an independent mental capacity advocate or a best interest assessor. A professional development nurse maintained the guidance provided to staff for currency and had added a flowchart decision tool to help staff decide if they needed to apply for a Deprivation of Liberty Safeguards (DoLS) authorisation for a patient. All

of the unit staff were able to explain the principles of DoLS and mental capacity to us and it was evident their level of knowledge on the subject was beneficial to patients.

- Staff used an escalation plan and resuscitation status (EPARS) process to guide physicians to discuss resuscitation and the withdrawal of treatment with patients and relatives. The EPARS process included prompts for staff to assess if the patient had the mental capacity to make decisions regarding their care.

Are critical care services caring?

Good ●

We rated critical care at West Suffolk Hospital as good for caring because:

- Staff demonstrated a commitment to obtaining feedback from patients and their relatives and using this to shape and develop the service. This was partially achieved through a bi-monthly survey, the results of which were widely disseminated amongst staff.
- A dedicated follow-up sister worked in the unit and led an established follow-up clinic programme for patients and their relatives after discharge. This nurse tailored the follow-up service to individual patient needs using innovative research they conducted to find out how patients perceived their critical care experience.
- Our observations of care and conversations with patients and relatives indicated consistently that doctors and nurses involved people appropriately in care and treatment plans. There was slight room for improvement in making sure such conversations were documented in electronic patient records.
- Staff considered the psychological and emotional welfare of patients and their relatives when making clinical decisions and providing care. This included referring people to bereavement and counselling services and requesting a unit visit from the psychiatric liaison team.

However we also found,

- There was room for improvement in the consistency with which doctors and nurses involved patients and relatives in their care.
- Doctors did not always record conversations with relatives in patient notes in a timely manner.

Critical care

Compassionate care

- Staff encouraged patients and relatives to contribute to a bi-monthly critical care patient survey, which was used locally instead of the national Friends and Family Test survey. The audit nurse analysed the results, which were displayed prominently in the unit and distributed to staff. The results from July 2015 to December 2015 were consistently positive. More than 99% of respondents said they felt staff treated them with dignity and respect and were friendly and approachable. The survey included space for patients and their relatives to record additional comments. Recent comments included, "The doctors and staff were truly amazing, and they worked so hard and were so caring. We are so grateful for their care" and, "Absolutely fantastic care - couldn't fault any of the staff."
- The unit did not comply with Department of Health Building Notes in relation to the space available in each bed bay or side room. To ensure privacy and dignity was maintained, doctors asked visitors to leave the unit temporarily during confidential ward rounds. This meant personal information was protected.
- Staff used 'do not enter' signs on bed bay curtains and doors to side rooms when helping patients with personal care. This meant individual privacy and dignity could be maintained. A patient said they were "very impressed" with the care they had received since being admitted in relation to maintaining their dignity.
- During a bedside handover a student nurse introduced themselves to a sedated patient, which demonstrated they understood how to deliver compassionate care regardless of the consciousness of the individual.
- Staff demonstrated an unwavering degree of compassion and care to people who were particularly vulnerable. For example, they became concerned about the welfare of a visiting relative and whether they had access to food, clothing and somewhere to live. In response to this, staff sourced clothes for them; made sure they had access to food and completed an urgent referral to the local authority safeguarding team.
- Compassion, dignity and respect were included in the critical care service philosophy, which staff were trained to work within at all times.

Understanding and involvement of patients and those close to them

- Where a patient with psychiatric care needs was treated, staff considered the input of the patient's parents and psychiatric nurse as part of their care. This included ensuring the parents and psychiatric nurse were present when the patient was awakened.
- Patients in the unit felt involved in decision-making and were kept up to date with their progress.
- Patients and relatives were able to return to the unit after discharge to speak with staff or to look around the area in which they were cared for. This helped them to understand the environment they had spent time in and look at the equipment used to care for them. This formed part of the follow-up process and helped people to contextualise their memories.
- We observed a physiotherapist talking with a patient about the importance of daily exercise in their recovery. The physiotherapist treated the patient as an individual and used information about their likes and dislikes from their personal profile to help them plan exercise. This approach was very effective and the exemplary communication of the physiotherapist meant the patient was demonstrably pleased to be included in their recovery planning.
- Patients and relatives told us staff had been very informative and had kept them up to date. Doctors and nurses recorded conversations in electronic patient records, which we found to be detailed and appropriate. This was evidence staff placed importance on maintaining communication with patients and the people important to them. This was usually documented, however in the records of one person who had been recently admitted, staff had not recorded a conversation they had with relatives on admission.
- Patients and relatives were aware of the multidisciplinary nature of care and treatment plans, including the role of the dietician, pharmacist and speech and language therapy team. A relative whose family member had been admitted as an emergency told us staff had involved them in planning care, particularly when the relative told them about other health issues the patient had. They said staff had obtained specialist referrals from other medical services and felt valued because staff had taken their concerns seriously.
- Patients who took part in the critical care patient survey reported broad satisfaction but did not always report they felt involved in their care. For example, in the

Critical care

September/October 2015 survey, ten patients participated. Three patients said they had not been involved in their care and five said they had been involved to some extent. However, this figure was not representative of how patients reported their experience overall. In the July/August 2015 survey, all patients who took part said they had been involved and in the November/December 2015 survey, 75% of patients said they had been involved.

- Junior doctors were given advice on strategies to involve patients and relatives in their care and treatment decisions as part of the induction programme.
- The audit nurse conducted a monthly assessment of patient experience indicators. The indicators were based on the number of mixed sex breaches, the number of complaints and the results of environment and cleanliness feedback from patients and visitors. Between May 2015 and January 2016, patient experience was consistently reported to be between 92% and 97%.

Emotional support

- As part of the rehabilitation process, follow-up staff used the stepped care model included in NICE clinical guidance 113 and 90, in relation to patients who experience anxiety or depression. This meant the follow-up team could refer patients for cognitive behavioural therapy or counselling as needed.
- A bereavement service was available locally 24 hours, seven days and week. Staff facilitated rapid access to this service for relatives.
- The follow-up nurse used patient feedback from a research project they conducted in patient perceptions of critical care to establish how emotional and psychological support could be provided in the follow-up clinic. For example, patients described a type of 'relocation stress', which they experienced when leaving the critical care unit for a medical ward. As a result the follow-up nurse ensured patients were involved in early planning and preparation for their discharge, including what to expect in different wards.
- Patients gave positive feedback about the type of support they received in the follow-up clinic. One patient said, "I found it beneficial to have ongoing support during an anxious year, to have help dealing

with emotional and psychological aspects, to have a professional view of my progress with realistic timeframes for achieving normal things, to feel someone still cared and not feel alone to cope."

- The follow-up nurse was able to tailor the usual follow-up clinic schedule to the individual needs of patients who needed additional psychological and emotional support. For example, they provided additional clinics for a patient who experienced a delay in accessing counselling services.

Are critical care services responsive?

Requires improvement ●

We rated critical care at West Suffolk Hospital as requires improvement for responsive because:

- Patients were sometimes cared for in the post-anaesthetic care unit for extended periods.
- We were not confident patients cared for in side rooms were always appropriately monitored when they were not able to call for help themselves.
- The service last reported a mixed sex breach in September 2015. However, during our inspection patients of the opposite sex were cared for in adjacent bed spaces. We were not assured of the accuracy of patient classification which would affect the accuracy of compliance with mixed sex legislation.

However we also found that:

- A multidisciplinary team developed services to the needs of the local population, including specialist support for patients with mental health needs and addiction support needs.
- A paediatric stabilisation bay was available in the unit and was equipped and managed appropriately based on the skill mix and experience of staff.
- The unit included facilities for relatives, such as quiet rooms and catering facilities.
- Nurses had undertaken an innovative research project to help the unit meet individualised care needs through the use of patient profiles.
- The rate of delayed discharges had significantly improved in the previous 12 months and was below the threshold identified by the critical care network.

Critical care

- The unit performed well in comparison to national averages and expectations in the number of non-clinical transfers and unplanned readmissions.

Service planning and delivery to meet the needs of local people

- A specialist nurse in organ donation was available in the unit. This individual was able to talk with patients and relatives about organ donation and support unit nurses and doctors during difficult conversations. A regional tissue donation coordinator attended unit meetings on request and provided staff with additional support in speaking with people about donation.
- There was a paediatric stabilisation bay equipped with resuscitation and diagnostic equipment specific to children. A stock of paediatric medicine was stored in the bay and there was a computer system for use by paediatric consultants. The electronic patient records system included a drug dosage calculator. This bay was used to stabilise children who staff would then transfer to a specialist paediatric critical care. Children cared for in this bay always had access to critical care nurses with paediatric training and two consultant intensivists had experience in paediatrics.
- The critical care outreach team (CCOT) referred patients in distress or with post-traumatic stress to the follow-up clinic as part of their care of sick patients. This team also supported elderly patients who were very frail and used an established process to discuss the withdrawal of treatment with relatives where this was considered to be in the person's best interest.
- Staff had on-site access to an alcohol liaison team and a drug liaison team. A local rehabilitation service was available and could visit patients in critical care once they were medically fit. Staff had a good understanding of the roles of each team and explained how they would make a referral for both intentional and unintentional drugs overdoses. A link to a poisons advice unit was in place in the clinical records system.
- A nurse-led mental health liaison team was available on site seven days a week. Staff were able to obtain rapid referrals from this team who were also able to liaise with community mental health and social care services.
- The pharmacist and PDNs were proactive in scoping the potential benefit of using new-to-market drugs for

specific patient groups. For example, a new antipsychotic drug for patients with alcohol abuse problems had been sourced and a stock was maintained with another hospital.

Meeting people's individual needs

- Two relatives' rooms were available; one room was in the secured critical care unit and another was shared with the cardiology suite. Both rooms included printed information for relatives on critical care services and procedures and how to raise a concern, including through the Patient Advice and Liaison Service. One of the rooms included a television and facilities to make hot drinks and snacks. The rooms were private and were used for quiet reflection, private conversations between people and staff and as accommodation for relatives who wished to stay for extended periods of time. The larger room shared with cardiology contained a direct-line phone to the critical care unit.
- Staff used soft mittens for patients who were delirious and were at risk because they tried to remove their intravenous lines. We observed this in practice and saw the strategy was only used when a doctor had completed a mental capacity assessment and was confident this form of restraint was in the patient's best interest. Where mittens were used, staff documented a re-assessment of need for them every two hours.
- Staff had successfully secured funding for a 'bed bike', which meant patients who were bed bound could maintain strength in their legs and improve their rehabilitation progress.
- Staff had been able to safely take a critical care patient to the maternity suite to see the birth of their child following the completion of an appropriate risk assessment for their movement.
- We saw one patient being cared for in a side room was unable to use their call bell to attract attention from nursing staff. There were lengthy periods where this patient was left unattended and although passing nurses made eye contact with them, it was not immediately clear how they could obtain help. We observed this patient be unattended by a nurse for one hour and 20 minutes. We asked the senior leadership team about this. They told us the critical care policy meant patients unable to speak or to summon help using the call bell always had a nurse no more than a window away and would always be in sight of the nurse. We did not see staff always adhere to this in practice.

Critical care

- Staff used patient profiles to identify patients with learning disabilities and the support they needed. Nursing staff said patient profiles had been a good tool to help them develop their skills in working with patients with disabilities because it enabled them to eliminate assumptions about patient need.
- Patient profiles were the result of a research project undertaken by nurses who identified a gap in the tools available to them to get to know patients and provide individualised care. The profiles tool was developed in the unit with staff, patient and visitor feedback and included family photographs to help support the emotional wellbeing of patients. Staff said the profiles resulted in improved individualised care. For example, one new patient had been sleeping poorly and through the use of a patient profile, staff identified the person normally slept on their right hand side. Staff facilitated this and found the patient slept much better as a result. The tool was used to identify small details to help staff make people more comfortable, such as finding out which of their hands was dominant so they could choose where to insert a cannula.
- Relatives were able to visit patients whenever they wanted due to an open visiting policy. A relative told us this had made visiting much easier on them.
- One mixed-sex toilet was available in the unit and staff used a 'male/female' sliding panel on the exterior of the door to indicate the sex of the patient using the facility. This meant staff could respond appropriately if the patient needed help. However, this did represent restricted toilet facilities overall. In addition, patients cared for in the recovery unit did not have access to a toilet.
- The follow-up nurse made sure patients who were in the unit for longer than four days had a patient diary. Patients had given positive feedback about the diaries as part of a project to find out how they perceived critical care. One patient said, "It fills the gaps as you have no recollection of what happened to you" and another patient said, "Details would've been lost if they hadn't been written down."
- A learning disability liaison nurse was available three days a week from 9am to 4pm. This member of staff supported critical care nurses with desensitisation planning, communication needs, carer support, capacity and consent, pre-discharge planning and the development of accessible information for patients.

- The unit could be noisy when it was busy and staff had provided patients with eye shields and earplugs to mitigate the impact of this and help them get a more restful sleep.

Access and flow

- The unit recorded a consistent 100% admission rate within four hours from the decision to admit for the 12 months prior to our inspection. Admissions processes were robust and were always overseen by a critical care consultant and a consultant from the referring or admitting specialty.
- The average occupancy rate from January 2015 to January 2016 was 84%.
- Between April 2014 and May 2015, 54% of patients experienced a delayed discharge of over four hours. This was a significant improvement on the previous year, during which 71% of patient discharges were delayed. This was also below the 57% threshold for delayed discharges set by the critical care network.
- Doctors used a daily ward round to identify patients who were suitable for discharge or transfer. We observed this planning and saw it was detailed and involved multidisciplinary clinicians in the risk assessment process.
- There were sometimes significant periods of time where patients were cared for in the post-anaesthetic care unit (PACU). In one case we found a patient had been in PACU for 65 hours. The two beds in this unit were intended for short-term use only. The PACU did not have toilet or shower facilities for patients and meant patients had to be escorted into the main critical care unit or provided with a bedside commode, neither of which was appropriate. An average of 25 critical care patients per month were seen in the PACU from December 2015 to February 2016. Staff did not include patients seen in the PACU in local or national audits, which meant care in the area was not evaluated in the same way as care in the main critical care unit.
- From October 2014 to March 2015, less than 0.5% of patients had been transferred for non-clinical reasons.
- Staff recorded two mixed sex accommodation breaches in the 12 months prior to our inspection. However, during our inspection we observed male and female patients being cared for next to each other in bed bays. We spoke with the senior team about this, who said they would only report a mixed sex breach if it involved level one patients who were awaiting discharge to a ward.

Critical care

- As the patients were classified as level 2, or high dependency patients, staff adhered to the trust's policy on mixed sex accommodation. Two of these patients were sitting up and eating and drinking therefore we were not assured the classification level 2 was accurate which would impact on the compliance with a mixed sex breach
- The CCOT team were not directly involved in patient flow but could influence this where their expertise on patient safety was needed, such as when making the decision to transfer a patient from the emergency room who was intubated.

Learning from complaints and concerns

- The unit received no formal complaints between April 2015 and January 2016. During previous complaint investigations, staff invited the writer to the unit to meet with them and discuss the complaint in person. They used this strategy to gain a greater understanding of the factors involved in the complaint and so be more responsive in the resolution.
- Senior staff explained had made improvements in their complaints handling procedure as a result of learning from complaints received prior to April 2015. For example, if they received a complaint about a member of staff, this individual would be redeployed in the unit until the complaint was investigated. Staff were also given the opportunity to reflect on the complaint and to discuss it one-to-one with a member of the senior team for support.

Are critical care services well-led?

Outstanding ☆

We rated critical care at West Suffolk Hospital as outstanding for well-led because:

- There was an established and robust leadership team in place with clear lines of accountability and responsibility. Staff reported this system was supportive and responsive and they felt positive about being part of it.
- The clinical service manager used the results of a staff consultation to establish a five year local vision and strategy for the service, which aimed to address issues with the environment and further develop the skilled staff team.

- Risk management at unit level was effective and integrated into quality governance strategies. There was no consistent evidence that risks escalated above unit level were assessed or responded to appropriately.
- There was a significant track record of engagement with staff to engage with innovative research and piloting novel approaches to care and treatment, which had a demonstrable impact on patient outcomes and staff development.

However we also found that,

- Staff were not always aware of the vision, strategy and future plans of the service.
- The management of risks outside of the immediate clinical team did not always lead to demonstrable change or improvement.

Vision and strategy for this service

- The senior team established a five year critical care services strategy, which outlined future plans for the service in equipment, environment and staffing. The strategy had been created by gathering the feedback from existing critical care staff and represented a robust and ambitious programme of development. For example, the embedded approach to staff progression was further evidenced with the creation of a physician's assistant role, which had recently been filled. The strategy included plans for the refurbishment of existing space and the provision of additional facilities, including a shower for patients and a new space for private study for staff.
- Staff were not always clear on the local vision and strategy of the service. One nurse said this had not been shared with them but said they felt strongly the unit had a clear, positive ethos and was very well run.
- The clinical director told us the vision and strategy for the service was to expand the unit by utilising office space and large areas currently used for equipment storage. This was in the early stages of planning and would be progressed once the adjacent coronary care unit was relocated.

Governance, risk management and quality measurement

- Critical care services were situated within the surgical division with the recovery unit and resuscitation services.

Critical care

- Senior staff maintained a risk register for critical care, which was used to escalate risks identified by staff and incidents to the trust executive team. Nurses and doctors were encouraged to escalate risks to the senior team for consideration through the risk register. A named individual was assigned to the management of each risk and this person was responsible for exploring, trying and implementing solutions. Where a risk related to the need for new equipment or a finance-based resolution, senior staff had been proactive in obtaining this. For example, funding had recently been secured for the supply of a new MRI machine for use by critical care patients who were ventilated. This would significantly increase the range of tests and assessments available to critically ill patients.

- All of the risks identified at the time of our inspection were listed in the divisional risk register and critical care had no identified risks on the corporate risk register.

- The deputy general manager and the clinical services manager met monthly to discuss the progress of risks that could not be resolved at unit level. For example, the computer screens at each bedside were very old and were at risk of breaking down. Managers had instructed staff to report each breakdown as an incident as a method of tracking the severity and impact of the problem. Critical care managers escalated this risk to the electro-biomedical engineering department on a monthly basis although we found a lack of clarity about how such escalation contributed to substantive changes at a senior level. For example, clinical risks were managed by the clinical lead and the clinical services manager but the unit leadership team were not aware of the process senior executives used to assess and resolve risks. We saw evidence issues, risks and incidents could be escalated to the surgical governance steering group where needed.

- A risk manager assessed each risk on the risk register according to the 'red, green, amber' (RAG) rating system to highlight the severity of the risk. The risk manager conducted a root cause analysis of each risk and was accountable for the governance and oversight of the risk register. The senior clinical team said they were always consulted before a change of policy or procedure and said actions were never imposed on them. This meant they were able to work closely with the clinical team in the unit to ensure practice was developed by the appropriate staff with front-line knowledge of the service. There were no 'red' risks on the risk register, four

'amber' risks and one 'green' risk actively monitored by the clinical services manager. A further six 'amber' risks and ten 'green' risks were accepted as operational risks, such as the use of latex gloves, slips trips and falls and the levels of stress experienced by staff. Some risks were maintained on the risk register as a standard item, such as hand hygiene, which had been included for the 12 months prior to our inspection. There was no demonstrable benefit to staff practice or unit procedures from this as local audits indicated a high degree of adherence to trust infection control policies.

- The minutes of governance meetings did not always include evidence of how under-performance was addressed. For example, in the September 2015 governance meeting minutes, staff had noted the unit was 84% compliant in its environment and isolation audit, against a trust target of 90%. The minutes did not include an indication of the cause of this or the action staff had taken to rectify it.

- The senior clinical team prepared a business case for each improvement needed following a RAG rating from the risk manager. This included a cost measurement against the likelihood of patient complications, which enabled staff to demonstrate the benefits of investing in new technology and new drugs.

- The unit did not contribute to the Commissioning for Quality and Innovation (CQUIN) framework. CQUINs are used to continually improve standards of care and ensure better outcomes for patients. We spoke with the clinical director about this who said CQUINs were contributed too at trust-level only.

- Nurses belonged to special interest groups, which they used as a local quality improvement strategy to assess and improve care and treatment experience and outcomes. For example, the respiratory special interest group had attended an annual British Association of Critical Care Nurses (BACCN) conference to present their research and practice, which had led to the approval and introduction of improved local weaning guidance. The renal special interest group had established a monthly citrate simulation training exercise as a result of their work, which contributed to the quality of clinical practice.

- Staff used a local patient experience survey to gather the views and experiences of patients and their relatives. The results of the surveys were displayed in the unit and staff used them to influence the service.

Critical care

Patient experience and feedback was directly connected to quality development processes by the audit nurse and was shared informally amongst staff using the newsletter and communication book.

Leadership of service

- A clinical lead, clinical service manager and senior sister ward manager led the unit on a day-to-day basis.
- One individual held a dual-role clinical service manager and matron role, which had been created by combining a previous off-site clinical service manager and an on-site matron. This role was embedded with quality improvement and the manager was responsible for discussing the results of audits at monthly meetings with matrons and other departmental managers. This process helped the unit to share learning.
- We asked nurses about leadership on the unit, particularly around the dual role of the critical care manager and matron. One nurse said, "The manager is very visible on the unit and is proactive in approaching nurses to discuss their practice to give praise and otherwise. She also inspects the clinical areas and makes sure our quality standards are up to scratch."
- Managers and senior nurses used monthly unit meetings to keep staff up to date on developments and initiatives and to supplement other communication channels used for dissemination, including e-mail, a communication book and a staff newsletter.
- Nurse team leaders met monthly with the critical care pharmacist, physiotherapists and other specialists to discuss areas of good practice and areas for improvement. We saw from the minutes of meetings possible improvements had been identified in how staff cared for equipment and in the documentation used to record medicines patients bring with them.
- Staff at all levels spoke positively about the chief executive and the influence they had on the hospital. One nurse said, "He's made a massive difference to the place. He's engaged, passionate, he knows our name. He's visible all of the time." Another nurse said, "The chief exec comes in on a weekend, talks to us as equals and sees how we're doing. It's very unusual and we feel very privileged with him."

Culture within the service

- The unit's induction programme included information on the Duty of Candour. Staff who had recently undertaken the induction could demonstrate they had a good level of knowledge. One nurse told us the induction training included study of the Duty of Candour from a policy perspective as a well as from the point of view of clinical practice. They said this helped them to understand it in more depth and put it in practice. The surgical matron was responsible for adhering to the Duty of Candour for critical care outreach nurses.
- Senior staff told us they fostered a culture of openness to criticism and challenge from staff at all levels as a means to discuss how care, treatment and processes could be improved. Part of this process included analysis of actions staff undertook during M&M meetings, which contributed to how risks were managed by the trust risk manager.

Senior staff placed demonstrable value on the cohesion of the critical care team and their ability to work well together. For example, two members of staff who needed support to work together were given the opportunity to conduct a research project together and attend a conference to present it. This strategy enabled them to progress their work in the unit and to develop a better professional working relationship.

Public engagement

- Staff offered an annual open evening in the unit, which enabled former patients and their relatives to share their experiences with patients currently being treated.
- The follow-up nurse had sought the feedback of patients as part of their research on patient perceptions of critical care. This contributed to the structure of the follow-up clinic programme and prompted staff to offer additional referrals such as for counselling and depression services.
- Staff had provided a second relatives' quiet room in the unit following feedback from visitors about the lack of private space available to them.
- The follow-up clinic enabled patients and their relatives to provide constructive feedback on their experience of critical care, how the service performed well and where they felt changes could be considered.

Staff engagement

- The critical care manager had completed an information-gathering initiative to engage staff in ideas and strategies to develop and improve the service.

Critical care

- Professional development nurses (PDNs) and senior staff fostered a proactive and robust research culture amongst staff. Where staff could demonstrate learning value from a planned project, PDNs supported them to develop the research and attend national conferences to share their work and findings. Several posters from staff research projects were displayed around the unit, which clearly demonstrated how outcomes contributed to service delivery and patient outcomes. It was clear how staff had been engaged during the development of research. For example, nurses who piloted and evaluated the use of patient profiles as a method of individualised care had distributed a staff survey six months after the pilot to gather feedback to be used in the development of the final version of the tool. Staff used the survey to indicate they would like a link to the patient profile on the electronic patient records system, which was being developed. The survey also indicated guidance was needed on how to ensure staff using the patient profile tool adhered to information governance and confidentiality protocols.

- Another nurse-led research project resulted in a supernumerary induction period individualised to the needs and competencies of nurses who transferred from another hospital department.

- Unit meetings were held monthly with voluntary attendance. A nurse told us there was no set agenda and it was up to staff to bring topics for discussion.

- Senior staff used a unit meeting to discuss the range of communication channels available to staff for the dissemination of feedback, learning and new division and trust initiatives. In addition to meetings, a staff newsletter and e-mail, the PDNs facilitated a social media page available to critical care staff. The social media page was private to staff and there was a robust system in place to ensure it was not used inappropriately or in a way that would put information governance at risk.

- PDNs had enabled more staff to attend in-house study days by scheduling them around the school day for nurses who had children.

- The PDNs were members of the critical care educators group within the critical care network. This involved meeting other PDNs in the network to share good practice and training ideas at a regular forum. PDNs from other hospitals visited this unit to observe practice and to share their experiences to support the development of the service.

- Staff contributed to the publication of a newsletter each month. This was used as a communication tool with columns dedicated to the follow-up nurse, ward manager, technologist and any other staff who wished to contribute. Senior staff used the newsletter to introduce new members of the team and to praise staff for good work, such as to congratulate the recipients of trust 'shining light awards'.

Innovation, improvement and sustainability

- The critical care unit had received Anaesthesia Clinical Services Accreditation (ACSA) from the Royal College of Anaesthetists. This meant staff had undertaken a period of significant self-assessment and undergone peer review from other accredited units to assess and improve the standard of care.

- The unit operated on an electronic, paperless basis. This worked well and had streamlined and shortened recording processes, representing significant innovation in improving work processes.

- Staff had trialled, evaluated and implemented the use of bicarbonate hemofiltration in patients with acute renal failure. This was evidence of a commitment to developing innovation in care and treatment through the use of evidence-based pilot schemes.

- The development of patient profiles had been shared nationally with other hospital trusts, demonstrating awareness of how projects and research can be shared to improve practice and patient experience.

- A CCOT nurse was working with a colleague from the purchasing department to conduct a feasibility study into recycling medical plastics. This study was intended to reduce waste and cost and was being piloted in four areas of the trust, including critical care. The two researchers had established a recycling algorithm to ensure no waste contaminated with blood or other infectious material would be recycled. This meant the study could proceed without any risks to staff or patients.

- The CCOT team worked with the aim of empowering and educating ward nurses through study days and increasing competencies. A senior nurse said this strategy was important for the sustainability of the outreach service and was more important than simply looking at expanding the team.

- A small group of nurses who previously transferred from another hospital unit or ward identified the need for a more responsive initial period of induction and

supernumerary work. Professional development nurses supported this project and the nurses conducted a survey amongst colleagues regarding what they would like to see improved about the initial period of time. Nurses used the results to enhance the supernumerary period to include a more robust orientation of the environment and consistent mentoring. They also implemented a regular feedback column in the monthly staff newsletter to discuss the experiences of new staff.

• The unit established a number of beneficial relationships with equipment manufacturers, which helped them support staff development. For example, manufacturers were able to visit the unit to observe how equipment was used in situ to contribute to future improvements. In exchange for facilitating the visits, manufacturers funded staff attendance at critical care conferences to present their work and research.

• Staff were contributing to a research study involving five trusts nationally focused improved utilisation of data collection from the electronic patient records system.

Maternity and gynaecology

Safe	**Good**	🟢
Effective	**Good**	🟢
Caring	**Good**	🟢
Responsive	**Good**	🟢
Well-led	**Requires improvement**	🟠
Overall	**Good**	🟢

Information about the service

Maternity and gynaecology services for West Suffolk Hospitals NHS Foundation Trust are provided at West Suffolk Hospital, Bury St Edmunds.

West Suffolk hospital has 40 maternity beds and the trust reported the total yearly delivery rate for 2015 as 2,425.

Maternity services available to women include:

Home birth, a consultant led labour ward area consisting of an eight-bedded delivery suite and a midwifery-led birthing unit with four rooms. There is also a 28-bedded ward (F11) for antenatal and postnatal care.

Community midwives (CMW) are employed by West Suffolk Hospital. Within the local area of Bury St Edmunds the CMW have access to digital pens for women's healthcare records. Those women outside of this area had patient held paper records.

The community midwives worked in six teams across a wide geographical area, providing midwifery care and a home birth service in partnership with general practitioners (GPs), health visitors and children's centres.

There were 8 gynaecological inpatient beds, a gynaecological outpatient area, and an early pregnancy assessment unit (based on the gynaecology ward) which ran a five day week service. Specialist gynaecology services include clinics for colposcopy, fertility, gynaecology diagnostics, gynaecology outpatients, gynae-oncology, hysteroscopy, menstrual disorder, outreach, post-menopausal reassessment, termination of pregnancy clinics, uro-gynaecology and uro-dynamics.

During the inspection we visited all the wards and departments relevant to both services.

We spoke with 24 midwives and six nurses, and held focus groups for both, where staff were able to express their views as a professional group.

We also spoke with four consultants, six medical staff, and two administrative and managerial staff.

In the maternity service we spoke with 10 women, two with their partners, and in the gynaecology department we spoke with six patients.

We reviewed 20 sets of records and eight prescription charts across both services, along with information requested by us and provided by the trust

Maternity and gynaecology

Summary of findings

Maternity and gynaecology services were rated as good overall. Safe, effective, caring and responsive were rated as good with well-led rated as requires improvement.

All investigations of incidents were reported via an electronic incident reporting system. Approximately 70 incidents were reported on average per month from maternity and gynaecology services. Between December 2014 and November 2015 there were 835 incidents reported, of which two were classified as catastrophic, one classified as major, three classified as moderate, with 48 minor and 11 negligible. There was clear evidence of learning from these incidents with development for staff and changes in practice embedded. There was one never event declared from this service following a retained swab during gynaecology surgery. There are no separate obstetric theatres because patients are transferred to theatres for surgery under the care of the theatre staff.

The maternity service provided a ratio of one whole time equivalent (WTE) midwife to 29 births, which was against the national standard of 1:29. Between April 2015 and July 2015 the reported ratio was as high as 1:30, whilst In January 2016 the ratio was reported as 1:26. The last completed review of maternity staffing levels was in 2011. The Trust consistently achieves an average birth to midwife ratio of 1:29 using community and specialist midwives. This achieved a better than average coverage of 1:26 in January 2016.

Emergency drugs were stored securely and were not at risk of theft or tampering.

Appraisal rates for maternity and gynaecology nursing, midwifery, support and clerical staff was 95% overall. However, medical staff appraisal rates were reported at 93%. The six medical staff we spoke with all confirmed that they had completed their appraisal which supported revalidation.

Community midwives had access to information technology. However, we were informed that the wireless internet connection was more problematic for staff based at Bury St Edmunds rather than in the rural parts of the county. Senior staff were aware of this and the issue was recorded on the risk register which meant that the trust wide team were aware that this required addressing.

The gynaecology waiting times for 2015 received from the trust and discussed with the gynaecology lead consultant informed us of targets achieved. The 18 week to admission target had been achieved in 2015. There were no closures of the maternity unit between January 2015 and January 2016, which meant that the maternity team were consistently working to meet the needs of the local population. Quarter 1 report for 2015/16 showed the bed occupancy did not exceed 33%. This meant that staff had the capacity to deliver high quality care during this time.

The maternity service was operating with ratified guidelines but there was guidance cited relating to reviews that had no date.

Not all staff were aware of the vision of the maternity service which meant that it was not fully embedded. There were links to the trust wide strategy of "putting you first", one vision with three priorities and seven ambitions, all displayed on the wards.

The national targets for unassisted birth, caesarean section and instrumental delivery rates had been met. There was an anaesthetic consultant on-call rota for the maternity service 24 hours a day, seven days a week providing epidurals when requested.

The women's experience survey 2015 showed that the trust performed approximately the same as other trusts for all measures on the care they received and that they were supported to make informed choices.

There was 68% of medical staff trained to level three. The trust were supporting further training to promote staff awareness of safeguarding but had no action plans for addressing shortfall in safeguarding training.

The maternity service and the maternity services liaison committee (MSLC) was established but with recent multiple changes in leadership and interim cover there remained some instability. At the time of our inspection, there were no identified links with the trust and the clinical commissioning group (CCG) to improve care for women.

Maternity and gynaecology

There had been a reported bullying and unsupportive culture involving a small number of senior staff since April 2015. The trust informed us of a number of actions which it had taken to address the situation. However, staff appeared unaware of these plans. Staff had some unease regarding the sustainability of improvements.

PROMPT (practical obstetric multi-professional training), compliance was 85% for midwifery staff.

At the time of our inspection, there were no identified links with the trust and the clinical commissioning group (CCG) to improve care for women .

Are maternity and gynaecology services safe?

Good ●

We rated maternity and gynaecology services as good for safety because;

- The maternity service provided a ratio of one whole time equivalent (WTE) midwife to 26 births in January 2016, which was better than the national standard of 1:29.
- Clinical areas were visibly clean and there were ample hand gel dispensers with instructions on how to cleanse hands. Staff followed good hand hygiene and were compliant with "bare below the elbow" practices.
- The service was able to demonstrate how they met the requirements of the Abortion Act 1967 and associated guidelines through the recording of care.
- Mortality and morbidity meetings, led by the paediatric service, occurred with senior team members and midwives attending.
- The antenatal clinic waiting room was located on the first floor within the same area as the ultrasound service, which provided a good service for the women.
- Emergency drugs were stored securely and not at risk of theft or tampering.
- The bereavement suite was under construction on the labour suite which, once completed, will give improved privacy and dignity to grieving families.

However;

- The completion of the five steps to safer surgery checklist on the clinical performance dashboard was below 85% from April 2015-December 2015.At the time of our announced inspection feedback had been to the surgeon but not the theatre manager resulting in appropriate theatre personnel not being included. However by the time of our unannounced inspection feedback had been received by all parties and implementation of the lessons learnt had begun. The early pregnancy assessment sister had no development or involvement in the regional or national network support group which meant she was not involved in innovative and updated practices across these networks.

Maternity and gynaecology

- Storage of patient care records within the gynaecology area was insecure with records outside patient bed areas.

Incidents

- Across both maternity and gynaecology services an electronic reporting system was in place for incident reporting. All staff confirmed that they could access the incident reporting system and knew the outcomes of any investigations or completed actions required.
- The department was using the serious incident framework produced by the National Patient Safety Agency (NPSA, March 2015).
- The trust reported five serious incidents between October 2014 and September 2015 of which one was a never event involving a retained swab during gynaecology surgery. Never events are serious, largely preventable, patient safety incidents that should not occur if there are available preventative measures implemented.
- A root cause analysis (RCA) investigation was completed which considered the contributory factors as to why the incident happened, lessons learnt and how the incidents should be categorised. There was a standard template for RCA investigations when patients suffered harm. The five steps to safer surgery and World Health Organisation (WHO) checks include swab checks prior to wound closure.
- The clinical risk manager midwife was available between Monday and Friday during office hours and oversaw the completion of all root cause analysis following incidents. Outside of these hours of work there was a dependency on senior staff (band seven) midwives to support the completion of investigations. All band seven staff who reviewed incidents attended root cause analysis training.
- In the gynaecology service the multi-disciplinary team (MDT) reviewed all incidents weekly to identify any themes and trends.
- There were multiple routes for feedback of lessons learned to staff, for example: the staff risks update "risky business" newsletter and weekly review meetings. Incidents were discussed at individual specialty governance meetings and at whole team monthly meetings. The trust wide governance meeting shared learning on incidents with the rest of the trust.

- Never events and serious incidents were discussed at divisional meetings to ensure learning across the service.
- The paediatric team ran the perinatal morbidity meetings and midwifery staff attended to receive feedback about any changes in practice.
- Staff knew their responsibilities regarding duty of candour. Eleven members of staff described the duty of candour regulation, which has been in place since November 2014, requiring all NHS staff to be open and honest with patients when things go wrong.
- The February 2016 issue of 'Risky Business' raised awareness of the duty of candour. When a mistake occurred within the trust, consultants wrote to the patient or met them to explain what had happened, share investigation findings and service action plans to avoid such incidents happening again.
- Data protection and information governance was robust. There had been an incident where a bereaved family had received incorrect photographs. The trust took prompt action to avoid future errors occurring, the labour ward had purchased a camera and printer. Staff had received training to download photographs after each use.

Safety thermometer

- The services monitored monthly quality indicators for infection prevention and control, medication errors and number of complaints as part of the patient safety thermometer.
- The NHS patient safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and harm free care. This enables measurement of the proportion of patients that were kept 'harm free' from pressure ulcers, falls and urine infections (inpatients with a catheter) and venous thromboembolism.
- Safety thermometer and safer staffing information was displayed at the gynaecology ward entrance.
- The Royal College of Obstetricians and Gynaecologists (RCOG) launched the maternity safety thermometer in October 2014. The recommended areas of harm included; perineal and/or abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. Also included was an Apgar score of less than seven at five minutes, and admissions to neonatal units. (The Apgar score is an assessment of overall new-born well-being).

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- Staff had engaged with the maternity safety thermometer consistently providing 100% harm free care. Results were displayed at ward entrances in areas for women and visitors to see.
- Sepsis was not recorded on the maternity dashboard despite this being an agreed action from the quality improvement meeting held in November 2015. Inpatient audits for sepsis did not take place but was identified as the next target for CQUIN (Commissioning for Quality and Innovation) which meant the trust would begin to participate.

Cleanliness, infection control and hygiene

- Clinical areas were visibly clean and there were ample hand gel dispensers with instructions on how to cleanse hands. Staff followed good hand hygiene and bare below the elbow practices.
- Completed cleaning schedules and 'I am clean' stickers provided evidence of regular daily cleaning and equipment checks.
- Monthly infection prevention and control information was not on display at all entrance boards to the wards. This would have indicated to visitors and staff how many days in the previous month the ward had been free from healthcare acquired infections, for example methicillin resistant staphylococcus aureus (MRSA) and Clostridium difficile. During February 2016 there were no reported infections.
- Monthly infection prevention and control audits took place in all clinical areas. Submitted results were reviewed by the infection prevention and control team who would feedback results to staff and identify themes.
- The monthly audits included hand hygiene, standard precautions, care of peripheral vascular device insertion and continuing care, and patient equipment and environment, which showed results of increasing compliance.
- Hand hygiene audit results for the gynaecology service showed 100% compliance which meant that there was a minimal risk of infection.
- All areas across this service had a named infection prevention and control link nurse.

Environment and equipment

- The birthing centre had received compliments as it had an environment that balanced safety and practicality with a homely and non-clinical environment. The action plan produced by maternity services at this hospital

following the Kirkup report had identified the need to replace the suturing spotlights and identified additional space requirements for scanning small for gestational age babies.

- Access to the maternity areas was secure to ensure patient safety. The doors to gain entry to the ward areas were locked. Staff spoke with visitors and asked who they intended to visit, before allowing them entry. During the inspection, inspectors were asked to present their identification badges by staff when gaining entry to the wards.
- All equipment reviewed had been portable appliance tested (PAT) within appropriate dates. (A PAT test is an examination of electrical appliances and equipment to ensure they are safe to use).
- Every delivery room had a baby resuscitaire and baby scales. Check lists for the baby resuscitaire and baby scales indicated daily checks were completed.
- Adult emergency resuscitation trolleys were not available on ward F11 or ward F14. Emergency trolleys were shared with adjacent wards and this had been risk assessed and included on the risk register.
- Adult resuscitation equipment trolleys in adjacent ward areas for F11 and F14 were checked daily however this was not always consistent. Records identified gaps in documentation with two daily checks in one month that were not completed. All items that were held in the resuscitation trolley were checked against the required checklist and were present and within date.
- Cardiotocography (CTG) machines were available for women whose babies needed monitoring in labour, and these were clean and PAT tested.
- Epidural trolleys were visibly clean and well stocked.
- There were emergency evacuation plans to evacuate a mother from the birthing pool in case of an emergency. Staff supporting women having a pool birth had received training and emergency drills had taken place to embed this into practice.
- The antenatal clinic waiting room was shared with the gynaecology clinic area. Clinics were run at different times so that women were seen on an individual basis, in a sensitive manner and confidentiality, privacy and dignity were maintained.
- There was a community midwifery office based on the first floor that provided a base within the hospital for the community midwifery teams.

Medicines

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- In all areas checking of controlled drugs was according to trust policy. Staff were able to refer to the trust's medicines policy, British National Formulary (BNF) or ask for pharmacy staff support.
- Locked drug fridges were checked daily with temperatures recorded and monitored in line with requirements to ensure medications were stored at the correct temperature.
- Emergency drugs were stored in secured drawers on the resuscitation and epidural trolleys in the corridors of the postnatal ward and delivery suite.
- We reviewed 10 prescription charts on the postnatal ward. All charts had signed and dated prescriptions, allergies documented and venous thrombo-embolism (VTE) assessment completed. This meant that if a woman required VTE prophylactic medication, she would have received it, as her risk had been assessed. Staff signatures on three of the prescriptions seen were illegible which meant that should a query occur staff could not be easily identified.
- Although the wards had regular clinical pharmacists they were also able to contact the pharmacy for support and advice. Patient information was available to provide advice about prescribed medicines when breast-feeding. The information provided was detailed and allowed the patient to make an informed decision about the treatment prescribed.
- Learning from medicine incidents was shared through the service's newsletter with identified actions and outcomes.

Records

- We reviewed 20 sets of patient maternity and gynaecology records, 10 from each service. Handheld records were dated and signed and individualised care plans were documented and updated.
- The records included relevant information such as health assessments and screening tools.
- We examined the risk assessments used on women admitted for delivery which included weight, previous pregnancy history, pre-existing risk factors, new onset risk factors and venous thromboembolism risk.
- In both maternity and gynaecology services staff signatures seen within the patient care records were not always legible and had no staff grade to identify the

individual responsible. The trust is implementing an electronic patient record which will have the benefit of ensuring that all entries in the medical record are legible and identifiable to the individual making the entry.
- Patient nursing care records were left outside each patient room or bay in the gynaecology ward in an unsecure area. This meant that there was a risk of inappropriate access to confidential information.
- Red books' for child health records were distributed to mothers for each new-born baby.
- All 10 gynaecology nursing care plans and patient records reviewed had been completed appropriately with .clear pathways of care.
- Appropriate recording and documentation of termination of pregnancy was seen in eight sets of patient records. The service was able to demonstrate how they met the requirements of the Abortion Act 1967 and associated guidelines through the recording of care. All notes were signed, dated, legible and clear records of discussions with the woman were recorded.

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Safeguarding

- Safeguarding policies and procedures were up to date and incorporated relevant guidance and legislation. Staff demonstrated a good knowledge of safeguarding and easily accessed safeguarding policies on the intranet.
- Evidence submitted by the trust showed that 98% of all midwives were trained in safeguarding children to level three. However only 64% of medical staff had this training.
- In gynaecology 100% nurses were trained to level two and 90% medical staff (maternity and gynaecology combined) were compliant at level two.
- There was a named safeguarding link nurse for each area within gynaecology, and there was a part time specialist midwife for safeguarding. We were informed that this was a change that did not support the workload from across the service. There was no evidence of recruitment or backfill into this post which meant that the workload was increasing for the part time midwife.
- There was no identified nurse or midwife to lead or report on female genital mutilation (FGM), and no specialist midwife responsible for perinatal mental

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health, substance misuse or domestic violence. However there were posters informing patients of contact details if they were in an abusive relationship to enable them to get help should they require support.

- Systems, processes and practices to keep babies and adults safe were in place and communicated to staff. Staff knew how to identify and report abuse and neglect. All staff explained to us how they would identify a concern.
- There were forums to learn lessons about safeguarding with a weekly networking and peer group meeting for medical and nursing staff from across the trust. The purpose of this meeting was to discuss complex safeguarding cases and events.
- The service's safeguarding lead helped to raise the profile of safeguarding through developing a safeguarding newsletter.
- All staff had access to the safeguarding handbook April 2015 which incorporated the Mental Capacity Act and deprivation of liberty. This meant that staff had access to information to identify their responsibilities and what actions to take to safeguard their patients.
- Safeguarding issues were reviewed at the clinical safety and effectiveness committee, which included a report of safeguarding performance against indicators. These included indicators for having an up to date policy, training in safeguarding level one for all staff, and discharge planning meetings for all cases where there were safeguarding concerns.
- There were weekly safeguarding meetings attended by doctors and nurses, with safeguarding link staff present.
- Staff were aware of the abuse associated with FGM. They knew that they had a mandatory duty to report FGM or the imminent risk of FGM. They followed NHS England guidelines which included relevant questions and answers.

Mandatory training

- Staff had identified mandatory training days allocated each year. Mandatory training across the maternity and gynaecology service was compliant in all aspects apart from conflict resolution which was at 72%, against a trust target of 80%, this was recorded separately to the skills and drills training.
- Staff training for basic life support, a part of mandatory training showed that nursing and midwifery registered staff attendance was 96%, additional clinical services 95% and medical and dental staff 55%.

- A practice development midwife was employed by the service and they had the responsibility of facilitating all training and documenting compliance.
- Nursing staff felt supported to complete mandatory training and staff had individual files for both mandatory and non-mandatory training, documenting the courses they had undertaken and all competencies gained.
- The mandatory training was documented in the trust or department training needs analysis, however training needs could also be identified in action plans following audit or incident investigations and bespoke training was provided to address these.
- 80 staff, midwives and doctors, attended a cardiotocography (CTG) study day in April 2015 as part of PROMPT (practical obstetric multi-professional training), compliance was 85% for midwifery staff who attended updated PROMPT training.
- Perinatal training software online teaching packages were used, with 90% of midwives completing the learning and disability training.

Assessing and responding to patient risk

- The World Health Organisation (WHO) surgical checklist, five steps to safer surgery, was in place in gynaecology and maternity theatres. We examined the records of six women where safer surgery checklists were required and found that four were fully completed.
- An adapted WHO checklist was in use for emergency obstetric surgery. Compliance with WHO checks were reported monthly as part of the maternity dashboard. The dashboard showed non-compliance for nine months with a mean average of 79%. It was identified during the inspection that there was limited involvement of the theatre team in discussions to identify improvements. Feedback had been to the surgeon but not the theatre manager resulting in appropriate theatre personnel not being included. Theatre circulating staff completed the documentation and this group had not received any information or direction for the areas of inconsistency to enable improvements to take place. This was fed back to the service manager and on the unannounced there was evidence of improvements..
- Staff were able to demonstrate the correct completion of the National Early Warning System (NEWS) and

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described actions they would take to care for a deteriorating patient. Gynaecology records were reviewed and all were complete and demonstrated clear appropriate escalation and actions.

- There was a documented discharge pathway for women transferred from theatres back to the ward and a handover checklist completed.
- Staff had raised concerns regarding the appropriateness of allocation of patients to staff. Whilst there is no evidence to show that such concerns are substantiated, this was being addressed as part of the Band 7 development programme.

Nursing and Midwifery staffing

- The ratio of all midwifery staff to births at the trust was 1:26 in January 2016 which was better than the national average of 1:29 and the Royal College of Obstetricians 'Safer Childbirth: minimum standards for organisation and delivery of care in labour', 2007.
- On reviewing the ratio of midwife to births ratio for 2015 we saw a ratio of 1:30 in April, May, June and October 2015 and 1:29 for July, August, November and December. There was no submitted ratio for September 2015.
- Local monthly audits included clinical safety, safer staffing and quality assurance but results were not always displayed for patients and visitors to see.
- Boards at the ward entrances displayed the midwifery staffing levels, the midwifery to birth ratio and the expected levels and actual levels of staffing. All women had a named midwife.
- The maternity department last reviewed the staffing levels within maternity in 2011 using the maternity skill mix tool of Birth Rate Plus methodology. Monthly staffing figures were presented to the trust board through the patient safety and effectiveness group. Following publication of the National Institute for Health and Care Excellence (NICE) Safe Midwifery Staffing guidance in February 2015, the trust had started to review the complete service provided to its service users and their families.
- There was a business case, due to go to trust board in May 2016 following our inspection and on completion of the staffing review to present the reallocation of staff across maternity.
- The sickness rate for midwives 2014 to 2015 was 2.9% which decreased from August 2015 and was below the trust target of 3.73%.

- The early pregnancy assessment sister had no development or involvement in the regional or national network support group. An antenatal midwife covered when she was on leave or absent from work.

Medical staffing

- Consultant obstetric cover in the delivery suite was 60 hours a week. This meant a consultant was present on the delivery suite from 8am-8pm, Monday to Friday. Consultants undertook weekend ward rounds and then provided cover via on call system.
- There was a good skill mix of medical staff on duty at all times.
- Medical and midwifery staff told us that consultants often provided additional cover out of hours and responded to requests for help promptly when called.
- Consultant and anaesthetic cover was available 24 hours a day, seven days a week for both maternity and gynaecology services.
- There were daily medical ward rounds and all patients were seen one hour following admission.
- Medical or surgical outliers on ward F14 were seen at the earliest opportunity but not before general ward rounds had been completed. This meant that patients could have had a delay in transferring to the correct speciality ward.
- The divisional director said that the trust had worked hard to attract trainees. Trainee feedback had been good and the deanery had increased the number of trainees. Three trainee doctors confirmed that they received support and consultants were accessible and approachable.
- Junior doctors received a comprehensive induction and had teaching and learning opportunities within this service.

Major incident awareness and training

- The service followed the trust's major incident policy which was accessible to all staff on the intranet.
- Staff confirmed they were familiar with the major incident policy on the intranet and their individual roles in an incident. The trust E-learning on major incidents was mandatory.
- Staff could not recall when they were last aware or involved in a resilience practice test which meant they may not respond according to trust policy in the event of a major incident.

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- Staff had access to the business continuity plans via the intranet.

Are maternity and gynaecology services effective?

Good 🟢

Maternity and gynaecology services were rated good for effective because;

- The normal birth, overall caesarean section and instrumental delivery rates were all better than the national averages. This meant that the outcomes for women who use these services were better than expected when compared with other similar sized services.
- Women received support in achieving natural deliveries and commence breast-feeding (if that was their chosen method of feeding) after the birth.
- There was an anaesthetic consultant on-call for the maternity service 24 hours a day, seven days a week providing epidurals when requested.
- Community midwives had access to their own electronic tablet that enabled remote access to the trust website and current clinical guidelines.
- The service took part in national audits and completed a range of local and national audits to review their services in line with nationally published recommendations e.g. the Kirkup report 2015 from The Morecambe Bay investigation of maternity and neonatal services.
- The maternity service had achieved the United Nations International Children's Emergency Fund (UNICEF) Baby Friendly: stage two accreditation, which means the trust has educated staff to implement baby friendly standards and has been externally assessed by UNICEF UK.
- The termination of pregnancy process followed all elements of national guidelines and legislation.
- Consent to termination of pregnancy was in line with national guidance.
- The trust had a rolling audit programme that showed the outcomes of audits completed, recommendations and progress towards any agreed actions.

However;

- The maternity service was operating within ratified guidelines but review of guidelines was not robust.
- The service had higher than 10% admission rates of babies to neonatal intensive care unit, a level one unit from the maternity services. Some of these patients who require intravenous medication were looked after on the postnatal ward.
- The trust had set targets for clinical performance for most clinical outcomes. It had not done so for induction of labour or failed instrumental deliveries however the trust has performed in line with the national trend in the recent RCOG data for induction of labour.
- There was no action plans to support areas where the outcomes were higher than the national average.
- Appraisal rates for maternity and gynaecology nursing, midwifery, support and clerical staff were 67% overall against the trust target of 90%, there was a varied level of compliance across this service. .
- The trust employed sufficient supervisors of midwives (SoMs) to meet the national recommendation of 1:15 however at present, due to secondment and extended leave, the ratio has risen to 1:22. The trust told us that the remaining SoMs have had additional time allocated in order to enable them to meet their supervisory responsibilities. However this was not confirmed by the SOM's in post.

Evidence-based care and treatment

- Guidelines and policies were based on guidance issued by professional and expert bodies such as the National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetrics and Gynaecology (RCOG) safer childbirth guidelines. This meant that women were receiving evidence based care.
- The trust had no targets in some areas of maternity which meant that there was poor evidence on the clinical performance and governance dashboard, including the monitoring of women who had planned to have a vaginal birth after having a caesearian during .a previous birth (VBAC).
- The maternity service was operating within ratified guidelines but review of guidelines was not robust. For example antepartum haemorrhage guidance was last reviewed in December 2009, blood grouping for antibodies last reviewed in December 2011,

neurological physiological exam of new-born last reviewed in October 2011, group B streptococcus reviewed in November 2011 and guidance on guidelines last reviewed in Dec 2012.

- The mothers and babies reducing risk through audits and confidential enquiries across the UK (MBRRACE-UK) report released on 17 May 2016 showed that there has been a slight fall in the rates of stillbirths and neonatal deaths in the UK compared with rates in 2013 but that preterm deliveries are a problem. This trust was reported as better than the aspirational target for stillbirth rates and reported 4 stillbirths between April 2015 and January 2016. MBBRACE had reported that this trust had perinatal mortality rates 10% higher than the UK average for all births and 10% lower than the UK average for births 22 weeks plus. However due to the size of this unit, when compared to comparatively sized birth units, the trust delivered better than average performance for stillbirth, neonatal and extended perinatal mortality rates.
- Staff had access to guidance, policies and procedures via the trust intranet.
- Monthly clinical audit meetings were held and learning from audits was shared with staff at divisional governance meetings.
- Local audits were completed monthly and included clinical safety, safer staffing and quality assurance but results were not always displayed for patients and visitors to see.
- The service met or exceeded two out of five of the indicators for the National Neonatal Audit Programme (NNAP) 2014. The two indicators that were met or exceed related to babies having their temperature taken within the first hour after birth which was100% and mothers receiving antenatal steroids after delivering 24 +0 to 34+ 6 gestation baby 87%.
- The three indicators where the service failed to meet the standards were: babies receiving retinopathy of prematurity screening (to screen for a visual impairment) (96% against a national standard of 100%). Documented consultation with parents and a senior member of neonatal team within 24 hours of admission (98% against a standard of 100%) and babies having their mother's milk when discharged from a neonatal unit (50% compared to a standard of 58% or above).The trust had plans to address the areas where standards were not met.

- The government commissioned an independent investigation into maternity and neonatal services at Morecambe Bay NHS Trust to examine concerns raised by the occurrence of serious incidents. The report findings, published in May 2015, included recommendations directed nationally at the NHS, to minimise the chance that these events would be repeated elsewhere. The service had completed a full review and a quality improvement visit in line with the Morecambe Bay investigation report recommendations, benchmarking themselves as fully compliant for 17 out of 19 of the recommendations and partially compliant for two. An action plan to ensure full compliance with all the recommendations had been devised with a completion date of March 2016.
- We reviewed twenty patient records throughout the inspection, eight of which were from women receiving postnatal care. The care received was in accordance with The National Institute of Health and Care Excellence quality standard 37: postnatal care.
- The notes of six antenatal women who were inpatients on ward F11 demonstrated that the care received was compliant with The National Institute of Health and Care Excellence quality standard 22: antenatal care.
- The service had a clear process for booking women in to the antenatal service and checking them at identified points during the pregnancy. In the six women's notes reviewed all six women had been seen in accordance with maternity standards.
- The normal unassisted birth rate had been reported at 68% which was higher than the England average of 60%, the overall caesarean section rate was 20% lower than the England average of 26% for July 2014 until June 2015.
- The instrumental delivery rates were 9.8% and the Royal College of Obstetrics and Gynaecologists review during 2015 confirmed all targets had been achieved.

Pain relief

- There was a dedicated anaesthetic consultant on-call for the maternity service 24 hours a day, seven days a week. This meant if women requested epidural anaesthesia it was available to them at all times.
- All patients stated that staff assessed their pain regularly and offered them choices of pain relief as required and these medications were then given without delay.

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- A review of the medication administration records of eight women demonstrated that pain relief had been administered as required in line with the prescription. The birthing records included discussion about the woman's choice of analgesia during labour.
- The colposcopy service was accessible through the gynaecology clinic and was run by a nurse specialist and a doctor. Pain relief was administered after patient discussion and consent.

Nutrition and hydration

- The maternity service had the UNICEF Baby Friendly stage two accreditation. The 'Baby Friendly' initiative is a worldwide programme of the World Health Organisation (WHO) and UNICEF to promote breast feeding.
- Antenatal records confirmed that staff discussed infant feeding choices and the maternity records included the time when feeding was initiated in relation to the time of delivery.
- Patients all had access to drinking water beside their bed unless they were nil by mouth.
- A choice of meals was available and patients completed menu choices for the day. Snacks were available outside of meal times. Patient feedback about the quality of meals was mixed, with one patient stating the portion size was small but that staff went out of their way to get her extra food. When a patient did not like what had been requested they were offered an alternative.
- Malnutrition universal scoring tool (MUST) assessments were completed and had identified nutrition and hydration requirements and demonstrated effective management with support from a dietician and pharmacist. MUST was correctly completed in the six gynaecology patient records that were reviewed.
- There was no protected mealtime within labour ward which meant that women who had delivered but not moved to postnatal ward could be disturbed during this important part of the day during breast feeding.
- Patients received assistance with eating and drinking where necessary.

Patient outcomes

- The service maintained a maternity dashboard which reported against the clinical outcome indicators including those recommended by the Royal College of Obstetrics and Gynaecology (RCOG). This document was displayed on the ward for patients, relatives and staff to see. We saw the 4 stillbirths reported for April 2015-January 2016 and the postpartum haemorrhage mean average for the same period of time was 5%.There were no trust targets set for either indicator.
- The maternity service was not indicated as an outlier (performed significantly worse than national average) for maternal readmissions, neonatal readmissions or severe maternal infections diagnosed within six weeks of birth.
- The service had higher than 10% admission rates of babies to neonatal intensive care unit, a level one unit from the maternity services. Some of these patients who require intravenous medication were looked after on the postnatal ward. There were 2,425 babies born under the care of the service in 2015; 64% were normal births which is higher (better) than the normal birth rate in England of 60.1%.
- The elective caesarean section rate was 8.6% lower than the national average; and the emergency caesarean section rate was 12.3%, lower (better) than the national average. Overall the caesarean section rate in 2014 was lower (better) than the trust target and national average at 20.9% compared to 25.5%.
- The home birth rate for babies born between May 2015 and January 2016 was 3.4% above (better) than the national average of 2.3% and the trust target of 2.5%.
- Between April 2015 and January 2016, the induction rate was 25.2%, which was better than the national average of 25.9%. There was no agreed trust target for induction rate, which was being reviewed.
- The instrumental delivery rate between May 2015 and January 2016 was 10.3%, which was lower (better) than the national average of 12.9%. There was no agreed trust target.
- The rate of third and fourth degree tears was 7%, which was higher (worse) than the trust target of 6%. No action plan was seen but senior staff confirmed there was ongoing support to meet agreed targets which are reviewed by the CCG.

Competent staff

- All newly qualified midwives received a preceptorship programme, which they had to complete to enable progression to a higher pay grade.
- The trust target for appraisals was set at 90%. The breakdown of appraisals by ward area was:
  - Gynaecology clinic 100%
  - Antenatal clinics 25%

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- Community midwives 60%
- Midwifery-led birthing unit 100%
- Midwifery management 0%
- F11 (postnatal and antenatal) ward 50%
- F14 (gynaecology) ward 30%
- Administration and clerical staff 80%

- 100 percent of Medical staff had completed an appraisal in 2015. This information was presented from SARD (strengthened appraisal and revalidation database) which does not interface with the electronic staff record (ESR) database used by the trust which stated incorrectly, 0% compliance.

- Supervisors of midwives (SoMs) help midwives provide safe care and were accountable to the local supervising authority midwifery officer (LSAMO). The national recommendation for a SoM is to have a caseload of 15 midwives. The trust employed sufficient supervisors of midwives (SoMs) to meet the national recommendation of 1:15 however at present, due to secondment and extended leave, the ratio has risen to 1:22. The trust told us that the remaining SoMs have had additional time allocated in order to enable them to meet their supervisory responsibilities. However this was not confirmed by the SOM's in post.

- Staff said that they were supported to gain additional qualifications and to maintain their professional development.

Multidisciplinary working

- Staff worked effectively together, both internally and in the community, although we were informed of a small number of senior midwives failed to support newly qualified staff.

- The maternity service promoted multidisciplinary team working, including antenatal services, community midwives, health visitors, neonatal unit, GPs and social services staff were all linked through joint working with women and their families to plan the women's care throughout the pregnancy and after birth.

- The antenatal screening and foetal medicine team had good working relationships with specialist referral units and the local hospice.

- Care and treatment plans were clearly documented and communicated effectively to other healthcare professionals; for example, general practitioners.

Seven-day services

- The early pregnancy assessment unit (EPAU) was open between 8am and 6pm Monday to Friday, with patient access to the service at weekends through the medical staff outside of the EPAU.

- The physiotherapy and occupational services department supported patients Monday to Friday with a reduced service at weekends.

- A consultant obstetrician was present on the delivery suite from 8am to 8pm, Monday to Friday and weekend cover provided through ward rounds and on call service.

- There was an anaesthetic consultant on-call for the maternity service 24 hours a day, seven days a week providing epidurals when requested.

- Community midwives provided an on-call service to facilitate home births and cover for labour ward.

Access to information

- The service had a paper-based notes system, with all care documented in individual hospital notes. Pregnant women had hand held notes which they carried with them.

- Records were readily available to staff to refer to during the time of a woman's admission.

- Staff were able to access patients test results and trust policies and procedures via the trust intranet system.

- Community midwives had access to information technology, via individual electronic tablets, and could access digital health records. This meant they did have remote access to current clinical guidelines to support consistency of care.

- All community midwifery teams had bases to work from attached to health centres or general practitioners.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients consent to care and treatment complied with national legislation and guidance, including the Mental Capacity Act.

- Consent to termination of pregnancy was undertaken in line with national guidance.

- Mandatory safeguarding adults training included training on consent, the Mental Capacity Act, Deprivation of Liberty Safeguards and caring for patients with a learning disability. 90% of midwifery and nursing staff were complaint with this training against the trust target of 95%.

Maternity and gynaecology

Are maternity and gynaecology services caring?

Good 🟢

We rated the maternity and gynaecology good for caring because;

- The care observed during the inspection showed women being treated with dignity and respect. Women were very positive about being informed about their care and said they were supported to make informed choices.
- Women attending the focus group were positive about the staff going beyond their expectations.
- Observed interactions between staff, women and their relatives were good.
- The percentage of women who would recommend friends and family to give birth at this hospital and would recommend its' postnatal services was consistently above the England average at 98%.
- The 2015 maternity survey results were in line with other trusts for all aspects of care.
- Across the gynaecology services we observed that staff providing care were dedicated, compassionate, caring and delivered the best experience possible for the women in their care.

Compassionate care

- Between July 2014 and June 2015, the percentage of patients recommending the antenatal and postnatal community services ranged from 98% to 100%, with 100% achieved in January 2016.
- The percentage of women who would recommend friends and family to give birth at this hospital was consistently above the England average between Feb 2015 and Feb 2016, reporting between 98% and 100%.
- The percentage of women who would recommend the postnatal services in this hospital was consistently above the England average between Feb 2015 and Feb 2016 reporting between 98 and 100%.
- The gynaecology ward, F14, had returns from Friends and family testing with a mean of 96% between July and Sept 2015 with people recommending the service to their friends and family.

- The service performed in line with other trusts for all 17 questions in the 2015 Care Quality Commission survey of women's experiences of maternity services.
- 20 women we spoke with were very positive about the care they received. All the women told us that they had been treated with kindness, dignity and respect. There were good interactions between staff, women and their relatives.

Understanding and involvement of patients and those close to them

- All the women we spoke with within the maternity service were able to identify their named midwife and confirmed that they had been accessible to them throughout their pregnancy.
- The six patients within the gynaecology service were also able to confirm that they had a named nurse throughout their care.
- Woman and their families said they had been fully involved and included in all aspects of their care.
- Women were supported to make informed choices and stated that communication from doctors and nurses and midwives was good and they were involved with their care.
- Staff explained the details of patient care plans to patients to keep them well informed.
- Staff introduced themselves to women using the "my name is" approach.
- All women praised the staff for the way in which they had been treated and kept informed.
- Women said that doctors had told them of their diagnosis in a way that they understood and were fully aware of what treatment they would receive.
- Women told us of their birth experiences and described staff as 'fantastic'.
- One woman told us how staff had communicated clearly between each other about her specific needs so that she did not have to worry during her hospital stay.
- Another carer informed us of how she had been supported to stay overnight to allow the individual receiving care to feel supported.
- A focus group feedback informed us that not all partners were allowed to stop overnight in the maternity ward.

Emotional support

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- Midwives interactions with women were observed as kind, caring and compassionate during the inspection. The midwives were clearly trying to provide the best possible experience for the women in their care before, during and after their birth.
- Within gynaecology the service provided women with the opportunity to meet the staff and discuss their care prior to making decisions regarding their treatment.
- There were specific emotional individualised care pathways for women following a miscarriage.
- All women confirmed that they were able to ask staff additional questions they had regarding the procedure or process prior to their agreed treatment. They were confident in and understood their care pathway.
- Within the maternity and gynaecology service staff had considered all aspects of emotional care and support that the women who had lost a baby would require.
- A midwife was allocated to care for the bereaved women on a one to one basis.
- Individual and cultural practices were respected in relation to bereavement, with memory boxes and the 'loss of your baby' parent information leaflets.
- A counselling service could be accessed for women and staff. Staff had received training in counselling to help women in making decisions about their treatment.
- There was a list of chaplaincy services for staff to contact to meet the spiritual requirements of the women and their families.
- There was a poster displayed on the wards for partners and visitors giving advice on expectations of behaviour when staying on the ward.
- A patient's carer told us they were encouraged to stay on the gynaecological ward as staff recognised that the patient needed their support.
- A midwife-led clinic was provided to support women who wanted to come to terms with their birth experiences.
- Staff confirmed that birthing partners were not encouraged to stay overnight with women on the postnatal ward which would provide extra support to new mothers and enable early bonding for the family unit.

Are maternity and gynaecology services responsive?

Good ●

We rated maternity and gynaecology services as good for responsive because;

- The maternity and gynaecology services had been operating within ratified policies and guidelines.
- The gynaecology cancer waiting time for 2015 had been achieved.
- Every woman admitted for termination of pregnancy was allocated a bed in a dedicated bay on the gynaecology ward.
- Partners were encouraged to stay overnight on the antenatal ward and gynaecology ward. Reclining chairs were provided for their comfort.
- A new bereavement suite was being built within the labour suite area, following a successful bid and after the local need for this client group had been identified.
- The 18 week to admission target for 2015 had been achieved, with 6.71% patients who had waited over 18 weeks.
- The total number of patients waiting for a gynaecology first appointment was 72, within the expected number for this service, with 37 patients waiting over 18 weeks.

However;

- The last reported birth-rate plus review was in 2011. The interim Director of Nursing had commissioned a review of the staffing for this service.
- Ward F14 gynaecology often received patients from other specialities; this meant that at times staff were caring for patients with a greater needs than the staffing levels were set for. These patients could be admitted directly from accident and emergency with no senior review from the medical team, meaning their suitability for care on a non-specialist ward was not assessed.
- The postnatal ward did not encourage partners to stay overnight but within the same ward area women who were admitted for induction of labour were supported overnight by their partners.
- Four out of 12 women did not know about how to make a complaint about the service.
- We were informed of the patient admissions from other specialities to F14 and saw four patients from medicine and surgery admitted as outliers during the inspection.

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- There was a lack of specialist midwives to support women in vulnerable groups.
- Thirty-six percent of gynaecology and 54% of colposcopy clinics had one slot or more cancelled in 2015.

Service planning and delivery to meet the needs of local people

- Women were given informed choice about where to give birth depending on the clinical need. The community midwives offered an on-call service to support mothers who planned to have a home birth.
- The midwife-led birthing unit (MLBU) was a 'home from home' environment designed to facilitate normal birth. From April 2015 to February 2015, approximately 17% of women delivered in the MLBU, with the majority of them making use of the birthing pools for labour or delivery which was good.
- All of the women were impressed with the birthing facilities available within the midwifery led unit. The birthing pools supported those who wanted a water birth or preferred to labour in the birthing pool to reduce the need for pain relief. Staff reassured women who confirmed that their experience was exceptional.
- Every woman admitted for a termination of pregnancy was allocated a bed in a dedicated bay and admitted directly to the gynaecology ward.
- The trust performed 'about the same' as other trusts when women were questioned about staff and care during labour, birth and after birth (CQC Maternity Care Survey, 2015).

Access and flow

- There were no closures of the maternity unit in 2015 and no women in labour were diverted to other local hospitals.
- Maternity bed occupancy ranged between 33% between April 2013 and March 2015, which is below the England average of between 55% and 60%.
- 96% of women attended an antenatal appointment within 12 weeks six days of pregnancy, against (better than) a trust target of 90%.
- Senior staff told us that new criteria for non-gynaecology patient admission had been agreed for the gynaecology ward but there were times when staff felt pressured by operational staff to admit patients that did not meet the agreed criteria.

- Patients from other specialities were admitted to the gynaecology ward directly from accident and emergency department with no senior medical review or assessment against the agreed criteria prior to admission to F14. This meant that at times staff were caring for patients with a greater needs than the staffing levels were set for. No senior review from the medical team meant patient suitability for care on a non-specialist ward was not assessed.
- The 18 week to admission target for January to December 2015 had been achieved, with 6.71% patients that had waited over 18 weeks.
- Data submitted by the trust showed the total number of patients awaiting gynaecology admission was 72, within the expected number for this service, with 37 patients waiting over 18 weeks.
- The management of clinics or missed appointments required a review as 36% of gynaecology and 54% of colposcopy clinics had one slot or more cancelled in 2015 from 2,132 gynaecology and colposcopy clinics completed.

Meeting people's individual needs

- Women who needed specialist foetal medicine management were referred to the regional specialist centre.
- Specialist clinics were available which included a breech clinic, a vaginal birth after caesarean section clinic and a multiple pregnancy clinic.
- Women who were known to be having a still birth were cared for away from those delivering live babies. This area was away from the main ward and had en-suite facilities.
- Link nurses and community midwives were identified to support patients with learning disabilities.
- All information on notice boards and leaflets were presented in English. Patient information leaflets could be printed off form the trust internet site in a variety of languages including Portuguese, Russian, Chinese, Polish, Turkish and Lithuanian.
- Both interpreters and language line were used to communicate with women where English was not the woman's first language.
- There was an excellent service performed by volunteers across the trust and we spoke to one volunteer during the inspection who praised the staff across the service.
- The trust did not offer a specialist teenage pregnancy midwife, bereavement support midwife, or vulnerable

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women support midwife, meaning that women who experienced issues with mental health, substance abuse or domestic abuse may not get the specialist support they require.

- Female genital mutilation was reported on the maternity dashboard monthly and bespoke training for increased awareness was offered.
- Partners were encouraged to stay over on the antenatal ward to support women undergoing induction or early labour. Reclining chairs were provided .
- However the postnatal ward did not actively encourage partners to stay despite being within the same ward area. This had the potential to create conflict between partners of these two client groups, as this was not family friendly.

Learning from complaints and concerns

- Patient advice and liaison service leaflets (PALS) containing information on how to raise a formal complaint, were available and were given to patients when informal complaints were made. Patients and their families were advised if local resolution could not be reached to contact the PALS service to escalate their complaint formally.
- 'You said, we did' posters were displayed across the service for patients and visitors to see the changes implemented in response to feedback.
- Four out of the ten women we spoke were not aware of the PALS service or how to access it.
- F14 had addressed concerns raised through "You said, we did" patient feedback with noise disturbance at night and all patients were offered earplugs or eye masks to promote rest.
- A patient 'formal complaints' leaflet was displayed on the entrance to the labour suite and gave access details for their complaints office, patient advice and liaison service office, NHS complaints advocacy service-voiceability and the health service ombudsman.
- Between January and December 2015 the service had received ten complaints. The complaints related to staff attitude and patient information. The majority of complaints were following poor communication or staff attitudes.

Are maternity and gynaecology services well-led?

> **Requires improvement** 🔶

Maternity and gynaecology services were rated as requires improvement for well-led because ;

- There was a level of uncertainty and lack of direction within the workforce in maternity due to the changes in local leadership.
- At the time of our inspection there was no identified link within the trust to attend the maternity service liaison committee (MSCL) meetings. However a senior member of the midwifery management team attended regularly.
- There had been a reported bullying and unsupportive culture involving a small number of senior staff since April 2015. Despite beginning to address these concerns response had been slow and staff were unaware of the plans in place.
- Whilst there was no evidence of impact the practice of allowing junior staff to manage complex patients was accepted practice. The trust were mitigating any risk through a band 7 development programme.

- The service had no targets in some areas of maternity which meant that there was poor evidence on the clinical performance and governance dashboard, including the monitoring of women who had planned to have a vaginal birth after having a caesearian during .a previous birth (VBAC).

- There were limited action plans for areas where the service did not meet national standards.

However;

- Staff retention was mostly good. Staff and clinicians felt a strong sense of loyalty to the trust and described with passion how they wanted to provide good patient care.
- The clinical lead for medical training for obstetrics and gynaecology confirmed two extra medical students had been allocated placements within this service, which was good.
- The senior sister for gynaecology was described by staff as supportive and approachable.
- The interim head of midwifery was praised by staff as being visible, a good communicator and supportive to all staff.

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- There was chaplaincy support across the trust which provide an appropriate level of support for maternity and gynaecology services.

Vision and strategy for this service

- The overall trust values, vision and strategy were known by 30 of the 38 staff spoken to within maternity and gynaecology services.
- Staff across the gynaecology service described how that the vision was to provide "the best for our patients".
- There was no clear service strategy and no defined stable leadership at the time of the inspection. Staff did not know what the strategy or direction for maternity services was. This demonstrated that the service vision and strategy was not embedded in practice.

Governance, risk management and quality measurement

- .Risk registers were in use across the service and monitored monthly via the divisional team. Senior staff were aware of local risks and those identified as the top three were staffing levels, communication and medication errors. The risk register identified most of the risk that the inspection team identified.
- However, despite staffing levels being stated as a risk, there was no recorded recent skill mix review to ensure sufficient numbers of staff as well as development support for staff and supervision. The supervisor of midwives number to midwives did not meet national guidance.
- The clinical lead for medical training for obstetrics and gynaecology confirmed two extra medical students had been allocated placements within this service by the deanery, which was good.
- The service used a quality dashboard that was reviewed on a monthly basis which used the red, amber, green (RAG) flagging system to highlight areas of concern. However these dashboards were not displayed across the service which meant that not all staff were aware of performance.
- Governance meetings at ward, divisional and senior clinical level helped staff manage and learn from risk and incidents.
- The service had no targets in some areas of maternity which meant that there was poor evidence on the

clinical performance and governance dashboard, including the monitoring of women who had planned to have a vaginal birth after having a caesearian during .a previous birth (VBAC).
- There were limited action plans for areas where the service did not meet national standards.

Leadership of service

- Local leadership of maternity services had undergone a significant amount of change and was not finalised or embedded which meant that there was a level of uncertainty and lack of direction.
- The interim head of midwifery was in the substantive role of clinical risk manager. Five months into the interim covering there were no plans to backfill the substantive post.
- Staff described the interim local leadership and support as good. Managers were visible and approachable and said there was effective communication within the service.
- Improvements were beginning however support provided to the interim head of midwifery by the executive team needed to be consistent to ensure continued progress.
- During our inspection we saw the senior sister for gynaecology to be credible, professional, and visible. She was observed to nurture and empower staff. All six of the gynaecology staff we spoke with described her as supportive and approachable.
- Whilst there was no evidence of impact the practice of allowing junior staff to manage complex patients was accepted practice. The trust were mitigating any risk through a band 7 development programme.
- All staff were able to name the chief executive who was highly visible across the maternity service. There were regular forums available to meet the chief executive and the medical director. There was no allocated non-executive director NED or specific hospital chaplain for maternity and gynaecology, despite quality walk rounds being completed by the executive team. There was chaplaincy support across the trust which provide an appropriate level of support for maternity and gynaecology services.

Culture within the service.

- There had been a reported bullying and unsupportive culture involving a small number of senior staff and support to junior staff was inconsistent. The trust had a

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whistleblowing policy however some staff stated that concerns had been raised but were not addressed in a timely manner. The trust informed us of a number of actions which it had taken to address the situation. However, staff appeared unaware of these plans. There was a concern raised by staff regarding bullying during inspection, that concern was escalated to the trust executive team by the head of hospital inspection and appropriate action was taken.

- Investigations into the previous bullying allegations were ongoing and were being undertaken appropriately, as per trust policy; however sickness had led to delays in the conclusion of staff disciplinary proceedings.
- At the time of inspection, the culture was affecting staff morale but was not affecting the quality of patient care as perceived by the patients. However, there was a potential risk to patient safety from a lack of supervision and support for junior midwives. There was no evidence of a robust plan to address these issues and we were not assured that there was adequate oversight to ensure improvement.
- Staff predominantly had positive working relationships with other multidisciplinary teams and other agencies.
- Despite some challenging behaviours within a small group of individuals, staff presented a flexibility, willingness and overwhelming desire to ensure the best care for the patients within maternity and gynaecology services. Staff and clinicians felt a strong sense of loyalty to the trust.

Public engagement

- The service had advertised on the trust website an established maternity service liaison committee (MSLC) which is a forum for maternity service users, providers and commissioners of maternity services to come together to design services to meet the needs of local women, parents and their families.
- However, the chair of the MSLC told us the group needed a new identified trust link to support 'listened to and valued' values. Senior managers of the service described the MSLC as having a positive and proactive influence on the care of women.

Staff engagement

- Several staff in the service had been nominated for local awards. The shining light awards recognised staff that had gone beyond the expectations of their role.
- Following the death of a young midwifery colleague a staff annual award ceremony began in 2013 in their honour.
- Four awards were presented recently to staff for 'midwife of the year' in recognition of a forward thinking midwife who introduced the same level of care across the labour suite as women experience in the hospital's midwifery led birthing unit. Midwifery care assistant of the year was an individual who received excellent feedback from the women she has looked after and for her positive attitude and willingness to help whenever necessary across the clinical areas. Student midwife of the year was awarded to a student after self-funding and organising a placement in Africa to learn more about maternity care in Ghana. The final award was to the personal assistant who provided support to the whole maternity team and arranged this annual event.

Innovation, improvement and sustainability

- A second birthing pool was created in the memory of the deceased midwife to give more women the chance to deliver in water after the hospital's existing birthing pool proved extremely popular. This funding was supported by the family, friends, colleagues and local community.
- The senior team had prepared a business case to be presented at trust board in May 2016 following a review of community staffing levels which had extended across the service and showed positive staff numbers in the community against the hospital site which required additional staff.
- The maternity department had won a bid to develop a new bereavement suite within the service which is due to open in April 2016.The project includes an en-suite bedroom and small office set up on the labour suite corridor. The room will be used by women who have lost a baby, meaning they can deliver without the distress of transferring to the labour suite and can also be offered psychological and practical support in calm and comfortable surroundings. The funding was raised by local people who held a variety of events and sponsored challenges.

Services for children and young people

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

Information about the service

Children's services at West Suffolk Hospital consist of children's outpatient services, children's day surgery, dedicated paediatric recovery and intensive care areas and the children's ward (Rainbow Ward F1). There is also a children's assessment unit open 24 hours a day next to the children's ward to provide rapid assessment andcare. The children's ward has 15 inpatient beds and three day case beds. There is a separate room on the children's ward for children who are oncology patients. There is a two-bedded cubicle on the children's ward for high dependency care.

The children's inpatient ward sees children for planned medical, orthopaedics elective, ear, nose and throat (ENT) procedures and , and oncology and orthopaedics patients. They also see emergency cases from general surgery and other surgical specialities such as ENT. There is a consultant presence on the ward and neonatal unit between 7am and 8pm on weekdays and 7am to 1pm at weekends.

There is planned day surgery for children, and a children's recovery area and a dedicated paediatric equipped area in the intensive care unit and in theatres. The children's service sees children up to the age of 16. It is a small to medium sized children's service when compared nationally, and had 3553 spells of children's care from September 2014 to August 2015.

The children's outpatient department sees and treats children in a variety of specialities: general medical; neurology; pathology; orthopaedics; cardiology; urology; endocrine; neonatal follow up; dental; oncology; genetics; psychology; palliative care; dermatology; and hypnosis. Opening hours are 8.30 am to 5.30 pm Monday to Friday with late opening until 7.30 pm two evenings per month.

The trust has a 12 cot neonatal unit on site looking after new-born babies. It is a level one unit which means that it provides special care but does not aim to provide any continuing high dependency or intensive care. It cares for babies born after 30 weeks gestation. Care levels are flexed as required. It offers intensive care for initial stabilisation prior to transfer to specialist care as well as high dependency and special care cots.

We visited the children's areas of the hospital and the neonatal unit. We spoke with five children and seven parents, 16 members of the medical staff, eight members of qualified nursing staff, two healthcare assistants and one play specialist.

Services for children and young people

Summary of findings

Services for children and young people at West Suffolk Hospital were good. The children's wards and treatment areas were visibly clean. Management and storage of medicines was appropriate and safe. Staff knew how to safeguard children and undertook relevant specialist paediatric training. The services managed risk well and used a paediatric early warning system to identify if a child's health was deteriorating. There had been no serious incidents in the services in 2015 and staff learned from minor incidents and shared their learning.

The services planned and delivered children's and neonatal care in line with national, regional and local guidelines and carried out clinical audits. Nursing staff and doctors had high levels of skills and competencies and worked well with other teams in the hospital to find the best solutions for children. There was seven-day access to diagnostics and fast tracking was available for children's x-rays for the same morning/afternoon if needed.

Nursing staff and doctors were compassionate and dedicated to the welfare of children. Care was tailored to individual children. The services offered a high level of psychological and emotional support.

Consultants worked to provide access for patients. They set up outreach clinics in GP premises and held telephone clinics so that patients could stay in their own surroundings. Staff saw and treated children promptly in the hospital in most cases.

Nurses, doctors and managers had a vision for children and neonatal services which reflected the trust's strategy of working with other providers in the community. There was clear leadership in the services and staff told us they enjoyed working for the services. Staff listened to children and their parents and had made improvements in response to feedback.

Are services for children and young people safe?

Good ●

Children and young people's services were rated as good because:

- The service learned from incidents and mortality and morbidity meetings. They shared their learning with other services across the trust.
- The wards, treatment rooms and play areas were visibly clean and there were good infection control procedures in place.
- Safeguarding systems were well developed and staff were trained in safeguarding to the appropriate level for the care of children.
- The service used a paediatric early warning system to identify children with deteriorating health so that staff could take early action. The services had detailed policies to manage clinical risks.
- Staff stored medicines safely and made efforts to avoid prescribing or dosage errors.
- Staff undertook mandatory training and this included how to identify and treat a child whose health was deteriorating.
- Whilst planned staffing numbers did not always conform to those of national standards based on the number of beds. Staffing was planned in line with the numbers of children they cared for and additional staff could be used when the number of patients or the acuity of patients deemed it necessary.

However,

- Patient records were kept on an open trolley and we noted two records which were incomplete.

Incidents

- There were no Never Events or serious incidents reported in children's services or the neonatal unit from January 2015 to February 2016. Never Events are serious, largely preventable incidents involving patient safety that can be avoided through adequate safety systems. There were no declared serious incidents over

the same timeframe. Where the trust had identified that there had been an incident there was evidence that action had been taken. Staff were able to articulate where training and learning had occurred.

- The trust found that the service was not always clear about when to report incidents externally. It reviewed three babies' cases in June and July 2015. After the review it learnt that one of the cases should have been reported to the local clinical commissioning group for potential inclusion in Strategic Executive Information System (STEIS) serious incident data. The trust was working with the paediatric team to ensure accuracy of reporting and grading of incidents.

- Consultants and staff ensured that they learned lessons from incidents and also investigated a death in the paediatric intensive care unit (PICU) at the local specialist care provider. Consultants had Friday and Tuesday morning meetings to discuss lessons from incidents. There were 'Bitesize Teaching' sessions at handover for junior doctors and nurses including specialist nurses and advanced nurse practitioners.

- Incidents were reported on the electronic incident reporting system and graded green amber or red. If green, a local manager investigated, if amber, then the head of service investigated, and then the head of department investigated for red. Any incidents were discussed at governance meetings, at individual specialties meetings and at whole team meetings. The 'Risky Business' monthly newsletter featured learning from complaints and incidents. Attendees at the Monday morning divisional meeting discussed incidents. The general manager reviewed all incidents to check whether they were correctly rated. The trust wide governance meeting shared learning from incidents with the rest of the trust

- Two detailed case reviews took place in 2015. These were for deaths of children which consultants felt to be unavoidable or which happened after transfer elsewhere. The consultant who was responsible at the time of the death investigated with the governance lead. Other consultants offered support and objectivity. These investigations resulted in actions such as revising the high dependency unit (HDU) policy and developing a paediatric early warning system (PEWS) escalation policy for the emergency department. The children's and neonatal ward managers raised awareness of incidents with staff by putting a list of incidents and learning points on a white board in the staff room.

- Paediatricians held mortality and morbidity meetings within the service and jointly with the paediatric intensive therapy unit (ITU) and emergency department consultants. These meetings reviewed and learned from serious cases and deaths. The last detailed review concerned the death of a young baby who was transferred out of the hospital, which led to actions such as four-hourly reviews day and night for all children and babies in the high dependency and the development of an escalation policy.

- Staff and consultants in children's and neonatal services acted in accordance with the duty of candour. We saw the February 2016 issue of 'Risky Business' which raised awareness of the duty of candour. When a mistake was made either within the trust or on transfer to another provider, consultants wrote to the parents or met them to explain what had happened. They shared the findings of the investigation and how the service would avoid such incidents happening again.

Safety Thermometer

- The services monitored a range of safety and quality indicators on a monthly basis such as hand hygiene, pain management, (quarterly) peripheral cannula insertion, ongoing cannula insertion, number of falls, number of medication errors and number of complaints. However, they did not draw this information together on a dashboard or paediatric safety thermometer. As a result, it was difficult to measure trends in safety performance or quality over time.

Cleanliness, infection control and hygiene

- There were no recorded cases of methicillin-resistant Staphylococcus aureus (MRSA) and one case of Clostridium difficile (C. Diff) recorded in 2015 in children's and neonatal wards.

- The children's ward and neonatal unit were visibly clean and mostly clutter free. Staff adhered to the 'bare below elbows' rule and used protective equipment such as gloves and aprons when necessary.

- Cleaning schedules showed that toys were cleaned and changed daily in the waiting rooms to both the ward and the outpatients areas. The lead nurse cleaned toys in the oncology waiting area in outpatients were cleaned before and after each use and at least once a day. The service gave oncology inpatients their own toys to play with for the duration of their stay.

Services for children and young people

- In outpatients, we saw weighing scales and height checking equipment with stickers showing that they were cleaned the day before. The housekeeping schedule was up to date.
- The staff in the children's and neonatal wards were 100% compliant with hand hygiene training. This was checked in an audit which observed staff before and after seeing patients in November 2015.
- The children's nurses used the UK sepsis trust tool on the children's ward. Nurses and doctors completed sepsis training as part of their induction, and as part of ongoing mandatory training. Senior house officers audited staff use of the tool and ensured that it was applied well.

Environment and equipment

- We checked resuscitation equipment on the children's ward, and in children's outpatients. Contents were appropriate and up to date. The resuscitation trolley was checked daily.
- All rooms in the children's ward had oxygen and suction facilities. The high dependency unit also had piped air.
- Staff checked fridges for temperature-sensitive medication daily and recorded the fridge temperature on a check sheet. If the temperature was outside of a safe range they reported that the fridge was not working and looked for alternative storage.
- Plug sockets were covered in the outpatients department to avoid children putting their fingers in them
- We saw in the children's ward, outpatients and day surgery that entry and exit were controlled. Visitors needed to use the buzzer to gain entry and staff approached people they did not know for identification. We checked blinds and internal doors and they were child friendly and minimised the danger of trapped fingers.
- The service kept hazardous substances under lock and key and checked that they were stored away.
- All of the equipment in children's outpatients was within its date. However, epi-pens (pre-filled syringes for use in severe allergy emergencies) and blood tubes were approaching their end date. The nurse in charge was aware of this and was vigilant about acquiring in-date equipment.

Medicines

- Arrangements for medicines had controls to keep children safe. Controlled drugs were stored following good guidance procedures. Two nurses carried out daily checks on quantities and records. Medicines requiring cool storage, such as cytotoxic drugs for cancer patients, were put in a lockable medicine fridge and the temperature was maintained within a safe range. The children's ward kept medicines and intravenous (IV) fluids behind a locked door.
- Paediatric staff and pharmacists shared learning from medicines incidents. A 'safety bulletin' was emailed to the ward manager who shared the learning with nursing staff. Pharmacists informed the service's medicines management meeting and clinical governance meeting if there were any prescribing problems. The medicines management meeting developed actions and a single checking policy had been agreed. The service's practice development nurses gathered drug calculations for the pharmacy to audit once a year. If there was a miscalculation or any other kind of error, the practice development nurses helped to re-train the person making the mistake. This sharing led to pharmacists developing two specific prescription charts for paediatric and neonatal doses of antibiotics. This helped to ensure that the correct dose was prescribed. The children's ward December 2015 antibiotic audit showed 100% compliance, showing that all staff understood the correct dosages.
- The last medicines incident occurred in February 2016 when medicines were given to a patient too early and then the dose was repeated. The service responded by giving training so that the incident did not happen again. The ward manager distributed information about medication errors so that staff could learn from them.
- There was good joint working between the service and the pharmacists. A clinical pharmacist visited the ward five days a week. They worked with nurses and doctors to determine children's individual medicine needs and helped identify issues which could be dealt with immediately. There were two nurse prescribers on the children's ward. This helped to ensure that medicines were prescribed and given promptly. Pharmacy supported the services with appropriate tables for other drugs and infusions and for example a handbook for neonates on individual drug doses.
- Staff recorded the administration of medicines appropriately. We checked seven sets of records and

found that children's allergies and weights were clearly documented in both prescribing documents used and patient records. The records showed that children were getting their medicines when they needed them.

- The service provided a full day of intravenous training at induction including intra venous antibiotics (IVAB), pumps and drug dosages for children.

Records

- We reviewed seven sets of patient notes. We noted that all drugs charts, paediatric early warning (PEWs) scores, pain scores, weight and allergy details were completed correctly. There were clear care management plans which were signed and dated. For one patient we noted that the birth history, development and social and family history was incomplete. We reviewed two sets of nursing notes and found in both that there was no evidence of discussion with the family and that notes were not signed and dated. The nursing notes were not in a chronological order which would be confusing for a nurse who was new to the service.

- Notes were hanging on an open trolley in front of the reception desk and not in a lockable container. However, no patient identifiable information was on view.

- The trust had a system to flag some children with particular needs. It had an electronic flagging system to identify children on a child protection plan, and staff explained this to us. However, it did not have a flagging system for Looked after Children (children in local authority care), which meant that there was a risk of overlooking some of the child's social and psychological needs.

Safeguarding

- Systems, processes and practices to keep babies, children and young people safe were in place and communicated to staff. The trust had a child safeguarding policy which covered all types of abuse. This outlined actions to be taken to safeguard children and young people. There was also a supervision policy and a child abduction policy.

- Safeguarding level three training for nurses, essential for clinicians who work with children showed 94% compliance in the children's ward and 95% compliance

in the neonatal unit. The shortfall was due to the sick leave of one staff member in each unit. The target was 100% and the services had a plan to ensure that this would be achieved.

- Staff knew how to identify and report abuse and neglect. Healthcare assistants and neonatal staff explained to us how they would identify a concern through a child's disposition or through physical signs. Staff knew how to access safeguarding guidance on the intranet, how to complete a referral form and they would report concerns to a senior staff member.

- The trust had forums to learn lessons about safeguarding. There was a weekly networking and peer group meeting for medical and nursing staff from the emergency department, paediatrics, maternity, neonatal. The purpose of this meeting was to discuss complex safeguarding cases and events. The multiagency safeguarding hub (MASH) was working to give the trust more outcome feedback on referrals.

- The service's safeguarding lead helped to raise the profile of safeguarding through developing a safeguarding website, and produced a newsletter twice a year. A task and finish group developed guidance to manage deliberate self-harm in young people, including a checklist, which it distributed to partner agencies. The children's safeguarding lead checked whether her guidance and messages had cascaded effectively to stakeholders by sending out online surveys. As a result the lead could plan training events to meet gaps in knowledge.

- Safeguarding issues were reviewed at the clinical safety and effectiveness committee, which included a report of safeguarding performance against indicators. These included indicators for having an up to date policy, training in safeguarding level one for all staff, use of paediatric proformas for medical examinations in child protection cases and discharge planning meetings for all cases where there were child protection concerns. The trust met the targets except for the use of paediatric proformas for medical examination in child protection cases, because they had not completed the audit. There were weekly safeguarding meetings attended by doctors and nurses. There were safeguarding link staff and consultants in surgical specialities and anaesthetics.

- There was patient and multi-agency access to a paediatrician with child protection experience and skills who was available to provide immediate advice and

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subsequent assessment if there were child protection concerns. There was a paediatric liaison health visitor in post to ensure early intervention and regular communication with GPs and other clinicians.

- In 2015, the trust made 200 child safeguarding referrals and 65 of these came from areas outside midwifery. Half of these were for children 'in need' rather than concerns for 'significant harm'. Most of the non-midwifery referrals came from the emergency department nurses or doctors (71%), which indicated that staff were noticing issues concerned with the child's background or physical welfare.

- All medical staff working directly with children were trained in child safeguarding to level three. There were safeguarding named professionals in line with the Intercollegiate document 'Safeguarding children and young people – roles and competencies for health care staff' (2014) The service had a named lead consultant. All cases were seen by a consultant or middle grade doctor who followed a proforma for appropriate actions and investigations, then reviewed by a consultant.

- The trust investigated and contributed to serious case reviews. The trust was investigated a serious case which concerned a child who died during resuscitation at the point of being admitted to the trust. As a result, staff were regularly trained on a variety of resuscitation scenarios.

- Staff were aware of the abuses associated with female genital mutilation (FGM). They knew that they had a mandatory duty to report FGM or the imminent risk of FGM and had relevant training. They followed NHS England guidelines which included relevant questions and answers. The trust's FGM guidance was in the process of being updated.

- A pathway was in place to follow up on children who did not attend outpatient appointments. Staff received an electronic alert if this concerned a looked after child, and they would follow up with phone calls immediately. If a flagged child did not attend despite subsequent appointments, the lead outpatients nurse informed their general practitioner (GP).

- Safeguarding supervision was supported by a policy, supervision record and learning log. However, not all clinical staff had access to supervisors. The trust had two trained supervisors which was not enough to provide supervision for all those who needed it, leaving a gap in arrangements to support staff.

- There was a trust wide adult policy on chaperoning, but no separate policy for children. For children and young people, a parent would be present in most cases to chaperone. In cases of an intimate examination, a nurse or another consultant of the same sex as the patient was offered as a chaperone. Sometimes specialist registrars'would offer to act as a chaperone.

- The trust safeguarding policy did not include guidance for Looked after Children (children in local authority care). As a result, there was a risk that care might not be tailored to the child's needs.

Mandatory training

- Staff had four mandatory training days a year, and nursing and midwifery groups had 95.65% compliance with their mandatory training in February 2016. This fell short of their target of 100% because two members of staff were on sick

- Mandatory training days in 2015 included training on moving and handling, infection prevention, medicines management, safeguarding children and recognising the deteriorating child.

- There was a structured induction programme for new starters. For staff nurses and sisters this included shadowing key members of staff and clinical sessions, including paediatric intensive life support (PILS). There was also a structured approach for nursing assistants. New starters also had to do training on a list of specialist skills, which included regional database training, intravenous therapy, conflict resolution and drug calculation practice.

- All nurses at Band six and above are trained to at least European Paediatric Life Support (EPLS) level, and two Advanced Nurse practitioners have Advanced Paediatric Life Support training. Three out of the 7.5 whole time equivalent band five nurses have EPLS training. The trust delivered this training on site and planned to train the remaining band five nurses by the end of 2016.

Assessing and responding to patient risk

- Children's and neonatal services used a paediatric early warning system (PEWS) to monitor and flag any risks to children. Compliance with this was checked through a monthly audit. The September 2015 audit showed an incorrect score and the emergency department paediatric sister responded by training staff on how to use the scoring mechanism correctly.

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- The services had a paediatric escalation policy for circumstances such as high demand or lack of beds, and staff understood the policy.
- A paediatric high dependency care policy from October 2015 was still in draft format awaiting formal trust review. This covered transfers of children to and from the high dependency unit to theatre or to other providers. It also covered time critical transfers for children with neurological problems, such as epilepsy. The service flagged up a child or neonatal transfer by logging the transfer as a risk on the electronic incident reporting system.
- The neonatal service managed risk appropriately. There was a regional neonatal trigger list in place. We saw a log of transfers and refusals which were discussed at the regional centre of excellence meeting, showing that risks were reviewed.
- A policy for safe anaesthesia in children was in place. The services worked in line with the East of England standards for children's surgery and anaesthesia, and key staff and clinicians were trained in these standards. Staff in theatres used the 'five steps to safer surgery' World Health Organisation (WHO) checklist, which minimised risk through high quality communication.
- The consultant team in paediatrics operated a consultant of the week system. They recognised a possible problem with multiple readmissions which might not show continuity of care. As a result of this, readmission data was circulated to all consultants weekly. The review of the readmission data showed that there was not negative impact on care as a result of the consultant of the week system.
- The services had checklists and tools to reduce risk. For example, there was a range of clinical assessment tools for fever, gastroenteritis and bronchiolitis, which the services publicised on their webpage. These included red, amber and green risks and signs of deterioration to look for, for example, if a child had difficulty waking this would be a red or high risk.
- Children's services reported as risks the lack of paediatric nurses in the emergency department and children not seen in children only areas of the emergency department at night. When we inspected, it was clear that staff in the emergency department had competency packages for the care of the critically ill child which were completed. Whilst children were seen within the main unit during the night time this was to meet the safety of children in the department. Plans were in place for a redesign of the emergency area which would take these concerns into account .

Nursing staffing

- The ward worked to a ratio of one nurse to every five children (of all ages) and consistently met this target. The ward capacity was for 15 children, but usually it treated a much smaller number of children. The ward did not use a formal acuity tool to assess staffing levels. An informal acuity review was undertaken and this was assessed regularly within the unit. Additional staff were available if required through use of specialist nurses, senior nurses and the trusts nursing bank staff. The trust had agreed staffing levels which were maintained.
- The children's ward did not always plan to meet best practice guidelines for nurse staffing. It did not always plan to have the required staff to meet Royal College of Nursing (RCN) guidelines of one nurse to every three children under two years and one nurse for every four children over two years. This was due to the small number of children it usually provided care for. However there were additional staff who could be called on to address any shortfall in nurse staffing levels.
- The service ensured that sufficient numbers of appropriately trained staff covered each shift and unit. Staff mandatory training was up to date. It used a small pool of bank staff who had kept their paediatric competencies up to date to cover any shortages. At least one European Paediatric Life Support trained staff member was present on any given shift.
- Children's services could respond to any short term need to increase staffing. Nurse sickness levels were below 3%, but in the case of staff sickness, the ward used ward staff and re-planned shifts to fill any staff shortages, or used fully trained bank staff. The assessment unit and the ward shared the same pool of staff, and could flex between the two units dependent on demand. Children's advanced nurse practitioners, who could cannulate, prescribe and assess, supported the ward staffing levels, although they were not counted in the staffing ratio. Senior staff such as the ward manager and matron and specialist nurses kept their skills up to date and could step in if necessary. This flexibility kept children safe.
- Neonatal services had an agreement to staff to 75% of the target ratio of the British Association of Perinatal

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Medicine (BAPM) categories of staffing levels. The trust met this target. We found that in the first three weeks of March 2016, there were eight night shifts which were not staffed to the BAPM standards. However, the unit had sufficient staff to meet its own target. On inspection there were sufficient numbers of staff to meet the needs of babies.

- Two paediatric nurses worked in day surgery. This was enough as there were small numbers of children using the day surgery.
- Nurse sickness levels were below 3%. The ward used trust bank staff to fill any staff shortages. Advanced nursing practitioners helped out on the wards in cases of sickness. This kept children safe.

Medical staffing

- The trust employed a greater percentage of consultants than the national average. The medical workforce consisted of 48% consultants whereas the England average was 35%.
- The medical rota was not compliant with Royal College of Paediatrics and Child Health (RCPCH) and British Association of Perinatal Medicine (BAPM) guidelines, which recommend that consultants attend during the hours of 9am to 9pm. However, there was a consultant paediatrician available in the hospital in times of peak activity, seven days a week. Paediatricians attended from 9am to 7pm on weekdays and 9am to 1pm at the weekend, and stayed longer if they were busy. This meant that medical staffing met regional guidelines and was better than average when compared to other English NHS Trusts.
- The trust did not employ a paediatric radiologist but had access to advice and opinions from a paediatric radiologist at the local specialist provider if needed. This radiologist attended the hospital to undertake a weekly paediatric list and to provide opinion and education.
- All consultants in the department had a special interest and a departmental role, such as safeguarding lead. This meant that consultants added to their knowledge and to departmental capacity.
- Medical handover was safe, informative and inclusive. The registrar leading the meeting completed a safety briefing as part of the clinical handover. The handover systematically covered a safeguarding case on the ward,

patients at risk of deterioration and discussed discharge summaries. The team were able to immediately access x-ray and blood results for discussion and relevant reports.
- A junior doctor of FY2 grade and a registrar covered nights on the children's ward and neonatal unit. There was consultant on-call availability.
- Surgeons and anaesthetists took part in an emergency rota which covered emergencies in children. They stayed with the child and travelled with them on transfers if required. They also had access to the on-call paediatrician out of hours.
- Between March 2015 and March 2016, locums filled an average of 7% of out-of-hours shifts. Internal locums filled two thirds of these shifts. No daytime locums were employed. These locums had worked for the service before or had received an induction, so the impact on the service was minimal.

Major incident awareness and training

- Staff were familiar with the major incident policy on the intranet and their individual roles in an incident. E-learning on major incidents was mandatory.
- Staff were also trained in their roles in business continuity. The paediatric escalation policy contained a flowchart explaining action if there were major problems with beds or staffing.

Are services for children and young people effective?

Good ●

Effectiveness was rated as good for the children and young people's service because;

- Children's and neonatal care and treatment was planned and delivered in line with national, regional and local guidelines.
- Children told us that their pain was controlled.
- The services monitored patient outcomes through clinical audit.
- There were high levels of specialist paediatric skills and competencies within the services.
- The services used multidisciplinary teams to find solutions for individual babies and children.

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- Diagnostic tests and pharmacy advice could be accessed out of hours and at weekends.

However,

- Nutrition for children was not imaginative, nor fully differentiated for different age groups.
- Children's services lacked a comprehensive transition policy to help all teenage patients adjust to adult health services.

Evidence-based care and treatment

- The service participated in the MBRRACE (perinatal mortality surveillance audit) baseline assessment. This resulted in changes to the service such as offering post mortems to bereaved parents in all cases of neo-natal death and training staff in bereavement skills. The trust performed better than the national average in 2014 (published in May 2016) for neonatal deaths at 1.10 against 1.33 nationally. However the report recommends that all neonatal deaths are investigated which the trust currently undertake.
- The neonatal service complied with the BLISS (the UK charity for babies born premature or sick) Baby Charter. This charter specifies a range of good practice standards such as supporting the dignity and privacy of babies and their families; regular skin to skin contact with their parents and assigning an individual to provide parents with proactive information on the care of a baby with complex needs. This showed that the service aimed towards best practice.
- The service was working toward its May 2016 assessment for the UNICEF Baby Friendly Initiative Stage 2 when we inspected. This is an initiative designed to support breast feeding and parent-infant relationships. Stage 2 ensures that staff education is in place.
- Nurses and doctors assessed children and delivered their care in line with evidence based guidelines. They worked to local, national and regional guidelines, for example, the East of England standards for children's surgery and anaesthesia. Surgical procedures for children followed the regional surgical guidelines for children and the regional paediatric network was established five years ago. The service followed regionally agreed levels of training for resuscitation and regionally agreed numbers for medical staffing. The

intensive therapy unit followed the Children's Acute Transfer Service (CATS) and Acute Neonatal Transfer Service (ANTS) protocols and audited all child transfers to other providers.

- The neonatal unit worked to the East of England neonatal guidelines, which involved 19 units working together. There was regular benchmarking and the unit had improved its thermal management of babies through comparing with other trusts. The trust had implemented an audit of room temperatures to ensure that babies born with a core temperature of lower than 36.5 degrees Celsius were born into a room which would enhance their core temperature. The governance lead undertook this audit. All data for comparison was loaded onto the regional electronic database. At the time of our inspection, the unit was piloting a proforma for a new regional pathway for the first hour of a baby's care.
- The service had policies based on National Institute for Health and Care Excellence (NICE) guidance. For example, treatment for feverish illness in children. The lead paediatric consultant developed in house clinical guidance for gastro-enteritis in children based on NICE guidance and the views of a variety of experts. The service used NHS England guidance on the management of acute exacerbation of asthma and wheeze. Relevant NICE guidelines were followed for epilepsy and diabetes. There were understood pathways for common conditions such as asthma and diabetes.
- Neonatal services had guidelines for admission. They admitted babies born over 30 weeks or twins over 32 weeks gestation. The trust was part of the East of England network and adhered to regionally agreed guidance such as the small baby pathway. Staff attended a quarterly regional clinical oversight meeting and learnt from other trusts in the network.
- There was good access to clinical guidelines in the neonatal and children's ward in staff rooms. Staff signed a check sheet to indicate that they had read the guidelines.
- The service had a clear process for reviewing clinical guidelines. Consultants reviewed guidelines and submitted them to a central panel for scrutiny. There was a section for feedback and review. However, this

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process sometimes delayed the issuing of policies. For example the revised high dependency policy which consultants submitted to the panel in October 2015 was still in review when we inspected in March 2016.

- However, the neonatal peer review in 2014, although it had many positive findings, showed that the service was not formally assessing itself against NICE compliance. Staffing levels were 85% compliant rather than 100% compliant with standards. The service ensured that it started to assess itself against NICE guidance and regional best practice.

Pain relief

- Staff used various tools to quantify pain in children. They used pictures of faces with expressions, FLACC (Face, Legs, Activity, Cry and Consolability) – to assess pain levels in children who are too young to cooperate verbally. They used a pain ladder for child cancer patients. The children's emergency department assessed pain at triage using the Manchester scale 1 – 10.
- Staff managed pain in children after surgery. The trust had several named paediatric anaesthetists and a paediatric recovery nurse trained to assess and manage child pain. The service offered a multidisciplinary team approach to pain with consultants and a full time psychologist. Two consultants were trained in hypnosis. This addressed the biological, social and psychological components of their pain, and was also helpful in helping children to relax before diagnostic procedures.
- We spoke with three patients aged four, six and nine about their pain relief and they said it was 'good'. One of these patients added that it was 'brilliant.'
- Children's pain management was supervised by consultants and nurses with appropriate training and competencies. Children's care plans included an appropriate pain assessment and management plan.
- The service gave parents an information sheet on pain control for children which included details on medication and alternative pain relief such as distraction or guided imagery.
- The service had access to the trust's pain team, but no specific paediatric pain nurses or a pain link nurse.

Nutrition and hydration

- Staff assessed and met the nutritional needs of the majority of children and neonatal babies. We reviewed

five records which included an appropriate nutrition and hydration assessment plan. We saw two records which had a partially completed nutritional assessment after admission.

- The services had guidelines for fluid management and fluid charts for each child to ensure that children did not become dehydrated.

Patient outcomes

- The service reviewed the effectiveness of its care and treatment through local and national audits. In 2016, its clinical audit programme included: child health clinical review programme, neonatal intensive and special care, and febrile neutropenia management.
- The trust participated in the regional paediatric surgical network benchmarking audit for the last five years in which they were in the top three out of 17 for adhering to standards. In 2015 the trust met all of the standards.
- The national paediatric diabetes audit showed the service in West Suffolk was the best in the East of England. The paediatric diabetes audit for 2013-2014 showed that 27.9% of children had diabetes which was well controlled compared to the national average of 18.5%
- The service benchmarked against national audits and developed action plans to improve. For example, the trust took part in the Epilepsy 12 audit annually. The first audit identified improvements such as using a 12 lead electrocardiogram (ECG) for all children presenting with a first time seizure; magnetic resonance imaging (MRI) scans under sedation; and setting up a transition clinic with the adult neurology team. Round two improvements focused on consultants and nurses with at least one year's experience of epilepsy care seeing children.
- The neonatal unit took part in the national neonatal audit programme 2015. They trust performed better than nationally for indicators such as: eligible babies receiving their mother's milk at the time of their discharge from neonatal care; 100% babies born at less than 29 weeks gestation having their temperature taken with an hour of birth, compared to 94% nationally.
- Local audits included auditing how the paediatric early warning system (PEWS) was applied. The 2015 results of this showed that occasionally staff calculated the PEWS score wrongly, particularly in the emergency department. The service responded by putting PEWS training in place and changing the escalation plan.

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- There were local audits on antibiotic prescribing to check that children were given the correct amount and breast feeding levels to check that children were benefitting from this.
- Data for 2015 showed that for this trust, multiple admission rates were similar to the England average. Only non-elective paediatrics and colorectal surgery reported six or more emergency readmissions, and at similar rates to the national average 3.3% against 2.7%.
- Fewer children were admitted to the ward after an asthma nurse specialist arrived in post to help parents and children manage the condition. We saw data which compared January to June in 2014 and 2015 which demonstrated a 31% reduction in year on year clinical assessment unit asthma admissions.

Competent staff

- All anaesthetists, theatre and recovery staff who cared for children and young people had up to date competencies. All clinicians treating children had level two or three safeguarding training. Teams worked to regionally agreed levels of training. 100% of theatre staff had Paediatric Intermediate Life Support (ILS) training, two recovery staff had neonatal life support (NLS) training and four recovery staff had European Paediatric Life Support (EPLS) training. There was a comprehensive paediatric recovery nurse pack. Surgeons and anaesthetists took part in a rota to cover for emergencies in children. There were seven anaesthetists with paediatric training
- There were sufficient trained staff with maintained competencies on any one shift. There was at least one nurse who had advanced paediatric life support (APLS) training on each shift.
- Paediatric nursing staff on the ward, in day surgery and in the emergency department were assessed on the Children's Workforce Development Council's competencies. This framework represented good practice and included skills in safeguarding and promoting the welfare of the child or young people, teaching and educating parents and skills for the safe, accurate and appropriate administration of medications.
- Nine out of the eleven paediatric consultants had at least European Paediatric Life Support training, with six

having Advanced Paediatric Life Support training. The two remaining consultants had training diarised to validate their skills. All consultants had up to date paediatric resuscitation training

- Joint simulation sessions with the emergency department worked well to refresh knowledge and foster stronger co-working. These sessions covered key skills such as intubation and resuscitation scenarios.
- There was partial coverage in the emergency department by paediatricians on the children's ward. Two paediatric consultants worked in the emergency department for two sessions each week providing clinical care to children and staff education. If the emergency department require the skills of a paediatrician this would be released from the paediatric ward as required outside of these sessions.
- There were 'bitesize teaching' sessions for junior doctors which covered a variety of issues. One example we saw was a session led by a registrar on disorders of sexual development in children.
- Staff were given opportunities to develop. If staff took part in external training they were encouraged to report back to others, for example after attending regional network meetings. Staff were 100% up-to-date with their appraisals.
- If the external transfer service was delayed, the trust would organise the transfer. Clinicians and the anaesthetics concerned discussed how best to transfer the child and who should accompany them on the transfer. The service operated a consultant of the week system and the children's assessment unit had access to a paediatrician's opinion at all times. Specialist paediatricians were available to give telephone advice on acute problems.
- Nurses in the neonatal unit had enhanced skills to carry out their work. They were trained to cannulate babies and take bloods 74% of staff were qualified in speciality-trained competencies. All of the qualified in speciality trained staff had neonatal life support training.
- Nurses did not receive training in bereavement and delivering bad news and a perinatal audit identified this. The service was reviewing which staff should be trained in bereavement

Multidisciplinary working

- All appropriate staff were involved in assessing, planning and delivering the care and treatment of a

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child patient. For example, there was access to paediatric pharmacy advice 24/7 on an on-call basis, there were paediatric multidisciplinary team and ward rounds, and there was access to physiotherapy and occupational therapy for children. The service used multidisciplinary teams to benefit patients in a variety of contexts. For example, it had a diabetes multidisciplinary team which included consultant paediatricians, paediatric diabetic specialist nurses, a paediatric dietician and a paediatric clinical psychologist. The service was designed for patients with urgent queries such as very low or high blood sugar levels. The aim was to help children and parents become experts at managing diabetes, meeting them on the ward. They were offered the help of the clinical psychologist and providing four outpatients appointments and regular telephone or email support.

- Multidisciplinary teams were planned around surgery. We heard from other clinicians, for example a paediatric surgeon, an anaesthetist and a radiology lead that they had a good working relationship with the paediatricians. This led to good early discussions about sick children. This included planning joint training and simulations, joint mortality and morbidity meetings and joint governance meetings.

- Clinicians also worked with professionals externally in multidisciplinary teams. For example, they had a monthly multidisciplinary team meeting with the local specialist care provider to discuss the care of child cancer patients.

- The service had one full time play specialist available who worked jointly with the clinical psychologist. Parents could request extra care from the play specialist for particular child needs. The play specialist prioritised children undergoing emergency treatment and worked across departments such as the emergency department and children's outpatients, supporting consultants and sometimes nurses if they request her. This was of particular help with children with needle phobias or experiencing traumas or fussy eaters. However, as the play specialist worked alone, they found it difficult to build on their knowledge, as there was no one to cover if they went away for advanced play specialist training, for example. The service planned to train a nursery nurse in play skills in autumn 2016.

- Psychological and psychiatric expertise were readily available to the service. A consultant paediatric psychologist addressed the mental health needs of patients and worked effectively with local mental health services.

- When children were discharged, there were clear mechanisms for sharing information with the general practitioner (GP).

- There was access to advice from tertiary paediatric services in and out of hours which is sufficient. Consultants established formal links with the local clinical commissioning group (CCG) and with four GP surgeries. They organised an annual study day for GPs.

- The service lacked an overarching transition policy and a consistent approach to transition of children to adult services. Transition depended on the speciality. Children's services had clear transition arrangements for diabetes and epilepsy to adult neurology. However, patients with needs outside of these defined pathways received no transition support between paediatric and adult services. Staff were unclear about transition arrangements with community services.

Seven-day services

- There was seven-day access to diagnostics such as ultrasound, x-ray and computerised tomography (CT) scan, but on an on-call basis. For acute or emergency situations, there was a seven-day service for radiology.

- CT scans could be undertaken on the same day if necessary for children in the outpatient department.

- Emergency MRI scans for children were undertaken at the local specialist care provider. A private outsourcing company dealt with any paediatric brain MRIs and this included on-call and overnight.

- Child x-rays were prioritised and could be supplied in the same morning/afternoon.

Access to information

- The service encouraged the use of personal child health records (red books) and asked parents to bring them if they had them. This facilitated sharing of child health records and hospital admissions to all healthcare staff that came into contact with the child. In this way, clinicians and parents had the complete picture of care.

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- Medical staff reviewed and updated the electronic patient record system every four hours. This ensured there were up to date changed for case notes. This was used by the department to supply current information for open access patients.
- A medical handover and the electronic system were observed. The service had no outstanding discharge summaries.
- GPs did not have direct access to records but they could speak to a consultant or registrar on the phone. The service had a rota for this purpose and a junior doctor took the call and triaged it first.

Consent

- The trust had a consent policy and children and parents were supported to make decisions about their care. There was a specific form for children and parents which included guidance for professionals. The trust re-issued its consent policy in 2015 which clarified the rules about consent. The policy provided guidelines so that children of 16 and 17 could consent for themselves if they showed competency. Staff had training in Gillick and Fraser competencies but as the unit treated mostly small children, this was rarely applied.
- The service could organise telephone consent with the appropriate checks in place, if appropriate.
- Staff involved the safeguarding lead nurse if they felt parents lacked capacity to give consent. They explained that there were options such as involving grandparents and discussing with relevant services.
- The trust's consent audit in 2015 did not provide a separate analysis of consent by parents or children. It did not therefore result in any specific actions for children's services.

Are services for children and young people caring?

Good ●

Caring was rated as good in the children and young people's service because;

- Positive and caring interactions between staff and children and parents and a high level of dedication from nursing staff and doctors.

- The children's survey 2014 showed the hospital to be comparable with others in response to caring questions. Other surveys show high levels of satisfaction.
- Staff listened to children and their parents and planned care around them
- The services offered a high level of emotional support through the availability of specialist nurses and a clinical psychologist.
- The neonatal service showed sensitivity and understanding of bereaved parents.

However,

- Not all staff working with bereaved parents had skills in counselling or bereavement.

Compassionate care

- We observed a positive and caring relationship between healthcare assistants, nurses, doctors, parents and children. Consultants introduced themselves and other clinicians to parents and children and put them at ease.
- We spoke to seven sets of children and parents. The parents described nurses, doctors and other health professionals as 'caring,' 'respectful' 'friendly' and 'lovely.' We saw a nurse go and pick up a crying baby and an HCA play with a child whose parent was absent.
- Services had imaginative ways of inviting feedback. Neonatal services had a 'listening tree' which showed patient feedback. The children's services had a form for young children to draw pictures to describe their experience of care. The service also used tokens to put in jars with smiley or serious faces on for the children to indicate how they felt.
- The Children's survey 2014 graded the trust as "about the same" as other trusts for all of the 'caring' questions.
- Friends and family test results showed consistently high scores in the last six months. For example in January 2016, 99% out of 69 family/friends responded that they would recommend the children's service.
- The ward quality report of November 2015 reported high levels of children and parent satisfaction. The only amber area was 80% responded positively for 'Were you offered age appropriate activities?' The service responded to this by researching facilities for teenagers.
- Staff were attentive to children's needs. We observed them comforting crying babies and playing with children to distract them.

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- The consultant paediatricians had a high level of dedication to their work. For example, the lead paediatrician phoned all of her seriously ill outpatients every week.
- Parents were not automatically given information about the ward. They were asked to refer to a laminated folder in the parents' room.

Understanding and involvement of patients and those close to them

- We observed staff communicating appropriately to children and young people and their relatives. They were kind and respectful.
- Parents told us that staff listened to them and planned around their needs and those of their child. Clinicians took parent's concerns seriously and discussed them at handover meetings. All of the parents were confident that they understood their child's treatment plan and the timescales involved. One parent told us that he was particularly impressed that paediatricians liaised with ear, nose and throat (ENT) staff to bring forward an ENT appointment vital to their toddler's progress through treatment.
- Staff did their best to make parents and children comfortable if they had to wait to be seen. Staff took time to familiarise children with the ward, including the play area.

Emotional support

- Parents told us they felt confident leaving their child with the staff on the ward
- Specialist nurses added to the quality of emotional support by supporting parents and children to manage their conditions, going to schools and nurseries and training their staff, and supporting at outreach clinics. They used appropriate tools so that children informed others of their issue such as the NHS England 'my asthma' action plan for under-fives.
- Care was centred on the child or young person. The service could plan care at home if this was best for the patient.
- The children's ward occasionally offered palliative care for children who were also seen at the local specialist care provider. Staff told us that the lead paediatrician telephoned these children and their families on a weekly basis between appointments.
- Bereaved parents who lost a small baby could stay in the parents' accommodation in the neonatal services

for as many days as they needed. The patient affairs officer, who was trained in bereavement, offered support. Nurses did not receive training in bereavement and delivering bad news and a perinatal audit identified this. The service was reviewing which staff should be trained in bereavement
- A clinical psychologist helped with counselling services, breaking bad news, training nurses on mental health issues, and ensured the children were cared for mentally as well as physically.
- The service offered hypnotherapy for child behavioural or psychological issues and instead of a sedative to prepare children for a magnetic resonance imaging (MRI) scan.

Are services for children and young people responsive?

Good ●

Responsive was rated as good in the children and young people's service because;

- The service worked well with other providers in setting up clinics in general practitioner (GP) surgeries which would be easier for patients to attend.
- Facilities were mostly appropriate and attractive for children.
- There were good facilities for parents, including parent's rooms in the neonatal unit and a parent's lounge in the children's ward.
- We heard from parents that they were seen promptly with their children.
- The service offered telephone clinics which avoided the need for families to travel.
- The services adapted care for children and young people with a variety of different needs.
- The services learned from complaints. They invited feedback and offered parents and children various mechanisms to do this.

However,

- The service had one play specialist for all areas where there were children, which meant that sometimes not all children benefitted from this service.

Services for children and young people

- A small number of children were seen in adult settings in some outpatients specialities. In orthopaedic, dermatological or medical specialities, a very small number of children might have to wait longer than 18 weeks for their first definitive treatment.

Service planning and delivery to meet the needs of local people

- The service worked well with other health providers in the community. Outreach clinics were set up in general practitioner (GP) surgeries in nearby towns for common problems such as diabetes and asthma. This reduced travelling distance and facilitated parking for parents and children.
- The neonatal service provided an outreach nurse to support families. This did not reduce the baby's age at discharge but families appreciated the support.
- Families were involved in designing some aspects of service. For example, they were involved in the design of the overnight facilities in the neonatal unit. The neonatal service used a feedback tree displayed on the wall for parents to give their feedback.
- The facilities and premises were mostly appropriate for children's and young people's services. There were attractive play areas and a separate treatment room for child cancer patients which could accommodate two children. However, as the waiting room was shared there was a risk of cross-infection. There was also a small play area in outpatients designed specifically for child cancer patients. We saw in the day surgery ward there was a separate area designated for teenagers. Funding was in place to redecorate the area.
- We saw a paediatric recovery area which could be used for two children at a time and separate from adults. There was a paediatric area in the intensive therapy unit (ITU) which had ventilators and appropriate equipment for all ages of children.
- The children's ward had a private lounge for breaking bad news or sessions with the psychologist. This was refurbished using external funding. It also had a parent's room with some facilities such as a microwave oven and television.
- The neonatal unit received funding from BLISS (charity for babies born too soon, too small and too sick) for parent's rooms which were well designed and

comfortable. The unit could provide towels and nightclothes if their parent was not expecting to stay. These rooms were also used by bereaved parents so that they could spend some time with their baby.
- However, in the childrens ward, in order to reach the reception desk, visitors needed to walk through the waiting area for paediatric assessment where unwell children were waiting with their parents, which compromised the family's privacy.
- Not all children were seen or treated in designated children's areas. A small number of children were seen or treated in adult based areas. Some children's outpatients ear, nose and throat (ENT) and orthopaedic consultations took place outside of the children's outpatient's area, though staff were appropriately trained in paediatric intermediate life support and safeguarding level three. We were told that while the service tried to run children-only clinics, this could not be guaranteed, depending on the child's clinical need.

Access and flow

- Children were admitted to the children's ward via the children's assessment unit, the emergency department or through elective surgery. There was a children's assessment unit and the average length of stay was less than 24 hours for 75% of children.
- Staff planned operations around clinical priority and children with urgent needs were seen quickly. Theatres generally prioritised children's operations although they could not guarantee a children only list. There was a recovery area specifically for children. Outpatient's clinic also left urgent slots available for children who needed to be seen quickly. For example, they were available in every epilepsy clinic.
- The service responded quickly to sick children who arrived in the emergency department. It learned from an incident where an unwell baby waited more than an hour and a half and when we inspected all babies less than three months were immediately triaged and, if unwell, a paediatrician would see them straight away.
- The service met the Royal College of Paediatrics and Child Health (RCPCH) standard for seeing children within timescales. All children with an acute medical problem were seen by a consultant paediatrician within 14 hours of admission, which was within the 24 hour standard.

Services for children and young people

- There was capacity to adjust to increased demand. The children's assessment unit could accommodate five beds. However, this put pressure on staffing as there could be 16 patients and three nurses without any other nurses or health care assistants at night.
- Parents who were referred to paediatrics by their GP told us that they did not have to wait too long, usually less than 20 minutes. In outpatients there were clocks on the noticeboard to give the wait times if clinics were running late, and staff told parents at reception how long they would have to wait. The service did not record the actual times that patients waited to be seen, however.
- The service offered telephone clinics, mainly for follow up purposes, or for issues such as allergies or constipation. This was helpful to families but also freed up time for new patients in face to face appointments. The ratio of new appointments to follow ups for children in January 2016 was one new to every 2.9 follow-ups. Offering telephone follow-ups provided the service with more clinic time for new appointments.
- The service made efforts to ensure that children and their parents attended for appointments as planned. They sent text reminders to parents in advance as a reminder of the appointment and with the aim of reducing the did-not-attend rate. They also had a flowchart for action on repeat non-attendances so that consultants could take action to avoid a situation where children may be at risk.
- Consultants reviewed or saw all children with an acute medical problem before discharge. With other clinicians, they reviewed children at the daily handover meeting or a consultant with the necessary skills and competencies saw them on the ward round before discharging them. A summary was sent to their GP within 24 hours.
- There was a link paediatric consultant for four GP practices.
- Children occasionally had to wait over 18 weeks for their first definitive treatment. There were between 2 and 5 l breaches of the 18 week target for each month from January to October 2015. These were for ear nose and throat treatment, orthopaedics and general surgery. The service organised evening and weekend clinics to avoid excessive delays.
- However, the services did not routinely monitor how long children waited to be seen in outpatients or in the children's or neonatal wards.

Meeting people's individual needs

- There was a hearing loop for children with hearing difficulties. The play specialist had sign language skills and all staff had a basic knowledge of Makaton, which uses signs and symbols to communicate with people with cognitive or linguistic impairments
- The ward had braille books for blind children. Nurses told us that visual impairment could be one facet of multiple disabilities.
- All rooms and bathrooms were wheelchair accessible.
- For children with mental health needs who required acute care, a full time consultant psychologist was accessible and also supported parents and children receiving bad news. These skills enabled the service develop a mental health pathway, deal with behavioural referrals and supervise community nurses.
- Two consultants were trained in hypnosis which helped manage behavioural problems, phobias and psychological aspects to medical problems.
- There was a learning disabilities nurse who advised about learning disabilities in children and adults.
- Specialist nurses were available to help with key childhood health problems. There was a specialist nurse for epilepsy (22.5 hours each week), diabetes (three whole time equivalents), and respiratory care (22.5 hours each week).
- Age appropriate nutrition was not fully in place. The service was in the process of developing menus for children of different ages. For example, they were developing appropriate finger food for toddlers. There was a children's menu with choices that children would find appetising such as fish fingers, chicken burgers and snack boxes with fruit. Otherwise children could choose from the adult menu, which was traditional in style. Feedback from parents showed that staff were flexible about providing meals, and would also provide meals to nursing mothers who could not leave the ward. Suitable meals were provided for children arriving on the ward out of the normal time, such as late in the evening.
- An autistic needle-phobic child was given a general anaesthetic so that a GP could take bloods and do electroconvulsive therapy (ECT)-
- It was unusual for the ward to see a child at the end of their life, but if this was the case, they received personalised care in a side room for privacy. If returned home they received telephone follow-up from the lead paediatrician.

- The service had patient information leaflets and translations which they could print off from their intranet site in Portuguese, Russian, Chinese, Polish, Turkish and Lithuanian. They could use Language Line for face to face interpreting.
- The service could arrange for a school tutor to be available for children who were staying in hospital for more than 14 days.
- The children's ward posted 'you said, we did' information on their noticeboard and had responded to feedback by planning a room for teenagers and getting a bigger fridge for the parent's room.

Learning from complaints and concerns

- There were three formal complaints about the service between January 2015 and February 2016. The service responded by changing their policy on meal provision to ensure that they provided a meal to all mothers of babies of less than one month and all breast feeding mothers of babies of less than six months. A three month old baby waited 1.5 hours to be seen in the emergency department. The paediatric service learnt from this by changing the policy so that emergency department staff triaged all babies of less than three months old and the paediatric team saw the babies directly if they were unwell.
- The service had child-friendly ways of seeking feedback. There were three jars with counters in outpatients and in the ward which asked children to put a counter in jars marked 'very happy', 'happy' or 'no comment'. 'Unhappy' was not one of the options, which had the effect of limiting feedback.

Are services for children and young people well-led?

Good ●

Well led was rated as good in the children and young people's service because;

- There was a strong collective understanding of the vision for the neonatal ward and children's services which reflected the trust's wider strategy.
- Governance was mostly effective, and meetings at ward, divisional and senior clinical level helped manage and share learning from risks and incidents.

- Service leadership was good and staff felt that the trust wide management team and board were visible.
- Staff and clinicians felt that neonatal and children's services were friendly and a good place in which to work. They felt a strong sense of loyalty to the trust.
- The services engaged with staff and the public well to gain and act on feedback.
- There was a culture continuous improvement which encouraged innovation. The service had pioneered initiatives such as outreach clinics in general practitioner (GP) surgeries and hypnosis instead of sedation.

However,

- There was no written strategy or an overarching SMART departmental action plan setting out future objectives and relevant actions.
- The services did not have a paediatric safety thermometer or formal performance dashboard to monitor trends in service over time.

Vision and strategy for this service

- The service had a clear vision and staff at all levels were clear about their role in delivering the trust's ambitions. This was shared by staff we met at all levels and demonstrated in the strong sense of team purpose. The main priorities of the children and young people service were the trust's ambitions two, 'deliver safe care'; three, 'deliver joined up care'; and four, 'support a healthy start.'
- The service was active in developing joint strategies to benefit patients. Together with the county council and other health partners, it was active in the Health and Wellbeing Suffolk 2020 initiative, which was tailored around health need in the county. This programme was in the early stages so there were no actions plans at service or speciality level within children's services. The service demonstrated its commitment to community level services by developing joint clinics with GPs in a number of locations. It wanted to attract more paediatricians to be able do more work in the community and link into networks, so that children could access the right services quicker.
- The service did not have a written strategy for children and young people. There was no written strategy or action plans which mapped out development work

within the service or with other hospital services in future. This meant that staff in children's services felt that risks in the emergency department were not addressed.

- Staff, clinicians and managers understood the trust's values and were very focused on patients and keen to deliver joined up care.
- Clinicians and managers reflected national recommendations for children and young people in their delivery of services. The service aimed to meet The Royal College of Paediatrics and Child Health's 'Facing the Future' standards. There was immediate access to telephone advice, electronic discharge summaries and care pathway development for common conditions.
- There was no comprehensive plan for children's services or the neonatal ward which drew together progress towards departmental objectives with improvement actions from audits, complaints, and incidents. Progress against delivering objectives for children's services was monitored in governance meetings, but not systematically.
- Consultants had job plans which were addressed yearly. Some specialities had team job planning and staff felt this was transparent.

Governance, risk management and quality measurement

- Children's services had an effective framework to support the delivery of good quality care. They had monthly clinical governance meetings and reviewed results from audits on alternate months. There was a systematic programme of clinical and internal audit, and staff and clinicians used this to improve services.
- The service had a system to identify, record and manage risk. It used the electronic incident recording system to log risks. Managers developed action plans to mitigate the risks, which they stored on the electronic incident recording system and monitored. They identified key risks such as insufficient paediatric nurses to cover peak hours and emergency department paediatric staffing. The service identified the same risks as the inspection team, for example it had not eliminated all points where cord or sheet could be attached in the bathroom, which was a mental health risk. The service reviewed risk at its clinical governance meeting and the consultants worked with the governance lead to do risk assessments, which were stored on the electronic

incident recording system. There was a surgical paediatric committee, attended by a multidisciplinary team, which met twice a year. This ensured that everyone was aware of good practice guidelines.

- The service had a profile at board level. There was a non-executive director to represent the service at board level. In July 2015, the lead consultant and nurse gave a presentation to the board about child safeguarding processes.
- The service lacked a performance dashboard to bring together performance and quality measures with patient feedback and financial performance. It did not routinely measure referral to treatment times for children. However, the clinical and management team discussed these issues at the paediatric division meeting, and quality concerns were referred upwards to the clinical governance meeting. Discussions were under way about a paediatric safety thermometer but it was not in place.
- The neonatal unit had new measures to improve quality. It agreed commissioning for quality and innovation (CQUIN) targets of an admission temperature for babies of less than 36 C and a review of term admissions. Managers were planning to develop this into a neonatal safety thermometer.
- Working arrangements with partners and third party providers were managed effectively. The service worked with the clinical commissioning group and contributed to an annual study day for GPs. There were formal links between four surgeries and the service's consultants. This facilitated a joint understanding.

Leadership of service

- Leaders had the skills, knowledge, experience and integrity to lead effectively. Leaders in children's services and the neonatal unit were knowledgeable and respected. The lead consultants were influential within the wider trust.
- Consultants and nurses told us they saw the chief executive regularly and that he and other leaders were visible and approachable. There were regular forums available to meet the chief executive and the medical director. Staff told us that they received strong support from the children's safeguarding nurse and the hospital's executive safeguarding lead who they described as knowledgeable and approachable.

Services for children and young people

- The service aimed to grow its own leaders through the hospital's development plan. They offered leadership development to band five nurses. This included link nurse responsibilities and was about individual development towards band 7 responsibilities.

Culture within the service

- We found that staff, managers and clinicians were focused on improving child health outcomes and took a pride in the children's services and their work.
- Staff and consultants felt a strong sense of loyalty to the service. Two consultants told us that they were trained at the trust and had worked elsewhere but had returned because of the friendliness, commitment to paediatric services and teamwork. Nursing staff were complimentary that the hospital was a good place to work. Managers spoke warmly about their teams, and teams were complimentary about their managers.

Public engagement

- Questionnaires were given to parents and young adults on the ward and in outpatients whereas younger children gave feedback in the form of pictures which have been displayed on the boards. Feedback in August was mostly positive. Written comments are mainly positive and there have been few suggestions for improvement i.e. improvement for parent beds, televisions and DVDs, and a room for teenagers.
- The service used patients' and carers' suggestions to improve the environment and service delivery. There was a 'you said, we did' noticeboard to demonstrate to parents that the service took action on their suggestions. For example: breastfeeding mothers pointed out that it was difficult for them to leave the ward to eat a meal while they were breastfeeding. The service responded by bringing a meal to breastfeeding mothers.
- The service no longer has a parent's group, so it lacked a regular forum to inform parents or to discuss their concerns collectively

- Children and young people were encouraged to share their views on the quality of the service. The service provided a form for young children to express pictorially their views about their care.
- The service reviewed feedback at paediatric division meetings.

Staff engagement

- Staff acted on opportunities to influence service improvement. For example, a neonatal nurse attended a study day in her own time and identified that cerebral function monitoring would be useful in the neonatal unit. This was useful in identifying babies at high risk of a seizure. The service could then respond to this by cooling the baby.
- Leaders and staff understood the importance of staff raising concerns. Staff were encouraged to report 'whatever they feel they should.' There were no restrictions. If a staff member raised a concern, it was logged and graded. They were kept informed of the investigation.

Innovation, improvement and sustainability

- Contributions to quality and innovation were recognised. We heard examples of staff and consultants in neonatal and paediatric services receiving recognition in the trust's 'Shining Light Awards'. They were also congratulated by email.
- Staff and consultants continuously sought ways of making treatment easier for the children.
- Two consultants learnt hypnosis skills to help treat children with behavioural problems, phobias and psychological aspects to medical issues.
- A full time psychologist consultant had developed links with local mental health services and offered support to patients or parents after they received bad news.
- Consultants delivered clinics jointly with GPs in the community which avoided travel time for the children, provided a more familiar care setting and gave education and support to GPs.

End of life care

Safe	**Good**	🟢
Effective	**Requires improvement**	🟠
Caring	**Outstanding**	☆
Responsive	**Good**	🟢
Well-led	**Good**	🟢
Overall	**Good**	🟢

Information about the service

West Suffolk Hospital provides end of life care to patients across all its clinical areas and treats a variety of conditions including cancer, cardiac and respiratory diseases, dementia and orthopaedic conditions. The Specialist Palliative Care Team (SPCT) consists of 2.12 whole time equivalent (WTE) clinical nurse specialists that provide advice, assessment and treatment to patients across all clinical areas within the hospital. There is also 0.96 WTE palliative care practice development matron within the SPCT. The hospital has a palliative care consultant on a service level agreement (SLA) from the onsite hospice for 0.5 WTE hours, equalling two half days, per week. At the time of inspection a new palliative care consultant had been appointed and is due to start at the trust in April 2016. Advice can be sought from a palliative care consultant 24 hours a day, seven days a week, via telephone for urgent enquiries and concerns.

Palliative care champions are within each clinical area and team, including allied health professionals. Champions are given additional ongoing training to support them within their roles. This is mainly undertaken by the practice development matron for palliative care.

West Suffolk Hospital does not have a dedicated ward for end of life care. There were 1,023 in-hospital deaths reported in 2015. The SPCT received 855 referrals from April 2014 to March 2015, with 51% of these being for patients with a diagnosis of cancer.

The Chief Nurse has responsibility for end of life care within the executive team. In addition, the bereavement office provides support to relatives and the chaplaincy service provides a 24 hour service for patients at the end of life, their relatives and staff.

During the inspection, we spoke with 1 patient and 1 relative. The majority of patients that were end of life were not suitable to speak with due to their current clinical state. We spoke with 39 members of staff which included medical and nursing staff, allied health professionals, the SPCT, the director of nursing, porters, mortuary and chaplaincy staff. We reviewed 38 sets of patient notes and information requested by us and provided from the Trust.

End of life care

Summary of findings

End of life care at West Suffolk NHS Foundation Trust was rated requires improvement overall. Safe and responsive were all rated as good and caring as outstanding with effective and well led rated as requires improvement.

Staff were aware of how to report incidents involving patients at the end of life and evidence of this was seen throughout the inspection. Infection control practices were adhered to, particularly within the mortuary. The specialist palliative care team (SPCT), mortuary, chaplaincy and bereavement staff had all completed 100% of their required mandatory training. Patient records were in the main accurate and completed in a timely manner. However we found discrepancies and omissions on the trusts Escalation Plan and Resuscitation Status (EPARS) forms.

Patients were able to access food and drink when they required it, and were assisted to eat if needed. Pain relief was prescribed and administered in a timely manner and in accordance with trust policy. The trust scored well in the March 2016 National Care of the Dying Audit, meeting four out of the five clinical outcomes. The trusts policies around the Mental Capacity Act (MCA) and Depravation of Liberty Safeguards (DoLS) were ambiguous and left staff confused about how to interpret the MCA and when to apply for a DoLS. The completion of the trust EPARS was inconsistent and often did not reflect the patient's medical notes.

Patients and their families were cared for with dignity, compassion and in a respectful way throughout the inspection. Staff gave examples of exceptional practice that enhanced patient's physical and emotional wellbeing. Staff used their initiative in often difficult situations to ensure patients and their families received the care they required.

There was a mixture of patients referred to the SPCT with both a diagnosis of cancer and those without cancer. Care planning was seen, documented and implemented across all clinical areas inspected. Patients at the end of life or those with a do not resuscitate order in place were highlighted on the trusts electronic patient data system with symbols; an E for those at the end of life and an R for those not for resuscitation.

Fast track discharge arrangements were not robust. There was no target for the trust to discharge patients where funding was not required. These patients were not identified. The trust had a target of three days to complete a referral for funding and this was monitored. The trust achieved this in 81.5% of the time at our inspection. Between April 2014 and March 2015, 87.9% of fast track referrals were seen within 24 hours by the SPCT. Between April 2015 and March 2016, this had reduced to 79.7% of patients. In the same reporting periods there were 902 fast track referrals to the SPCT in 2014/2015, reducing to 582 in 2015/2016. However, all patients continue to be supported by the SPCT.

The chaplaincy was able to contact religious leaders of other faiths, however this was limited and rarely used.

The trust had a clear strategy and vision in place for end of life care. The trust was not robustly monitoring the effectiveness and the responsiveness of the service to patients and their families.

Minutes of meetings both operational and business meetings did not demonstrate a review of key performance indicators. Although no substantive medical leadership was currently in place, this was mitigated in part through an active nurse led specialist team. Formal staff and public engagement was lacking, however informal feedback was sought from staff on a regular basis through discussions within ward areas.

End of life care

Are end of life care services safe?

Good ●

End of life care services were rated as good because:

- Incidents involving palliative care patients and those at the end of life were specifically recorded.
- Infection control practices were adhered to within the mortuary.
- Patients at the end of life and those who were not for resuscitation were appropriately identified.
- Nurse staffing was in line with national guidance and was sufficient for the service demands.
- Records were generally completed in a timely manner and with all required documentation completed.
- Mandatory training amongst the specialist palliative care team, mortuary, chaplaincy and bereavement staff was all at 100%.

However:

- Medical staffing was not in line with national guidance and no substantive palliative care consultant was in post at the time of inspection. However the trust had an agreement with the local hospice to provide medical cover.

- The completion of and documentation on EPARS forms was often confusing, contradictory or incomplete. However records from the specialist palliative care team were well documented.
- The documentation of mental capacity assessments was limited
- Dissemination of learning from incidents was not consistent across the trust.

Incidents

- The trust electronic incident reporting system records incidents relating to end of life care. We reviewed incident data between December 2014 and September 2015 and found that 19 incidents mentioned 'end of life care'. Two incidents were classified as minor, one as moderate harm and the remaining 16 as no harm. The classification and identification of incidents was appropriate.

- Staff knew how to report incidents, and had a good understanding of what should be reported. There were no incidents relating to end of life care that weren't reported during the inspection that should have been.
- The chaplaincy department knew how to report incidents and staff were able to provide an example of when an incident had occurred and describe actions that had been taken in response.

Cleanliness, infection control and hygiene

- All four mortuary staff had completed the trust's infection control training.
- The mortuary manager explained the process for standard decontamination following autopsies and the process in relation to decontamination following the autopsy of a patient with an infectious disease. There was a risk assessment in place for the handling of high-risk patients and associated policies for decontamination and cleaning of the mortuary areas and the storage of high-risk patients within the fridges.
- Personal protective equipment (PPE) was readily available throughout the mortuary setting for use by staff and visitors, including funeral directors. Appropriate PPE was being used when disposing of waste and during autopsy within the mortuary and good hand hygiene practices were seen throughout. Appropriate policies were seen following the inspection to support the use of PPE within the mortuary.

Medicines

- The Clinical Nurse Specialists (CNS) within the Specialist Palliative Care Team (SPCT) were part nurse prescribers. This allows them to prescribe certain medications under the guidance of a consultant. This allowed prompt prescribing and administration of anticipatory medication to patients at the end of life.
- There was no permanent full time palliative care consultant at West Suffolk Hospital at the time of our inspection. This meant that there was a potential of an increased risk of errors in the prescribing of end of life medication due to the lack of senior specialist medical oversight. The CNSs were regularly recommending treatment and medication pathways, however were leaving the final decision on implementation of these to a non-palliative care specialist consultant to implement. This could have a potential for delays in the administration of end of life medication, however we saw no evidence to support this.

End of life care

- We found evidence of prescriptions written by the CNS, which were clear, legible and appropriate for the patient. The CNSs worked with junior and senior medical staff to ensure that appropriate end of life and anticipator medication was prescribed and administered in a timely manner.
- Regular medications were being stopped in a timely appropriate fashion for patients at the end of life where it was no longer required.

Records

- The Specialist Palliative Care Team (SPCT) made detailed entries within the multidisciplinary notes. Documentation was clear and concise and considered all aspects of patient care. Patients at the end of life or who were palliative were identified promptly and documentation reflective this.
- Following the review of a patient, the CNS's typed up their findings in detail and filed this within the patient notes. This promoted clear and concise communication within patient notes and reduced the risk of confusion from hand written documentation.
- Nursing staff were using a last days, patient safety rounding tool to assess patients in the last days and hours of life. The last days rounding tool is a prompt for nursing staff to undertake and monitor a patient for mouth care, comfort, hydration, safety and pain, amongst others, to ensure maximum comfort and dignity at the end of life. We saw the last days rounding tool in use and it was completed appropriately across all areas we inspected. Nursing staff also knew when the last days rounding tool should be used and were confident when to implement this.
- The last days rounding tool was completed in line with trust guidance. However this could leave it vulnerable to becoming a 'tick box' form. Nursing documentation within care plans and communication often did not expand on issues highlighted on the last days tool. For example, the effectiveness of pain relief or what nutrition had been offered and taken.
- The trust's Escalation Plan and Resuscitation Status (EPARS) form contained an area for nursing staff to sign and acknowledge handover of a decision that a patient is not for resuscitation. This improved patient safety, as nursing staff were made aware of the changing status of

a patient. This will reduce the likelihood of inappropriate resuscitation being undertaken. However, the completion of this by nursing staff was inconsistent across the trust.
- Do not attempt cardiopulmonary resuscitation orders were signed by a medical practitioner.

Safeguarding

- All four of the Specialist Palliative Care Team (SPCT) nurses had completed their mandatory training in respect of safeguarding.
- We found no concerns during the inspection in relation to safeguarding end of life patients. Staff across all clinical areas inspected were aware of what abuse is and were confident on how to report any concerns.
- The SPCT did not know of any recent safeguarding incidents involving palliative care patients or those at the end of life where a safeguarding alert had been raised.

Mandatory training

- End of life care training was part of the trusts wider mandatory training and was completed as part of an e-learning package by all clinical staff. This was refreshed every three years in line with trust policy.
- All four of the SPCT nurses had completed 100% of their mandatory training appropriate to their roles and in line with trust target. Training records seen after the inspection supported this.
- All three chaplaincy and bereavement staff had completed 100% of their mandatory training required for their roles and in line with trust target. Training records seen during the inspection supported this.
- All four mortuary staff had completed 100% of their mandatory training required for their roles and in line with trust target.
- Evidence of syringe driver training was seen following the inspection. This included 196 nurses trained in the use of the McKinley syringe driver and 24 of these trained to deliver training on the McKinley syringe driver.

Assessing and responding to patient risk

- The trust had a system in place for identifying patients who were in their last days or hours of life. Patients identified as end of life had a blue triangle with an "E"

on it placed next to their name on the main patient board to alert staff. Patients not for resuscitation also had a symbol next to their name, a red and white circle with an "R" in it.

- Escalation plans were widely documented using the trust's Escalation Plan and Resuscitation Status (EPARS) forms. Of the 27 EPARS we reviewed, 24 had clearly documented escalation plans. However three did not contain clear escalation plans; these were highlighted to the nurse in charge and were reviewed and updated swiftly.
- Between April 2014 and November 2015, 84.7% of patients referred to the SPCT were seen within 24 hours of the referral being made.
- Physiological observations were stopped when patients are at the end of their life in line with trust policy. Although no national guidance on stopping physiological observations exists, in patients at the end of life it is generally considered good practice to stop observations in the last hours of life. Physiological observation monitors patient deterioration and supports decisions to intervene with further medical treatment. In the last days or hours of life, this would be considered inappropriate. The last days rounding tool should be implemented when the decision is made to cease physiological observations, this was observed across the trust.

Nursing staffing

- Staffing levels for the Specialist Palliative Care Team (SPCT) exceeded those recommended by the Association of Palliative Medicine and the National Council for Palliative Care. The SPCT consisted of 2.12 whole time equivalent (WTE) clinical nurse specialists (CNS). In addition a further 0.96 WTE palliative care practice development matron (PDM) was in post. SPCT provided a nursing service Monday to Friday between 8am and 4pm.
- The Association of Palliative Medicine for Great Britain and Ireland, and the National Council for Palliative Care recommends there should be a minimum of one specialist palliative care nurse per 250 beds. The trust currently has around 450 beds. Based on national recommendations, to provide a seven-day service the trust would require two WTE specialist palliative care nurses. As the trust had already met and exceeded this, nurse staffing was sufficient and appropriate for the current workload.

- SPCT members told us that staffing was, ordinarily, sufficient to meet the demands of the service. At the time of inspection there had been no permanent palliative care consultant in post since June 2015 and the current absence of 0.4 WTE CNS has created added pressures upon the team.
- Palliative care 'link nurses' were on all wards we inspected. The link nurses had additional training to enable them to fulfil their roles.

Medical staffing

- A palliative care consultant was providing 0.5 WTE hours, in the form of two half days a week, as part of a service level agreement with the onsite hospice, to provide medical support to the CNS within the SPCT.
- Medical staffing was not in line with national guidance and no substantive palliative care consultant was in post at the time of inspection. However the trust had an agreement with the local hospice to provide medical cover.
- The Association of Palliative Medicine for Great Britain and Ireland, and the National Council for Palliative Care, which recommends there should be a minimum of one consultant to 250 beds to provide a Monday to Friday service. The trust currently has around 450 beds, meaning a quota of two WTE consultants.
- A palliative care consultant was available 24 hours a day, seven days a week, contactable via switchboard for advice and guidance. This was provided by the on-site hospice.
- The trust had been advertising for a palliative care consultant since June 2015. A new substantive consultant had been appointed at the time of the inspection, however was not due to start until April 2016.
- During the time with no substantive consultant, the chief nurse and palliative care practice development matron were meeting weekly to ensure oversight of the service and highlight any concerns. This allowed for communication between senior management and front line staff throughout the time without specialist medical leadership within the SPCT.

End of life care

Are end of life care services effective?

Requires improvement 🔶

End of life care services were rated as requires improvement for effective because:

- The trust only provided a five-day specialist palliative care service with access to on call support outside of this..
- Knowledge around the use and implementation of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was inconsistent.
- Completion of Escalation Plan and Resuscitation Status (EPARS) forms was inconsistent and often did not match other documentation or had sections incomplete.
- During the unannounced inspection, an additional 17 patients were requiring a DoLS application to be completed. Staff informed us this was primarily due to a lack of staff, time and resources to complete them, and in part due to a change in policy.

However:

- The Trust's policy for the implementation of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) did not fully reflect national guidance. The Trust was made aware of this. We found that this had re-written and cascaded to staff on the unannounced visit.
- Pain relief was prescribed in accordance with trust policy and administered promptly.
- We observed patients receiving food and drink when clinically safe to do so and those requiring support receiving help in a timely way.
- There was good multidisciplinary working across different professions.
- End of life champions were in every ward area inspected and received additional yearly training to ensure competence.
- The completion of EPARS within the 24 hours of admission target was generally good
- The trust had participated in the National Care of the Dying Audit in 2015.
- The trust participated in accredited learning programmes.

Evidence-based care and treatment

- The last days rounding tool used across trust was developed in response to the withdrawal of the Liverpool Care Pathway in July 2014. This tool, as part of the individualised care planning, meets the recommendations set out in NICE guidelines from December 2015 and was developed following an internal audit of nursing documentation.
- The trust's policies concerning the provision of pain relief and the use of the Mental Capacity Act and implantation of 'do not resuscitate' orders are all evidence based against well respected research and bodies.
- The trust also demonstrated the majority of the recommendations in the priorities of care for the dying patient, published in 2014 by the Leadership Alliance for the Care of Dying People, during the inspection.

Pain relief

- Prescribing of pain relief was in line with trust policy. We reviewed three medication charts on ward G1 Macmillan Unit, one medication chart on the coronary care unit, one medication chart on ward G4 and one medication chart on ward F4 where patients had been prescribed end of life medication. All pain relief had been prescribed in accordance with trust policy.
- We found evidence of prompt administration of pain relief following pain assessments however reassessments of pain following the administration of pain relief were not always documented.
- Good use of a syringe driver was seen on ward G4 with appropriate anticipatory breakthrough pain relief prescribed and administered when needed.

Equipment

- Nursing staff across multiple areas told us they had no concerns in accessing equipment, such as syringe drivers and air mattresses, for patients at the end of life. Staff told us they would ring porters out of hours who would deliver equipment promptly.
- We saw evidence of an appropriate air mattress being used for an end of life patient on ward G4. Good documentation and review of skin integrity was evident before and after the change of mattress.
- Mortuary fridge temperatures were continuously monitored via switchboard. The fridges were 'banked' meaning not all fridges were running from the same

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system. This helped mitigate the risk of equipment failure across all fridges within the mortuary at the same time. Mortuary staff were knowledgeable about the procedure in the event of failure of the fridges.

Nutrition and hydration

- Patients were generally happy with the food on offer at the trust.
- Patients had drinks within easy reach and or were routinely offered fluids throughout the day.
- There was good documentation from Speech and Language Therapists (SALT) in relation to palliative care patients and their ability to continue to eat and drink. This was supported by the SPCT who said they have a good working relationship and communication with the SALT team.
- In all clinical areas inspected there was documented evidence on the last days rounding forms of nursing staff offering regular nutrition and hydration. This was also observed in many clinical areas. However, we noted that the last days rounding tool greys-out the nutrition boxes for the hours between midnight and 8am, preventing nursing staff from clearly documenting at these times. We felt that this might discourage nursing staff from offering food during these times if a patient is unsettled and awake overnight.

Patient outcomes

- In the latest National Care of the Dying Audit, published March 2016 by the Royal College of Physicians, the trust met four of the five clinical outcomes. The trust did not meet the outcome for documented evidence of a holistic review of needs in the last 24 hours of life. The trust achieved this in 51% of cases, with the national average being 66%.
- We reviewed 20 sets of multidisciplinary notes from patients who were at the end of their lives or receiving palliative care. Of the 20 notes, 16 had clearly documented that the patient was palliative or near the end of life. We found this was often documented on the Escalation Plan and Resuscitation Status (EPARS) forms rather than within medical notes.
- Information was requested from the trust regarding their participation in the Gold Standard Framework (GSF) Accreditation scheme, or any other similar schemes. The GSF scheme is a national initiative to

improve the care of patients at the end of life and awards trusts that consistently follow national guidance and deliver high quality care. The trust participated in accredited learning programmes.

- The trust currently participates in the National Care of the Dying Audit and had previously participated in the national End of Life Care Quality Assessment Tool. It supplements this through the use of local audits.
- The latest internal audit from January 2016 reviewed 300 EPARS forms. Of these 52% were fully compliant with trust policy on completion. This was an increase of 9% on 2015.
- We reviewed 27 EPARS forms. Twenty of these were fully completed in line with trust policy. In seven cases EPARS were not appropriately or fully completed, due to one or more of the following: a lack of identifying information, for example date of birth and hospital number on the EPARS. An unclear or inappropriate reason for admission, a lack of explanation around the treatment plan or multiple answers marked for the same question, for example both "Yes" and "No" marked. We also found multiple forms where both the "for resuscitation" and "not for resuscitation" boxes had been signed, with one crossed through. This could cause confusion in the event of patient deterioration, particularly in a medical or nursing team unfamiliar with the patient.
- The SPCT said that every death in the hospital is reviewed as part of a mortality review by the SPCT. This was a new venture and no supporting documents were available at the time of inspection. The SPCT said the reviews are designed to highlight "inappropriate over medicalised" care for patients at the end of life, with the view to feedback learning.

Competent staff

- The SPCT had a 0.96 WTE palliative care practice development matron in post that allowed both the SPCT and general ward areas to access ongoing and additional training. The practice development matron provided clinical supervision and support for staff.
- Supporting evidence was provided following the inspection that showed all SPCT staff, mortuary staff and chaplaincy staff had completed 100% of their appraisals, with the exception of one member of mortuary staff due to long term absence.
- End of life care champions were in place on every ward and we saw this for each area visited during the inspection. End of life champions must attend a yearly

mandatory training day to update their knowledge base around care of the dying patient and the processes to follow when a patient is at the end of life. Evidence of attendance at yearly update session was submitted by the trust.

- Staff were able to spend 'shadow shifts' with the SPCT as a learning opportunity. We saw evidence of, and were told about, the SPCT explaining and teaching junior doctors how to prescribe anticipatory medication for patients at the end of life. This helped to expand the knowledge base of the junior medical staff, which the SPCT felt was particularly important for outside of normal working hours.
- The mortuary team detailed additional training that was available. For example, all staff were trained to assist with tissue retrieval from the deceased and one member of staff was trained in enucleation, the removal of part of the eye.

Multidisciplinary working

- Multidisciplinary team (MDT) meetings were being held weekly, however these were attended by the SPCT nurses and, when available, the SPCT consultant who was covering as part of the service level agreement. The presence of allied health professionals, for example physiotherapists or speech and language therapist, at these weekly meetings would provide a more holistic overview when planning care delivery. Allied health professionals did not attend MDT meetings at the time of inspection.
- Referrals to the SPCT came from multiple professionals, including nursing, medical and allied health professionals. Nursing staff felt confident to refer to the SPCT for advice and support should the medical staff not be available.
- The CNSs also taught junior doctors the medications that were required at the end of life and why, and provided supervision to enable the junior doctors to prescribe end of life medication and to further their knowledge and understanding of end of life medication.
- There were end of life champions within physiotherapy, occupational therapy and speech and language therapy, as well as on each ward area. This promoted communication and effective multidisciplinary working between all professionals.

- We saw multidisciplinary working on wards G4 and G5 between nursing and medical staff and the SPCT. Detailed documentation was seen to support the decisions made.

Seven-day services

- The Specialist Palliative Care Team (SPCT) did not provide a seven-day service. The SPCT currently provided a Monday to Friday 8am to 4pm service. Staff could access a palliative care Consultant out of hours via switchboard. Staff were aware of the out of hours service and how to access it.
- The chaplaincy service was available 8am to 4pm Monday to Friday in the hospital. Out of hours, they provided a responsive service for any urgent referrals. The chaplaincy aimed for a one-hour response time out of hours and as soon as possible for urgent referrals during daytime working hours (Monday to Friday).
- The chapel was open 24 hours a day, seven days a week for staff, patients and visitors to access.
- Mortuary staff were on site during the day, Monday to Friday between 8am and 4pm. Mortuary staff provided an emergency service out of hours, contactable via switchboard, on a rota basis.

Access to information

- Medical notes and nursing notes were easily accessible within clinical areas when required. Ward based nursing staff were able to locate specific information within patient records. All members of the multidisciplinary team (MDT) documented in the same place. This meant all members of the MDT had access to all relevant notes.
- 'Last Officers' boxes had been introduced onto ward areas, containing all the equipment required to perform care after the death of a patient. The SPCT told us these had been brought in following uncertainty and lack of continuity between different wards and nursing staff relating to undertaking care following the death of a patient. We saw these boxes on several wards and nursing staff knew where to access them.
- The SPCT had a separate area of the staff intranet containing information on end of life care. Staff were aware of the intranet page and how to access it. Staff spoke positively about the SPCT and the ease of accessing information and guidance whenever they needed it.
- The bereavement officer ensured that all relevant information pertaining to a patient's death was gathered

and a written explanation was available for families upon the collection of the death certificate. The bereavement officer was able to contact medical staff to provide a verbal explanation, either on the day or by prior arrangement.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust uses its own version of a patient resuscitation form, which also includes a brief outline of the treatment plan should a patient deteriorate. The trust named these forms Escalation Plan and Resuscitation Status (EPARS).

- Patients with multiple or complex conditions, or those who lacked capacity, also had a "yellow folder". This was a joint community and trust wide venture where patients and/or their families are able to record the patient's wishes, escalation plan and store their 'do not resuscitate' form. Where patients lacked capacity, we saw documented evidence of consideration from medical and nursing staff as to the contents of the yellow folder.

- The EPARS forms contained an area to document if a patient had mental capacity. However, this was a tick box, either "Yes", "No" or "N/A". The inclusion of a "not applicable" box within the mental capacity section was of concern as we were unclear when a patient's capacity would not be applicable in the decision making process around their own treatment plan and resuscitation status. Staff were also unclear on the use of the "not applicable" option when questioned.

- All patients admitted into the trust should have an EPARS completed. This should be done within 24-hours of admission to be compliant with trust policy. The executive chief nurse said the target is 100%. No information on this was available in the 2015 or 2016 EPARS audit results submitted by the trust.

- The trust's EPARS forms complied with guidance from the UK Resuscitation Council, as there were clear areas to document mental capacity and for discussions had with the patient and or their next of kin. They also contained areas for documenting a clear escalation plan, which the UK Resuscitation Council is currently undertaking work on to include in future national guidance.

- During the inspection we reviewed 27 EPARS forms and a further 10 during the unannounced inspection.

- The trust's EPARS and DNA-CPR policy stated that the patients own consultant or doctor of ST3 grade or above, who is managing their care, must complete EPARS forms. Where this is not possible, the consultant or specialist registrar in charge of the ward at the time can make EPARS decisions. Of the 37 EPARS reviewed, 34 had been signed by a consultant, two by a specialist registrar and one was signed however no designation was present.

- During the inspection, concerns over the low adherence to EPARS completion were raised to the executive team. Assurances were given that these would be reviewed and actions taken where needed. All EPARS for patients who were not for resuscitation were reviewed and rewritten where required. On checking the EPARS of greatest concern, we found they had been reviewed and rewritten. However, another EPARS was found to not be completed in line with trust policy following the review of all 'not for resuscitation' EPARS the preceding evening by the executive team.

- During the unannounced follow up inspection a further 10 EPARS were looked at; three on ward G5 and seven on ward G4. Of the 10, six had incomplete mental capacity or DoLS documentation in line with trust policy, but this was only two days after the new policy had been implemented,

- One senior doctor had ticked the "N/A" box under the mental capacity assessment on the EPARS form on ward G4. When asked, the doctor suggested this had been done because no discussion had taken place with the patient, as it was felt the discussion would cause distress to the patient. As no discussion had taken place, the doctor stated that the capacity of the patient was therefore not applicable. This is in contradiction to the trust's EPARS and DNACPR policy, which stated that concern about causing the patient distress is not sufficient reason to avoid discussions, and that sufficient documentation should accompany any decision not to discuss the resuscitation status with a patient. No supporting documentation was found in this instance. The doctor informed the inspection team that the use of the "N/A" option was commonplace on the ward.

- During the unannounced inspection, 17 patients across wards G4 and G5 were found to require a DoLS but had not had the relevant application completed or submitted. Senior nursing staff sighted the implementation of the new MCA and DoLS policy as a

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possible reason for the delay. However, senior nursing staff also highlighted that a lack of staff, time and resources, in the form of computers, were key factors in the delays for completing DoLS applications.

- The trust's Mental Capacity and DoLS policy was potentially in breach of Article 2, right to life, and Article 5, right to liberty, of the Human Rights Act 1998. Between the inspection and unannounced inspection, the MCA and DoLS policy had been rewritten. The lack of application for and implementation of DoLS is potentially a direct breach of Article 5, the right to liberty and Article 8, the right to a private and family life, of the Human Rights Act 1998. The trust was made aware of this at the time of the inspection and the subsequent unannounced inspection. The inclusion of a "N/A" option for capacity was inappropriate and, even though capacity can be fluid, it should be assessed at the time a decision needs to be made. This means a patient will always either have or not have capacity, making a "N/A" box irrelevant.

- We found a good understanding of the trust's policy in relation to MCA and DoLS. We saw examples of completed DoLS on two end of life patients. However, the trust's policy concerning MCA and DoLS stated that following an MCA test that indicated a lack of capacity, there should be a further two reviews over a six day period before an application for a DoLS was made. Staff thought the MCA assessment was enough to deprive a patient of their liberty during the interim period. Following our escalation of concerns the trust responded and the MCA and DoLS policy was revised and implemented shortly after the inspection, on 21 March 2016. The new policy states that DoLS applications must be completed as soon as possible if there is a permanent lack of capacity. If capacity was transient, the trust's new policy stated that a DoLS must be applied for within 72 hours of a lack of capacity being identified.

- The executive chief nurse (ECN), who led on both safeguarding and end of life care, acknowledged that the completion of EPARS and MCA and DoLS knowledge were areas where improvement was required and could be made. The ECN was made aware of the additional concerns raised during the unannounced inspection.

Are end of life care services caring?

Outstanding ☆

Caring within end of life care services was rated as outstanding because:

- Medical, nursing and allied health professional staff all maintained patients dignity throughout the end stages of life.
- Mortuary, chaplaincy, bereavement and portering staff all promoted patients individual needs and ensured that compassion and dignity was as the forefront of everything they did.
- Chaplaincy staff gave multiple examples of when they had gone above and beyond to meet the needs and wishes of patients and relatives within the hospital.
- Mortuary and portering staff gave multiple examples of how patient's dignity is promoted and respect is shown to the deceased.
- There was an embedded culture of compassion and respect, throughout all staff groups involved and regardless of the length of time spent with the patient or relatives.
- Nursing staff went above and beyond, displaying a passion and strive to provide a dignified and peaceful death regardless of the logistical challenges faced to achieve this.
- Staff took the emotional wellbeing of members of the public and other staff into consideration when transporting the deceased between areas, for example by temporarily closing corridors when transporting deceased children or babies.
- Staff engaged with both patients and their families in positive ways.
- All staff, regardless of their role, when needed, provided emotional support to patients and relatives.

However

- There was no formal counselling or emotional support services within the hospital for staff, patients or relatives to access. However, staff from all groups provided support and guidance to relatives and friends throughout the dying process.

Compassionate care

End of life care

- Staff provided compassionate care in all clinical areas. Both nursing and medical staff communicated in a kind and gentle manner with patients and families. Staff took time to assist patients at the end of life to eat and drink in a calm and non-rushed way.
- There was an engrained culture of compassion and positivity amongst staff in all clinical areas visited. All staff spoken with had a genuine desire to want to provide the best possible care to patients at the end of life.
- Staff were aware of the limitations and challenges faced in providing continuous, high quality palliative and end of life care. However, individualised solutions for wards, departments and individual patients and situations had been sought to ensure a dignified and peaceful death.
- Staff on ward G5 told us of a time a husband and wife were both inpatients together. The husband was in a side room and was at the end of life. Staff arranged for his wife's bed to be moved into his side room so she could be with him during his last hours of life. Staff told us the gentleman died holding his wife's hand and his wife and family were extremely grateful for that opportunity.
- Chaplaincy, bereavement and mortuary staff were passionate and committed to ensuring that the deceased were cared for with compassion and respect, both before and after death.
- The chaplaincy staff told us of a time a patient's husband had died in the community whilst she was an inpatient. The chaplaincy organised a simultaneous service in the hospital chapel, attended by hospital volunteers and chaplaincy staff, as his wife was too ill to attend in person.
- The chaplaincy provided examples of marriage blessings that had taken place at the hospital for patients who had a limited life expectancy.
- Access to the mortuary was controlled. The mortuary fridge spaces were not visible until fully inside the mortuary. This helped to maintain the deceased's privacy and dignity throughout. The autopsy room was also enclosed and could only be accessed by appropriate staff such as the mortuary, pathology or autopsy staff. This also helped to promote the privacy and dignity of those deceased patients undergoing autopsies.
- During the movement of the deceased from the mortuary into the undertaker's vehicles, the deceased had to be taken a short distance along a public corridor.

Staff ensured that the corridors were free from members of the public before transferring the patient. This maintained the deceased's dignity and promoted the welfare of those visiting the hospital.
- Mortuary staff ensured the undertaker's vehicle was reversed under a covering before transferring the deceased as wards and offices looked out over the loading bay. This ensured the dignity and privacy of the deceased and ensued those looking out were unaware of what was happening.
- The mortuary staff informed us that when a child dies, the porters ensure that the corridors are temporarily closed during the transfer of the deceased child and often bow their heads as a mark of respect. This is something that the porters have not been asked to do however have felt that this was appropriate. This was a further example of the embedded culture of respect and compassion evident across the hospital, regardless of the role undertaken or the amount of time spent with the patient.
- The porters and mortuary staff stated that they do not have any concerns over the care delivered to patients from ward staff and believed that patients are cared for in a dignified manner.

Understanding and involvement of patients and those close to them

- Positive interactions were observed between staff and patients and their family and relatives.
- We observed multiple discussions between patients and nursing, medical and allied health professionals that were appropriate, caring and considered the wishes of the patient.
- On ward F10, there was detailed, holistic documentation seen for a patient at the end of life. The documentation clearly showed discussions between senior medical staff and the patient and their family in relation to the patient's ongoing treatment plan. The documentation clearly showed what the patient wanted to be told and what they were happy for their family to be told.
- The bereavement office staff organise for medical staff to be available when relatives come to collect the death certificate to answer questions relating to the death. This was something that was arranged either in advance or on the day.

Emotional support

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- The clinical nurse specialists (CNS) from the specialist palliative care team (SPCT) spent time with patients and their families to provide reassurance and support and answer any difficult questions that they may have in relation to the treatment being received.
- The SPCT acknowledged the importance of supporting not only the patient but their relatives and friends throughout the dying process.
- Chaplaincy, bereavement and mortuary staff demonstrated empathy for the relatives and friends of the deceased, stating the need for a holistic approach to the emotional needs of those left behind.
- The chaplaincy provided spiritual and non-spiritual support to patients and families regardless of religious beliefs in times of crisis and distress.
- The bereavement office was a place for relatives to relax, ask questions and be supported before and after the death of a family member. The bereavement office had the facility to host discussions between families and medical staff to answer any questions about the treatment of the deceased and provide reassurance and support throughout the process.
- The trust had no formal psychological or counselling support available to relatives of patients at the end of life. The trust had no plans to implement a counselling service.
- The oncology service provided volunteers, Monday to Friday within clinic opening hours, for information, advice, support and someone to talk with. Their service was located within the oncology waiting area and many of the volunteers had worked there for a number of years, ensuring a strong relationship with the patients. This has helped the staff in being able to provide consistent, high quality support to patients and their families in both the positive and difficult times faced by oncology patients.

Are end of life care services responsive?

Good ●

Responsive was rated as good for end of life care because:

- Care was planned on an individualised basis for patients at the end of life.

- Patients at the end of life and those with an active 'do not resuscitate' status were identified through the trust electronic database.
- The trust had undertaken audits into the use of the last days rounding tool and preferred place of care compliance.
- Families of patients at the end of life were given Family Packs containing information and discount vouchers for parking and food.
- Fast track discharge was being monitored by the trust and the discharge team were aware of patients awaiting fast track discharge and the reasons for the delay.
- The mortuary generally had sufficient storage for the deceased and had process in place to enable access to further storage for times of high capacity.

However:

- The trust had a process for fast track discharge where funding was required for care. However the trust did not have a target time for achieving a fast track discharge. This meant that some patients could be waiting for discharge.
- Patients requiring fast track discharges were not always being seen within 24 hours of the referral being made to the SPCT.
- There was a lack of space within the mortuary to facilitate religious requirements, for example washing the deceased by family members.

Service planning and delivery to meet the needs of local people

- There were 843 referrals to the Specialist Palliative Care Team (SPCT) between April 2013 and March 2014. This increased to 855 between April 2014 and March 2015. The SPCT stated that 51% of referrals in 2014/2015 were for patients with a cancer diagnosis and 49% with non-cancer diagnosis.
- The SPCT received and encouraged referrals from nursing, medical and allied health professional staff from across the trust. Examples were provided of nursing staff referring patients without the direction of the medical team. The SPCT also received direct referrals from patients and families. Examples were provided of patients that had self-referred, as they were concerned over the care they were receiving.
- The trust audited the use of the last days rounding tool on 14 wards between March 2015 and February 2016. Staff used the last days rounding tool on an average of

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52.2% of patients who died within the hospital. Use of the last days rounding tool had improved over time, from an average of 46.2% in the four months to the end of June 2015 to an average of 57.5% in the four months to the end of February 2016. However, this showed that on average 42.5% of patients, in the four months to February 2016, who died within the hospital did not have a last days rounding tool used.

- The outcomes from the trusts audit of the last days rounding tool could in part be due to the tool not being used for patients who unexpectedly died, or those who deteriorated quickly.

- The trust audited patients preferred place of care (PPC) versus outcome from September 2015 to February 2016 inclusive. The audit covered 242 palliative care patients or those at the end of life. The audit showed that 140 of the 242 patient achieved their PPC; however, 102 did not achieve their PPC. Of the 102 who did not achieve their PPC, six were not asked, 76 died before reaching their PPC and 20 were cared for in a place other than their PPC. This is an overall PPC achievement rate of 57.9% for the audit sample.

- The trust did not have a specific palliative care ward and patients at the end of life were cared for across the trust.

Meeting people's individual needs

- On ward G5 we found an example of an Escalation Plan and Resuscitation Status (EPARS) form where the patient had not had his resuscitation status discussed due to being "deaf"; the patient was assessed to have full mental capacity. This was highlighted to the nurse in charge and Matron for G5 and was swiftly brought to the attention of the consultant and a new EPARS form completed. No consideration had been documented to access a sign language interpreter should that have been necessary.

- The Specialist Palliative Care Team (SPCT) stated that following the Liverpool Care Pathways (LCP) removal the last days rounding forms had been introduced. The last days rounding forms, along with individualised care plans written by ward nurses, ensured that each patient was assessed and individualised care delivered. Both care rounding forms and individualised care planning were seen in all clinical areas inspected.

- Due to the layout of the wards, accessing a side room within the hospital was often difficult. However, staff were fully aware of the importance of maintaining dignity, especially in the last days of life. We saw

examples of staff moving patients to ensure the highest level of privacy and dignity could be maintained. For example reducing the number of patients in a bay and moving the patient at the end of life next to the window, as these are often more spacious bed spaces.

- Carers and family members of palliative patients and those at the end of life were given a 'Family Carer' pack that contained information about support groups, a 'My Care' booklet to fill in with likes and dislikes of the patient and a family carer badge. This entitled the carer or family member to discounted parking charges, discounted food and drink at the onsite restaurant, open visiting hours and access to drinks and comfortable chairs on the wards. These were readily available within all areas visited and staff were fully aware of them.

- The chaplaincy staff stated that of all the religions, only Christianity was represented on site. The lead chaplain was in the process of making arrangements with other local religious leaders, for example the local Imam, to facilitate them to come into the hospital should they be required. The lead chaplain stated that only 0.8% of local residents were of an Islamic faith. The Office for National Statistics found in 2013 that 0.5% of the local population to the trust identified their religion as Islamic.

- The chaplaincy gave examples of when wedding ceremonies, baptisms and special services had been organised for patients within the hospital. The lead chaplain stated that in the event of a request for a same-sex ceremony he would consult with the local registrar.

- There were no formal facilities within the mortuary for the deceased to be out of the refrigeration equipment for a prolonged period.

- There were no specific facilities within the mortuary to accommodate religious needs in terms of end of life rituals, for example allowing a family to wash the deceased. The mortuary staff stated that it could be possible to facilitate specific needs if they were told prior to the family arriving. Alternative arrangements could be made and or facilities brought into the viewing room to accommodate specific requirements.

Access and flow

- The trust did not have a specialist palliative care ward or any specialist palliative care beds. There was evidence of end of life patients being given side rooms wherever

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possible. Across the trust, there were a limited number of side rooms and at times clinical needs of other patients took priority, for example an infection risk, which meant that end of life patients were often nursed within open bays.

- The trust's End of Life Care Policy sets out the process for fast track discharge (FTD) for those patient's deteriorating rapidly and unlikely to survive if standard discharge planning is implemented.
- The trust had a fast track discharge procedure in place for patients whose preferred place of care is not within the hospital and are in the last days of life. The fast track discharge of patients was coordinated by the discharge planning team.
- When fast track discharge is delayed, patients were discussed at weekly MDT meetings to assess the ongoing problems. The trust provided a list of reasons for delayed fast track discharge; however no statistical data to show auditing of the specific reasons for delays in fast track discharging.
- The process for patients who require fast track discharge had the potential for delays in achieving the desired discharge. Patients were highlighted by staff on the wards and a referral made to the SPCT. The SPCT will aim to see patients on the same day wherever possible, however could take up to two days.
- Audit data submitted by the trust showed between April 2014 and March 2015 87.9% of patients were seen with 24 hours of the referral being made. Between April 2015 and March 2016, this had reduced to 79.7% of patients. In the same reporting periods there were 902 fast track referrals to the SPCT in 2014/2015, reducing to 582 in 2015/2016.
- The SPCT referred the patient to the discharge planning team following assessment to establish suitability for fast track discharge. Where funding for care was required the discharge planning team issued the required documentation to the ward for completion and then submitted it to the funding authorities. The trust had an internal key performance indicator (KPI) of three days to achieve completion of all relevant paperwork to secure funding for patients requiring this. In December 2015 the trust achieved 81.5% for completion to discharge within three days. The funding authority had a target of completion of the paperwork within four hours. Data held by the trust showed that this was not always met. This meant that discharge was delayed. However, all patients continue to be supported by the SPCT.

- The mortuary capacity was 86 spaces, with nine suitable for bariatric patients. These nine spaces could also be turned into freezer spaces when necessary. There was a process in place for mortuary staff to get access to further temporary refrigeration should that be required. There was specialist refrigeration for children, babies and non-viable foetuses.
- The mortuary had an agreement with the local undertakers that in the event of capacity issues at the hospital, the deceased could be moved out to refrigeration spaces at local undertakers.
- Portering staff received specific training on how to transport the deceased and had access 24 hours a day to the mortuary.

Learning from complaints and concerns

- The trust had conducted various audits into the provision of care, however no evidence of action plans had been provided during the inspection to suggest improvement and learning from concerns.
- Between March 2015 and February 2016, completion of the last days rounding tool varied between 38% and 64%. The SPCT and executive chief nurse raised this as a concern; however, no formal action plan had been completed and submitted to show a move towards improving compliance.
- The executive chief nurse gave an example following a complaint from the daughter of a patient that died at the trust of how the daughter had actively participated in the development of the end of life strategy and vision to ensure it met the needs of patients and their families.

Are end of life care services well-led?

Good ●

End of life care services were rated as good for well-led because:

- There was a clear vision and strategy in place for end of life care
- The service had an appointed executive and a non-executive to lead on end of life care
- The culture of the service was one of positivity and resilience.

However:

End of life care

- There was no systematic monitoring the service. Minutes reviewed did not demonstrate discussion of key operational indicators for the service. We could not be assured that the trust was aware of and taking action to address the impact of delays on patients.
- The service had not undertaken a full bereaved patient survey between 1 April 2013 and 31 March 2015 to assess the quality of the service. The trust had undertaken a pilot of a bereaved relative's survey. A biannual survey was proposed to be undertaken to gather views of patients and their loved ones to measure the quality of the service. Access to medical support was limited and the service delivered by palliative care nursing staff. There was currently no medical leadership within the Specialist Palliative Care Team. Although a consultant had been appointed and was about to commence at the time of our inspection.

Vision and strategy for this service

- The trust had a comprehensive strategy and vision for end of life care in place and provided relevant copies as supporting evidence prior to the inspection. The executive chief nurse (ECN) was the executive lead for end of life care alongside a non-executive director.
- The vision for end of life care had been set around the trusts seven ambitions, which make up the vision for the trust as a whole. The end of life vision focuses on five of the seven trust's wide ambitions.
- Under "Deliver personal care", the trust had highlighted end of life care was associated with poor patient experience. They aimed to "Deliver joined up care" by coordinating more integrated working with local hospice and community services. The trust planned to "Deliver safe care" by reducing the length of patient stay within the hospital environment and providing training and education to staff to deliver safe effective care.
- The trust would "Support aging well" by providing care wherever the patient wishes to be and "Support all our staff" through training, education and motivation to deliver the best end of life care possible.
- The trust end of life strategy set out the predicted need for palliative and end of life care over the coming years and proposed a five-year plan to improve end of life care at the trust.
- In additional to the normal daily care provided to patients in respect of end of life care, the trust strategy detailed 17 additional services in place to promote good end of life care. These included: specialist palliative care

team input in complex cases, the use of end of life champions within clinical areas and the implementation of the last days rounding tool. All of the 17 initiatives detailed within the strategy were seen during the inspection.

Governance, risk management and quality measurement

- The trust monitors the end of life service through the End of Life Operational Group. This group meets quarterly. This group is supported through weekly meetings of the multidisciplinary team who discuss patients at the end of their life, and delays in discharges and current plans of care. A quarterly business meeting and end of life care operational meeting also review services provided. However through the review of the October 2015 meeting minutes for the End of Life Care Operational Group there was a lack of oversight of the performance of this service. Whilst there had been discussion on the pilot of the bereavement questionnaire and the national end of life audit there was no discussion recorded on the experience of patients awaiting discharge. We were not assured that patients who wanted a fast tract discharge, with or without funding, were discharged in a timely manner.
- The pilot of the bereavement questionnaire, undertaken in August 2015, showed that 69% of patients' relatives were given the questionnaire to complete. The response rate was 30%. 80% of comments were positive but some relatives comments about the lack of availability of a side room. Only 50% of relatives had been asked if they required chaplaincy services. The trust proposed that this information would be sent to the ward areas. It was not clear from the minutes of this meeting whether the questionnaire would be rolled out or when it was to be undertaken again.
- The End of Life Care Audit – Dying in Hospital which was a national audit based on data collection from 2015 showed that documentation regarding relatives' insight and discussion of worries or questions and the food and fluids taken by patients at the end of their life required improvement. The End of Life Care Operational Group discussed actions to address these key areas and to highlight them to staff in wards caring for patients. The service had not undertaken a full bereaved patient survey between 1 April 2013 and 31 March 2015 to assess the quality of the service. The trust had addressed this in part by undertaking a pilot survey in

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August 2015. The audit also demonstrates that staff at the trust were good at recognising patients who may be in the last days of life with a score of 95% against a national average of 93%. A biannual survey was proposed to be undertaken to gather views of patients and their loved ones to measure the quality of the service.

- Minutes of the Palliative Care Business Meeting in January 2016 demonstrate that the continued education programme and planned and recently received audits were discussed. However there is no recorded discussion on the performance of the service in terms of numbers of patients, length of time to receive funding is appropriate, time taken to fast track discharge, numbers of on call contacts with palliative care medical team, or plans to continue to audit the experience of bereaved relatives. We could not be assured that through this meeting the effectiveness and responsiveness of the service was being monitored.

- The More Care, Less Pathway report, published July 2013 by the Department of Health (DH), recommended that all healthcare organisations appoint a non-executive member of the board to oversee end of life care. The trust adopted this recommendation and had appointed a non-executive director (NED) to oversee end of life care. This added a further layer of scrutiny to end of life care in the absence of a substantive consultant.

- More Care, Less Pathway also recommended that a yearly report be submitted to the board to establish the state of end of life care within the trust. This had not previously been done at the trust; however, plans were in place for the first yearly report to be submitted by the ECN towards the end of 2016.

- The trust risk register for end of life care was reviewed and a summary of the register submitted. The risk register contained concerns identified at the inspection. No further concerns were raised with regards to the risk register.

- The risk register for the mortuary was seen prior to inspection and discussed with mortuary management during the inspection. No further concerns were raised with regards the risk register.

- The chief nurse was part of End of Life Steering Group for Suffolk, which the chief nurse chaired on a bimonthly basis. This provided a benchmarking and sharing of good practice opportunities for the participants.

- No substantive specialist palliative care consultant was in place at the trust at the time of inspection. The service had not had medical leadership since June2015 although the trust had been trying to recruit. A successful applicant was to join the trust shortly after our inspecting in April 2016. The risk of no consultant oversight was mitigated through executive oversight, good nurse led service and champions across the hospital.

- End of life champions (EOLC) were on every ward visited during the inspection. EOLC's must undertake training relevant to their roles, such as expected death confirmation, syringe driver and the trust's last days of life study day. This allowed for local support and direction to be provided to ward staff when nursing a patient at the end of life. All staff asked knew who their EOLC was and how to contact them.

- Within the ward areas there was no specific referral system to end of life champions when patients are admitted to ward areas.

- All staff receive end of life training during induction to the trust and undertake mandatory three yearly on line refresher training.

- The SPCT told us they support and guide junior medical staff on the wards, particularly around prescribing of medication. Although not witnessed during the inspection, evidence of junior doctors prescribing with supporting documentation from the SPCT was seen. Speciality consultants were seen to prescribe end of life medication in line with trust policy, and with supporting documentation from the SPCT nurse specialists.

- The nursing staff within the SPCT were nurse prescribers; however this was under a patient group directive (PGD) system, where a palliative care consultant must oversee the prescribing. As no palliative care consultant was readily available to review prescribing, a join decision between speciality consultants and the SPCT was often made. Evidence of this was seen in patient's notes. This mitigated the risk of error in the prescribing of end of life medication as multiple practitioners were reviewing the prescription.

- The SPCT stated they felt comfortable to challenge a medical decision if in the best interests of the patient. Evidence of challenge from the SPCT was seen within patient's notes during the inspection.

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Leadership of service

- The SPCT and the ECN spoke positively about the collaborative working between the palliative care team and the executive team, especially over the preceding nine months when no medical lead had been in post. A new lead consultant for palliative care had been appointed and was due to start in April 2016.
- Weekly meetings were taking place between the SPCT and ECN to ensure the SPCT were supported due to the lack of medical leadership.
- All of the SPCT staff felt well supported within their role and felt having a specialist practice development matron in post had provided structure and leadership to the palliative care nurses.
- At the time of inspection there was no substantive specialist palliative care medical leadership at the trust. Medical support was being provided two sessions, equivalent to two half days, per week through a service level agreement (SLA) with the onsite hospice. There was access to consultant telephone advice 24 hours a day, seven days a week.
- Although no specialist palliative care medical leadership was in place, the chief nurse had and palliative care practice development matron (PDM) met weekly.

Culture within the service

- The SPCT said there was a good team ethic and felt well supported by local colleagues within the team. The SPCT also acknowledged that awareness of and the importance of end of life care was a high priority within the trust.
- All staff recognised the importance of end of life care and all spoke positively about the contribution the SPCT makes to patients and families.

- Although facilities, such as access to side rooms, often constrained staff, we found a culture of staff wanting to initiate unique ways of working to ensure patients and families could receive the best care that could be delivered and in a dignified way. This attitude appeared ingrained in all staff across the trust.
- The mortuary and portering staff demonstrated a strong team ethic and were proud of the services they delivered to patients. The chaplaincy and bereavement staff also demonstrated a strong team ethic, working together to ensure the best possible outcomes for patients, staff and families.

Public and staff engagement

- Feedback from patients and families was mainly undertaken informally. The trust had undertaken a pilot audit in August 2015 the results of which was awaiting ratification at the End of Life Care Operational Group meeting. It was unclear at the time of our inspection if this questionnaire was being continued. The trust requested feedback from those who were identified as carers through a questionnaire within the Family Pack. Not all packs we saw on wards contained the feedback form. Feedback that was received was reported through the patient experience committee. Also, any complaints or concerns raised regarding end of life care were discussed at the patient experience committee. Minutes of these meetings were seen following the inspection.
- The lead chaplain has spoken at local events and community groups in the local area several times over the past year to raise the awareness and profile of the chaplaincy service within the trust.
- The Suffolk End of Life Steering Group meets on a monthly basis, chaired bimonthly by the executive chief nurse at West Suffolk Trust, to discuss all aspects of end of life care and how better collaborative working across Suffolk could have a positive impact on patient care and outcomes.

Innovation, improvement and sustainability

- Prior to the unannounced inspection, a rolling program to retrain all senior nursing staff on the use of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) had been implemented. This was in response to the initial feedback after the comprehensive inspection. The action plan that was in place at the

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follow up inspection was for senior nursing staff to disseminate the new training within their own clinical areas. Evidence of this was seen at the follow up inspection.

- An ongoing action plan was in place during the inspection to improve the adherence to the EPARS policy in relation to the completion of EPARS. The action plan is due for completion and review at the end of March 2016.

- At the time of inspection a bid had been submitted to Macmillan for funding for a further two specialist nurses to join the SPCT. If the funding bid is approved, the medium term strategy is to move to a seven day a week service.

- At the time of inspection, there was a draft proposal, due to be ratified in May 2016, to introduce weekly training sessions of one hour across the trust. End of life training will be included within the weekly sessions that will be available for all staff to access.

- Plans were in place to introduce 30 community steps down beds, which could also be utilised for end of life

care, within Suffolk. The draft proposals showed 10 beds within a care home setting, ran medically by West Suffolk NHS Trust, however nursing care to be provided by care home staff. A further 20 beds were planned for Glastonbury Court, where all staffing, governance and oversight would be provided by the trust. No formal date for implantation had been set at the time of inspection. Evidence of the proposals were produced by the chief nurse and seen during the inspection.

- The chief nurse was in the process of creating a Clinical Council at the trust, consisting of nurses, midwives and allied health professionals (AHP) such as physiotherapists, occupational therapists and radiographers. The purpose was for the council to discuss and influence care delivery, including end of life care, to improve patient experience, care and outcomes. No formal date for creation had been set at the time of inspection. Evidence of the plans for implementation were produced by the chief nurse and seen during the inspection.

Outpatients and diagnostic imaging

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

Information about the service

Outpatient and diagnostic services at West Suffolk Hospital received 78897 referrals between April and November 2015 and 77223 referrals between April 2014 and March 2015. The trust provided 95732 outpatient appointments between April 2015 and November 2015 and 99132 outpatient appointments between April 2014 and March 2015.

Individual clinics run from the outpatients and separate diagnostics areas, which have their own reception desks. Clinics held include endocrine, infectious diseases, neurology, respiratory, vascular surgery, haematology, diabetes, rheumatology, dermatology, urology, trauma and orthopaedics, general surgery, x-ray, magnetic resonance imaging (MRI), and oncology.

During our inspection we visited the main outpatient areas including the clinics for cardiology, haematology, rheumatology, ophthalmology, dermatology, diabetes, orthopaedics and urology. Within imaging we inspected x-ray, MRI, computed tomography (CT), and ultrasound.

During the inspection we spoke with 63 members of staff including 11 consultants, eight managers, seven radiographers, 18 nurses, 16 administrative or support staff, one junior doctor and two volunteers. We spoke with 10 patients and three relatives of patients. One patient declined to speak with us. We looked at the environment, we observed staff interacting positively with patients and their colleagues and we looked at 22 sets of patients records.

Summary of findings

Overall we rated the outpatient and diagnostic services at West Suffolk Hospital as Good. Staff were safety and risk aware, knew how to ensure provision of a safe service and could describe how to escalate incidents and learning from these when things had previously gone wrong.

Cleanliness was good. The trust monitored this through audits, for example hand hygiene.

There was a process in place for maintenance of equipment within the departments and the trust had plans in place for replacement, maintenance or service interruption through major incidents.

Medicines were securely stored, monitored and information was available for patients regarding potential side effects. The trust used evidence based guidance to treat patients and monitored outcomes.

Staff were aware of their responsibilities to protect patients from abuse or harm and could describe how to escalate concerns or seek help. Staff could describe appropriate processes for protecting people who were vulnerable through intellectual disabilities such as dementia.

Caring was good, staff demonstrated how they go 'the extra mile' for their patients and we observed staff interact with patients, relatives and their colleagues respectfully and treat them with dignity. Patient feedback showed that people were very happy with the care they received.

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We saw that staff from different professional disciplines worked well together to provide the most appropriate care for their patients. The trust was achieving target times for referral to treatment for most services.

There were governance processes and risk management in place for most of the services. Risks were appropriately captured and documented.

Staff were universally positive about local and trust wide leadership. The executive team supported staff, encouraged them to suggest and make changes to improve patients' experience, and supported implementation of these. Local managers were respected and staff felt supported by the managers in diagnostic services.

We could not be confident that outpatient clinics were appropriately staff by skilled and qualified staff, for example paediatric dermatology.

Some outpatient areas, for example audiology, were very cramped.

Policy making in the outpatients department lacked timeliness, trust-led scrutiny or endorsement.

Are outpatient and diagnostic imaging services safe?

Good ●

We rated the safety of outpatient and diagnostic services as good because:

- Patients were protected from the risk of poor care. Staff knew how to identify, record and report incidents and there were mechanisms in place to ensure learning from incidents took place.
- Staff could describe incidents that had occurred and the changes in practice because of the learning from incidents.
- Staff monitored incidents and attempted to reduce the number each year.
- The environment was visibly clean. There were cleaning schedules in place and cleaned equipment was identifiable by the use of green 'I'm clean' stickers.
- There was a schedule for replacement of old or broken equipment.
- Medicines were securely stored and access was appropriately restricted.
- Records were generally well completed and were available for clinics.
- Staff could describe how to raise a safeguarding alert and whilst few of them had experience of making an alert they were aware of how to get help escalating a concern.
- There were good systems for identifying the correct patients for diagnostic tests.
- Diagnostic staff stated that risk assessment and management was paramount.
- Access to diagnostic test areas was appropriately restricted.
- Nursing and care staffing levels regularly exceeded planned activity.
- Within diagnostic imaging there was monitoring of radiology staffing levels and radiography colleagues' provided cover for shortfalls. There was good management of medical staffing shortfalls through outsourcing of some diagnostic reports overnight.
- The trust had a business continuity plan in place, which had been updated in July 2015 ,for equipment in diagnostic imaging services to ensure that services could be maintained.

Outpatients and diagnostic imaging

Incidents

- There were no serious incidents in the diagnostic or outpatient departments between February 2015 and January 2016.
- There were two never events for this service between April and June 2015; an incorrect insertion of a peripherally inserted central catheter (PICC Line) for a patient attending outpatients and an incorrect Lucentis injection was given to an ophthalmology patient.
- Evidence provided demonstrated that both never events had been investigated and procedures changed to prevent recurrence. For example in ophthalmology the error occurred due to duplicate referral paperwork and the referral for intravitreal injections was made in the main notes rather than a separate ophthalmology treatment document.
- We asked 33 staff about incident reporting and learning. 23 staff knew how to escalate and record incidents using the trusts incident reporting system. 20 staff told us about the duty of candour and seven staff described how this should be implemented. Twenty-one members of staff described lessons learned from incidents that had occurred in line with the trust incident reporting and management procedure issue 3.
- The department had introduced a six-point identity (ID) checking tool following an incident where the wrong patient (a child) was sent to the x-ray department and had an unnecessary chest x-ray. A copy of the incident investigation report included the duty of candour explanation given to the patient's representative.
- We saw a completed six-point ID check for a patient receiving a CT scan on 9 March 2016
- Monthly meetings within the diagnostic department had been started in January 2016 to discuss incidents and share learning from these by highlighting them through a new internal publication called 'Risky Business'. Nine of the 17 diagnostic staff we spoke with about learning from incidents told us about the incident-reporting newsletter. Copies of the newsletter were available on notice boards in the staff room and offices used by diagnostic staff.
- A senior diagnostic manager told us they monitored Radiation Medical Exposure Regulations (IRMER) notifications of radiology incidents. For example of when and unintended dose of radiation had been given to the wrong site or the wrong person.

- Staff were able to describe examples of when the duty of candour applied and demonstrated understanding of when it should be applied. For example a senior radiographer explained they had notified a patient's relative of an unintended dose of radiation for a child.

Cleanliness, infection control and hygiene

- Staff adhered to the trust uniform policy requiring them to be bare below the elbow and wearing personal protective clothing including gloves and protective aprons where required.
- The trust carried out patient led assessments of the care environment (PLACE audits) .The outpatient and diagnostic departments scored 100% for cleanliness. The areas inspected were visibly clean.
- The trust had undertaken monthly hand hygiene audits between June and November 2015. The outpatients and diagnostic departments consistently scored 100% between September and November 2015 for hand hygiene. From June to August the results were below 100% at 98-99% but remained above the trust target of 95%.
- There was evidence of 'I'm clean' dated green stickers on equipment in the x-ray department and cleaning schedule in place within cardiology and x-ray services.

Environment and equipment

- Resuscitation trolleys were in easily accessible positions in the outpatient and x-ray departments. The matron in diagnostics checked the trolleys daily and records of the checks were consistent.
- The trust maintained equipment including medical devices.
- The trust had recently changed to a managed equipment service and had a schedule for maintenance and replacement through capital expenditure or leasing new equipment.
- Documentation demonstrated routine servicing for example an x-ray processor had a service appropriately in January 2016.
- Staff adhered to security and safety measures within the diagnostic imaging service. For example access to the x-ray areas known as 'pods' was restricted to radiographers who escorted patients into one of the four x-ray pods in the department. There was restricted access in the MRI area by the use of electronic tags worn by MRI staff.

Outpatients and diagnostic imaging

- Conditions were cramped in the audiology department. The consultation rooms were very small causing a trip hazard when more than one patient and or relative might be in the room together.

The trust had a business continuity plan in place, which had been updated in July 2015, for equipment in diagnostic imaging services to ensure that services could be maintained

Medicines

- Medicines, including contrast medication, were securely stored and access was restricted to nursing staff. Contrast medication is required in CT scans to pinpoint an area within the body and allow radiographers to identify normal tissue and or abnormal tissue which may indicate a problem.
- There were consistent checks in place of drug fridge temperatures to ensure medication was stored and maintained at the optimum correct temperature.
- Prescription pads in outpatients were stored securely in the sisters' office and monitoring of usage was by the outpatient manager.
- Patient information was available to explain the potential side effects of medication, for example leaflets for contrast medication used in MRI. There were other leaflets available and notice boards had information displayed for example what to expect in an MRI scan.

Records

- Records were being converted to a new electronic system in May 2016 and until the single electronic record system was implemented staff used a mixture of hard and electronic copies of records.
- Twenty two sets of hard copy patient notes were reviewed. Twenty were in good condition and 19 were in clear chronological order. Three sets of records had appropriate ionising radiation medical exposure regulations (IRMER) risk assessments for diagnostic tests.
- Staff we spoke with told us patient records were usually available in time for clinics. Staff told us hard copy notes are usually scanned within 3 days and uploaded to the electronic records system. Staff in a focus group told us occasionally if patients had more than one appointment in the same week the records were not scanned in time for more than one weekly appointment.

- The trust audited the availability of medical records using a department for health records audit tool. Results of the audit for September 2015 were good, showing that 19 out of 20 randomly selected records were tracked to where the electronic system identified they should be. This audit also reported this was an improved position from the previous six months when 30% of records could not be accurately tracked or located.
- The National Cancer Patient Experience Programme survey results 2014 for West Suffolk Hospital showed the trust scored 99% for the question - doctor had the right notes and other documentation with them. Confidence intervals are the range from lowest to highest responses in a survey. This result was above the lowest confidence interval for trusts nationally.
- Of 22 sets of records reviewed, allergy status was incomplete for two sets.
- Whilst records were completed correctly the doctor's signature was not legible in three sets of notes. There were other illegible entries in one set of notes.

Safeguarding

- We asked 10 staff members from mixed roles about safeguarding and they all told us how to escalate a safeguarding concern. One member of staff said there was information available on the staff intranet, but took several minutes to locate this. There was a safeguarding flow chart poster displayed in the waiting area for the x-ray department.
- A member of outpatient staff described an alert for a patient who disclosed domestic abuse the previous week. The safeguarding team had been involved and they were waiting for feedback upon completion of the investigation.
- Trust wide, 96% of nursing staff and 79% of medical staff were trained to level 2 safeguarding children and 92% of staff required to undertake safeguarding children level 3 were up to date with this training. (Level 3 training is required by all staff that have direct contact with patients).
- Data provided for level 3 training was trust wide and it was not possible to identify where in the trust staff were. None of the figures submitted identified the number of diagnostic and outpatient staff who were up to date with safeguarding training.
- Eight members of diagnostic or outpatient staff told us they were up to date with safeguarding training.

- Again the data was similar for adult safeguarding and reflected trust wide compliance of 88.8% at March 2015. There was no current information that broke this down further to identify staff within outpatient and diagnostic services.
- One locum doctor said that their employment agency did not provide safeguarding training and the trust had not provided either.

Mandatory training

- Nineteen staff members spoken with said they were up to date with mandatory training. Two members of staff told us there were gaps in their completion of mandatory training owing to clinical need.
- The trust had a target of 90% compliance for mandatory training. The trust monitored the 90% target and 93% of outpatient nursing staff were up to date with mandatory training.

Assessing and responding to patient risk

- Guidance, risk assessments and local rules for radiology exposure were available in each of the four x-ray areas known as pods including the details of the radiological protection supervisors and advisors. Records of reported x-ray machine faults were also available.
- There were identified outpatient and radiology department risks that had been categorised and logged on risk registers. Staff utilised the risk register appropriately to identify risk and mitigation. For example, a shortage of contrast medication had been risk assessed and included on the risk register earlier in 2016. This risk had been closed when the contrast became available but was then reopened when the supply became scare again in the week of inspection.
- The diagnostic services risk register was red, amber, green rated (RAG) according to severity. There was a clear process in place for managing the risks, those requiring actions, actions taken to mitigate risk and closing of a risk. For example where a piece of equipment had been condemned and subsequently replaced.
- Three senior radiographers described how IRMER compliance was achieved by ensuring the correct tests are performed and those unnecessary or contraindicated tests are not For example a radiographer described challenging an inappropriate x-ray for a patient. A senior MRI radiographer described that training was provided to the referring clinician of a

patient for an MRI when they had a pacemaker. The clinician was made aware that patients' with pacemakers cannot routinely have MRI scans due to the metal contained within the pacemaker.
- Each of the four x-ray, CT and MRI rooms had signage warning of the radiation risk.
- A member of diagnostic staff described how they supported a deteriorating patient following a reaction to contrast medication.
- The World Health Organisation (WHO) surgical safety checklist was used to undertaken safety checks prior to procedures in the radiology department. The WHO was audited six times in 2015. The results were variable but improving and started with 8% WHO checklists completion in January, ending with 86% of WHO checklists being completed in November 2015.

Nursing staffing

- Staff hours regularly exceeded monthly planned levels for nurses and care staff between September and November 2015. For example, nursing staff numbers were exceeded by 3% in September; 3% in October and 14% in November.
- The numbers of nursing support staff hours were also above scheduled levels. For example the numbers of hours exceeded for care support staff were 61% in September; 61% in October and 67% for care staff in November 2015
- The number of planned nursing hours in August was 1208. For outpatients there was shortfall of 151 hours. However, the number of care support staff planned hours was 1536 and the actual number hours exceeded planned levels by 877 hours.
- The trust had reviewed the skill mix monthly in the outpatient department in 2015. Figures seen for August to November 2015 showed the outpatient department was regularly staffed by more nursing and care staff than planned. For example in November nursing staff by 14% and care staff by 67%, October nursing 4% and care staff 61%, September nursing 3% and care staff 66%. However, in August there was 13% shortfall nursing staff and there were 57% more care staff than planned.
- There was no use of agency or locum staff. The outpatient budget did not encompass any locum or agency nurse allowance. Staff working overtime or bank shifts covered on a voluntary additional hours rota.

Radiography staffing

Outpatients and diagnostic imaging

- Radiology staffing levels were monitored weekly between August 2015 and December 2015 to ensure scheduled activity could take place as planned.
- There were radiographer shortages dues to sickness absence for the weeks commencing 7, 14 and 21 September 2015. In each case other departmental colleagues covered these absences to ensure unhindered service provision.
- The recruitment of qualified radiography staff was a challenge. The trust had a radiology department SLR strategy document covering the period 2014-2019. The document acknowledges staffing difficulties including recruiting sufficient staff; a proposed solution was recruitment of reporting radiographers for a fraction of the cost of a radiologist.
- In order to minimise delayed reporting of test results were outsourced overnight to another ISAS accredited service.

Medical staffing

- A senior radiologist told us recruitment of consultant radiologists was a challenge nationally and small district general hospitals' were competing for consultants who wanted to specialise at larger hospitals.
- There was a shortage of one consultant radiologist. The department outsourced the reporting of scans overnight (between 8pm and 8am) to an independent provider that is also imaging services accreditation scheme (ISAS) accredited.
- The shortage of radiologists was on the trust radiology departmental strategy document, and on the risk register. This had been on the register since 2007. An action to recruit locum and permanent staff in response to a radiologist leaving in December 2015 had been identified and finally achieved in March 2016. Despite this recruitment has remained as an active risk on the register due to increased service demand with a review date of 30 September 2016.
- Registrars and consultants covered an out-of-hours rota.
- One locum in outpatients said that the induction into the department and support was good.
- The trust stated there was no outpatient budget for locum medical staff; any requirement for additional staff would be met from the budget for the speciality, for example surgery.

Major incident awareness and training

- The trust had a business continuity plan dated April 2013. The trust had a major incident procedure dated October 2015 and a generic emergency and business continuity policy dated March 2015.
- E learning on major incidents was mandatory. Three members of outpatient staff had not completed this.

Are outpatient and diagnostic imaging services effective?

There is no current requirement to rate the effectiveness of outpatient services.

- Evidence-based practice guidelines were used in both diagnostic and outpatient services.
- The trust participated in a recognised accreditation scheme that required service monitoring in line with evidence based practice guidelines to maintain the accreditation.
- The diagnostic department monitored pain for patients experiencing uncomfortable treatments such as colonoscopy.
- The trust participated in national surveys and results were in line with similar trusts nationally.
- Staff were up-to-date with appraisals.
- Staff were very proud of the multidisciplinary working between colleagues and other teams within the hospital.
- Diagnostic imaging staff knew their responsibilities around safety and consent. They were able to describe how to support patients with impaired capacity due to illness or intellectual disabilities.
- Patients' records were mostly available in time for clinics.
- Patient surveys showed patients had been given information about their diagnosis and treatment.

However:

- Staff stated there were not always sufficient computer terminals for all the diagnostic staff to report the findings of tests.
- Ophthalmology and audiology staff said that electronic records were not always accessible in time for clinics.
- There was no formal process for the development of polices. Staff were unaware if new policies were subject to a trust review process.

Evidence-based care and treatment

Outpatients and diagnostic imaging

- Staff followed evidence based guidelines including National Institute for Clinical Excellence (NICE) or Royal College of Physicians guidance.
- For example the radiology service participated in the imaging services accreditation scheme (ISAS), a nationally recognised accreditation scheme jointly developed by The Royal College of Radiologists and the College of Radiographers.
- The department followed NICE guidelines CG164 'familial breast cancer: classification, care and managing breast cancer and related risks in people with a family history of breast cancer' and they had standard operating procedures for referral to MRI for symptomatic patients to have further investigations.
- Rheumatology outpatients followed NICE quality standard [QS33] for treatment of rheumatoid arthritis.
- The service undertook a regular audit programme including audit of:

WHO surgical safety checklist; department of health records; medical exposure to ionising radiation; management of medical equipment and hand hygiene and trust dress code policies.

- There was no formal process for the development of polices. Staff were unaware if new policies were subject to a trust review process to ensure they were evidence based, robust or ratified at trust level.

Pain relief

- Three sets of patients' notes were reviewed. Pain relief had been offered to the patient
- 10 patients and three relatives of patients waiting for outpatient or diagnostic appointments stated that they had no concerns with pain management.
- The national cancer patient survey results 2014 showed that the trust scored above the lowest score for the range of scores nationally for 'Staff definitely did everything they could to help control pain' at 83% as compared to the highest confidence interval of 93%. For the question 'Staff definitely did everything they could to help control pain' the trust scored 83%.

Patient outcomes

- The trust had not participated in the national outpatient survey since 2011 when the trust had scored similar to other trusts for many of the indicators. For example for

the section on overall impression of the outpatient department, satisfaction with visit; respect and dignity and overall care were about the same as other trusts nationally.

- The National Cancer Patient Experience Programme survey results 2014 for West Suffolk Hospital showed the trust scored 85% for the question 'Staff definitely did everything to control side effects of chemotherapy'. This was higher than the lowest confidence interval of 80%, but much less than the highest confidence interval of 90%. Confidence intervals are the range from lowest to highest responses in a survey.
- The ISAS accreditation required the trust to undertake a variety of audits on clinical outcomes and patient experience to maintain the accreditation. For example percentage of staff competent for each CT examination annually; patient consent annually and complaints quarterly.
- The trust compared the results of the ISAS audit activity year on year since first accredited in 2011. A senior diagnostics manager showed us the reduction in reportable IRMER incidents from five in year ending April 2015 to 2 in the last year to March 2016. IRMER reportable incidents include for example unintended doses of radiation or x-ray on the incorrect site.

Competent staff

- The trust collected information about staff appraisals by professional group within directorates.100% of radiography professionals in diagnostic services had an appraisal. 93% of nursing staff in radiology had had an appraisal.
- 78% of medical staff trust wide had an up to date appraisal and 78% of outpatient staff had an up to date appraisal.
- A senior nurse in the diagnostic department was a member of the nurses revalidation committee and had introduced some of the revalidation points into staff appraisals. She said that another member of staff was responsible for ensuring staff maintain revalidation and spreadsheet utilised for tracking and recording of compliance. There was a revalidation folder kept in the department for quick reference.

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- A senior radiologist said that there was a good appraisal system for doctors which included patient and peer feedback and training to be an appraiser of medical colleagues. The medical director signs off medical appraisals but actual copies of records were not seen.
- A senior member of medical staff said they received a good amount of continuing professional development (CPD) time, 30 days in three years, and CPD contributed to appraisal.
- There was bi-annual training for junior doctors and consultants on MRI safety.
- There was evidence of IRMER trained staff in the signed local rules and competency matrix seen in each x-ray pod.
- Two outpatient managers were unable to provide reassurance that there were appropriately staffed qualified paediatric nurses, who had basic life support training, working in the new children's outpatient dermatology clinic.

Multidisciplinary working

- Twenty-five diagnostic or outpatient staff members spoken to said they believed multidisciplinary (MDT) working between teams was good and they were proud of this.
- Staff said that the stroke unit staff had shown appreciation for the MRI team and made a cake to say 'thank you' for their collaboration providing a 'one-stop' trans- ischemic attack (TIA) clinic.
- Staff provided support and cover for the breast-screening clinic to ensure there was always a breast care nurse available for radiology. This included providing chaperones, assistance with ultrasound and administrative support. On the day we inspected there was a breast care nurse supporting the ultrasound department.
- We observed good MDT working between nursing and surgical staff in the trauma and orthopaedic clinic on the day we inspected this service. This was evident during the treatment of a young patient with the plaster technician and orthopaedic consultant worked well together.
- Two senior radiographers described how they challenged referrals for inappropriate tests or incorrect information. For example incorrect in-patient referrals

would be discussed directly with the referring consultant and externally referred patient scans were vetted by a senior radiographer and booked within two weeks.
- Feedback obtained from allied health professionals such as occupational and physiotherapists demonstrated the commitment to MDT working. Allied health professionals said they work as part of an integrated team. They provided an example of a project working in conjunction with social care agencies to improve the discharge of medically fit patients who require complex care packages in the community. This was a pilot project originally, but funding was secured to make the medically fit team permanent.
- The imaging department had recently become responsible for services at Newmarket and were exploring rotating radiography staff between sites. Staff described this rotation plan positively.

Seven-day services

- X-ray and MRI were provided in the emergency department seven days a week.
- The stroke team worked with speech and language therapists seven days a week.
- Physiotherapy and occupational therapy staff said that they had a voluntary paid weekend rota, but staff sickness meant that there were often gaps in the weekend rota. This meant that there were not always enough physiotherapy and occupational therapy staff available at weekends.

Access to information

- Records were most often available for outpatient clinics through the 'electronic records system. Medical records stated that handwritten clinic notes were scanned into the electronic record system within 72 hours of a patient appointment in clinic. There was a risk that if a patient attended more than once in 72 hours, previous visit records may not be scanned in time for multiple appointments.
- Audiology and ophthalmology staff stated that notes on the electronic system were not always accessible and occasionally hard copy notes were missing.
- One junior doctor said that there were not always enough computer terminals available to examine and report test results.

Outpatients and diagnostic imaging

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The patient experience consent audit in August 2015 showed that 88% of patients surveyed had been given sufficient information to give informed consent. This was above the target of 85%, but less than the previous year's score of 96%.
- Consent for chemotherapy, including possible side effects, was documented in three sets of electronic records.
- Consent was not always consistent and differed in two versions of the notes reviewed. Hard copy notes were checked against the electronic records. One record, where a spouse had signed the consent, it was identified that the patient had suffered a stroke and had been unable to sign themselves. One ophthalmology patient, having cataracts removed from both eyes, had a missing consent for the right eye, but this had been completed on the electronic record.
- The World Health Organisation (WHO) surgical safety checklist was used in the radiology department. Verbal consent had been audited six times in 2015. Results for November 2015 showed documented verbal consent at 91%.
- Nineteen staff could describe how they supported patients with reduced mental capacity through intellectual disability and or dementia.
- Six staff could name the lead learning disability link nurse within the trust and one member of support staff described how they had supported an elderly confused patient with support from the trust lead nurse.
- There was a dedicated Mental Capacity Act 2005 (MCA) champion, in the department, trained by the lead MCA nurse. There was a resource folder for colleagues within the department containing information about dementia and learning difficulties.
- Staff demonstrated on the electronic record an example of a best interest decision for a patient suffering from cerebral palsy requiring an MRI
- A member of support staff in the diagnostic department showed us small laminated cards used to indicate if a patient had particular needs for example, impaired hearing or dementia. The laminated card for dementia used the recognised dementia symbol, a butterfly. These cards were small and discreet and were placed within the patient's diagnostic tests folder when they arrived for their appointment to alert other staff.

- Seven members of outpatients staff provided examples of how they supported patients who lack capacity and that they often contacted the trust dementia lead nurse for advice.
- There was a resource folder in the department regarding the Mental Capacity Act 2005.
- Diagnostic staff said that they would seek advice and or support from their MCA champion colleague or the resource folder in her absence for help with people with learning difficulties and or dementia. Six other staff also said they might also seek the advice of the trust lead MCA nurse.

Are outpatient and diagnostic imaging services caring?

Good 🟢

We rated caring as good at West Suffolk Hospital because:

- Staff interacted positively and kindly with patients and their colleagues and they treated patients, relatives and colleagues with dignity and respect.
- Patients were happy with their care and described staff for example as "excellent".
- Staff were dedicated and empathically described how they supported vulnerable patients.
- Evidence in national survey results showed that patients felt they had been well- supported through their treatment.
- Six patients and two relatives stated they felt involved in their own or their relative's care.
- Staff provided good examples of how they provided patients and their relatives with emotional support.

Compassionate care

- During the inspection staff and volunteers interacted positively and respectfully with patients and their colleagues.
- Eight out of ten patients spoken with said staff were polite, friendly and helpful. Seven confirmed staff had used their chosen name.
- One patient regularly visited the diagnostic department for cancer treatment. She said staff always respected her privacy and dignity and that she never had to wait for long when she arrived or for patient transport when she returned home. She told us "I think it's excellent".

Outpatients and diagnostic imaging

- Staff in the x-ray department introduced themselves to patients and politely explained the sequence of their particular test in a kind and considerate manner.
- Staff in the oncology department supported a patient in a kind and supportive way when the patient became unwell during treatment. Staff moved the patient to a more private area whilst continuing to reassure other patients. One patient who witnessed this said that they had felt reassured by the support from staff.
- The diagnostic department had undertaken a patient satisfaction survey and made the results available on the public notice board. The results showed 99% of patients' who used the service rated it as good.
- The outpatients department friends and family test results for February 2016 showed 91.96% of patients rated the service as excellent or good.

Understanding and involvement of patients and those close to them

- Six of the ten patients and two relatives spoken to felt fully involved in their own or their relatives' care.
- The outpatient department monitored patient experience on a monthly basis. Between June 2015 and November 2015 the trust consistently scored between 92 and 99 for the question "Did you feel as involved as you wanted to be in decisions about your care?"
- The diagnostic service monitored patient satisfaction as part of the ISAS accreditation and results of an audit in 2015 showed 98% of patients asked agreed "The information sent to me was patient friendly and comprehensive".

Emotional support

- A senior radiographer told us how they had supported a terminally ill patient when the patient became upset during an appointment, including arranging with colleagues to complete a CT scan ahead of the scheduled appointment and collecting information from the MacMillan support unit to give to this patient. The patient's relative returned following their death to express thanks for the supportive way the radiographer had helped their relative.

Are outpatient and diagnostic imaging services responsive?

Good ●

We rated the responsiveness of this service as good because:

- The trust was meeting most target times for offering patients a first appointment including the two-week target time for suspected cancer.
- Patients were given information about their appointments and the trust monitored whether patients felt the information was useful.
- Staff were regularly willing to volunteer to work extra hours to cover the end of a shift and ensure that patients received tests on the appointment day rather than being rescheduled when the departments became busy beyond the normal working day.
- Three 15-minute imaging slots were reserved for requests for diagnostics before 9:30am. This enabled any patients identified on ward rounds to have tests and potentially be listed for operations that day.
- Staff informed patients of any delays within the department when they came for their tests and appointment delays where monitored.
- Staff worked hard to meet the particular needs of patients and were willing to 'go the extra mile' to ensure patients' needs were met.
- Patients without appointments were 'fitted into' the daily schedule rather than the appointment being made for another day.
- The trust complaints data showed that less than one percent of complaints received about services related to diagnostic or outpatient services.

Service planning and delivery to meet the needs of local people

- The trust collected information about the number of diagnostic and outpatient referrals past and present. The figures showed a year on year increase in demand for appointments. For example in 2014/15 there had been a total of 77223 referrals and between April and November 2015 the trust received 78897 referrals.
- The patient waiting times for outpatient appointments were within target times. Two outpatient department managers stated there were no breaches in meeting this target because extra clinics were scheduled when patients were close to the target.

Outpatients and diagnostic imaging

- The trust worked to a target of four weeks rather than the national target of six weeks for diagnostic tests
- The trust regularly met their own four-week target for a first appointment for MRI and CT scans between June 2015 and November 2015. No patients waited beyond six weeks for a first ultrasound appointment between September 2015 and November 2015.
- The trust met the two-week wait for diagnostic tests for suspected cancer. The trust monitored this between June 2015 and December 2015. The average wait for a diagnostic test when cancer was suspected was 1.7 weeks.
- Signage for the different services within outpatients and diagnostic areas was sufficient.
- Patients were sent information prior to attending their appointments. For example patients attending for CT scans were sent a leaflet that explained the test, included information about potential adverse reactions and safety questions for patients to answer before attending, such as previous adverse reactions or pregnancy. The leaflet also helpfully contained details of directions to the department.
- The referral to treatment time for diabetes/nephrology outpatient appointments was high at 36.4 weeks.
- The orthopaedic clinic was observed as cramped; some conversations about patient treatment were being held in corridors and this posed a risk to confidentiality.
- Cataract patients had telephone access to advice out of hours and there was an out of hours rota covered by registrars and consultants.

Access and flow

- The trust collected information about appointments where the patient did not attend (DNA). Figures seen for 2014/15 and 2015/16 showed the DNA rate was lower for this trust at 4.5% and following introduction of appointment management software the DNA rate was declining further. For example the May 2015 DNA rate was 4.4% and the November DNA rate was 3.7%.
- Saturday audiology clinics took place to meet target times for ear nose and throat (ENT) treatment.
- The diabetic clinic staff would see 'drop-in' patients upon request and they provided a one-stop diabetic clinic twice a week for patients with specialist diabetic pumps that required adjustment.

- Patients had a CT within one hour of a stroke being suspected. This was in line with NICE (CG 68) Stroke and transient ischaemic attack in over 16s: diagnosis and initial management guideline
- There was a voluntary 'mop-up' rota to ensure patients waiting beyond 5pm received diagnostic tests. Staff took turns and volunteered to stay later than scheduled finish time to complete tests for patients waiting beyond 5pm. Staff took time off in lieu of additional hours worked or were paid overtime for the additional hours.
- One of the 10 patients spoken with said they had waited a long time, "20 minutes", since arriving in the department.
- Referral to treatment time data showed with the exception of nephrology patients did not wait beyond the 18-week target for a first appointment. Data provided showed that between September 2015 and February 2016 trust results were better than the England average for both non-admitted and incomplete referral patients. With results ranging between 91.6% and 92.3% for incomplete pathways and between 92.3% and 93.5% for non-admitted. The trust worked to an 11-week target and this showed that between June and November 2015 there were 17 patients waiting for an appointment beyond the trust 11 week target.
- The rheumatology service included an early arthritis clinic and a telephone helpline. Staff in rheumatology outpatients said that there was no waiting list patients, they were referred one day and seen the following day.
- The radiology service audited patient waiting times during July 2015 to December 2015. The results showed that 84% of patients were seen early or within 10 minutes of arriving; 97% of patients were seen within 20 minutes and 3% waited more than 30 minutes. The best performing service was mammography with 96% of patients seen within 10 minutes.
- A senior radiologist responded to a request by doctors to improve efficiency of theatre time by keeping three 15-minute imaging slots free for doctors doing ward rounds and requesting diagnostics by 9:30am in the mornings. This enabled patients to be listed for operation on the same day if results indicated this was necessary.
- Not all patients were seen within target time frames of 18 weeks from referral to first treatment. As of December

Outpatients and diagnostic imaging

2015 there were a small number of patients waiting beyond 18 weeks 3% for cardiology; 2% for Diabetes; 27% for geriatric medicine, 2% for general surgery and 0.04% for ophthalmology.

- A senior radiographer described how the chief executive (CEO) thanked MRI staff for the support they gave other hospital teams for increasing through put and completing diagnostic tests to send able patients home and free up beds during a recent 'black alert'.

Meeting people's individual needs

- A senior radiographer demonstrated a plaster of Paris model of the MRI machine and told us this was used to inform children what to expect from a MRI test. The model had been made with input from a play therapist and used to reduce children's anxieties about the MRI machine.
- There was a full size model skeleton in the orthopaedic clinic with multiple plaster casts; two children were playing in the department with the skeleton during the inspection and were obviously not anxious about their appointment.
- Staff in the cardiology outpatient department supported patients using patient transport service (PTS), including ensuring patients were comfortable whilst they waited for their transportation home.
- There were magazines, leaflets, an information board, TV and Wi-Fi available for patients and toys for children in the waiting areas of outpatients and diagnostic clinics. However the minor operations room had nothing to entertain or distract children receiving treatment.
- On the day of inspection one patient had been told by her GP four weeks previously that they could 'just turn-up' for an x-ray. Although the patient's GP had referred the patient, because they had not attended within three weeks the referring GP had been informed the patient did not turn up. Staff in the diagnostic department discussed this patient's request and agreed to fit her in for an x-ray around the other scheduled patients the same day.
- Oncology staff had made information available for a visually impaired patient by arranging for patient information leaflets to be converted to Braille. A member of staff had taken the information to the patient's home because this had generated a large volume (one box) of information.

- Staff in outpatients and x-ray knew how to access a telephone translation service for patients whose first language was not English.
- A patient attending for MRI stated that he was self-employed and the hospital had quickly provided an appointment to fit around his work commitments.
- Some outpatient department consultation rooms were cramped or had narrow doorways.

Learning from complaints and concerns

- Information on how to raise a complaint or safeguarding concern was displayed on notice boards in outpatient and diagnostic test areas.
- There had been nine complaints about diagnostic services and 12 complaints about outpatient services between January 2015 and November 2015. Five complaints about outpatients related to delays or cancellation of appointments within the department. Complaints about diagnostic imaging were mixed with no clear themes identified, but included three complaints about poor staff attitude. There was no information stating whether any of the complaints were substantiated.
- One of the ten patients and one relative spoken to during the inspection mentioned car parking as a concern.

Are outpatient and diagnostic imaging services well-led?

Good ●

We rated well-led at this service as good because:

- There were trust wide and diagnostic services strategies and staff were aware of these.
- Outpatients and diagnostic services had processes in place to record and manage risk.
- The diagnostic services took part in a national evidence based practice accreditation scheme.
- We identified strong leadership in diagnostic services.
- There was a positive safety conscious 'will do' culture within the diagnostic department.
- Staff and the public were engaged and positive about diagnostic and outpatient services.
- There was evidence of innovation within the orthopaedic, diabetic and diagnostic services.

Outpatients and diagnostic imaging

However,

- There were no robust procedures for policy initiation and review within the outpatients department.
- The support from managers in outpatients was not always robust enough to provide consistent development opportunities or support for outpatient staff.

Vision and strategy for this service

- The trust has a vision and strategy and there was evidence of the values contained within the strategy on notice boards in x-ray and MRI areas. Staff were aware of the strategy and trust values.
- The strategy had seven ambition statements and included commitments to support all staff, deliver safe care, and support ageing well.
- Three senior managers were concerned about the increasing demand for diagnostic services. Year on year increases were referenced in the radiology department SLR strategy document dated 27 March 2015 and the strategy indicated how the trust intended to respond to the increased demand without compromising the ISAS accreditation. For example by referring some patients to other hospitals for tests or recruitment of more reporting radiographers.

Governance, risk management and quality measurement

- The diagnostic service was first registered in nationally recognised and voluntary imaging accreditation scheme in 2011. This scheme was jointly developed by the Royal College of Radiologists and the College of Radiographers and covers four areas of service including clinical; facilities and resources; patient experience and safety.
- The trust had separate risk registers of risk associated in both the outpatient and diagnostic services. The diagnostic imaging risk register was managed well with risks dated; nominated individuals identified and completed actions recorded. We were shown examples of the risks of failure to use the six-point check for identifying the correct patient and this was reflected on the imaging service risk register.
- The outpatient risk register contained appropriate risks for the department. These were colour coded to demonstrate the current level of risk.

- Oversight of policies and protocols was not in place. At the time of inspection no policies had been developed for the paediatric dermatology service recently started in outpatients. We were concerned about the implementation of a new service without appropriate policies and or guidance for staff providing the paediatric dermatology service. We were not assured that the service was staffed by appropriately qualified or trained specialist nursing staff which meant that the children could be at risk of harm from inappropriately skilled and qualified staff.

Leadership of service

- Twenty-two members of staff highlighted local leadership as good, they felt supported and trusted.
- The imaging service was led by an experienced manager who had worked for the trust for more than three decades. Staff who were line managed by the imaging services manager told us he was respectful, supportive and trusted staff to carry out their role. For example one senior radiographer told us " the imaging manager trusts me and will escalate concerns I raise with senior leadership." For example the chief executive came to thank staff for helping to get patients' test reports quicker during a period of black alert in January and for their support for in-patient staff to discharge patients who were well enough to go home.
- The outpatient department was led by a senior nurse supported by a service manager who respected each other and worked well as a team. The lead nurse told us she had "an open door policy", was responsible for all the outpatient nursing staff but was unable to explain how direct reports were formally supervised, performance managed or involved in the running of the department.

Culture within the service

- The environment was calm, friendly and staff were welcoming to patients, visitors and their colleagues.
- There was evidence of a welcoming approach, on promotional literature such as the 'My name is' campaign on notice boards, and staff introduced themselves to patients.
- A senior member of the diagnostic service described the ISAS accreditation system as promoting a "safety reporting culture rather than a police culture".
- The trust had a formal policy for addressing the duty of candour, 'Being Open – The Duty of Candour' dated

Outpatients and diagnostic imaging

January 2016. This policy contained definitions, explained why it had been developed to ensure that staff were aware of the processes and steps to follow in supporting patients and carers following an incident meeting the requirements for provision of Duty of Candour.

Public engagement

- The trust sought feedback from young patients to improve the experience of children in the radiology department and made more toys and books available to entertain them whilst they waited for their appointment.
- West Suffolk Hospital responded to feedback on the reviews and ratings section of the NHS choices website from patients who had been treated at the hospital. For example in March 2016 a patient attending for a sigmoidoscopy thanked staff for their help and support. The trust responded with "Really pleased to hear about your positive experience".
- The trust had a patient experience group made up of people who had been treated at the hospital. The trust used this group to engage about proposed changes to services.
- A separate patients council was used by the trust to engage the views of patients using the service on a variety of issues.

Staff engagement

- Staff were positive about their own local and trust wide managers. They felt "valued" or felt "trusted" by their managers and the chief executive.
- The trust performed well in the national NHS staff survey 2015; 93% of staff who took part agreed "their role makes a difference to patients / service users", and 89% of staff believed that "the organisation provides equal opportunities for career progression or promotion".
- Radiological staff, doctors, nurses and support staff confirmed that they felt listened to and that the CEO was visible, approachable and they had confidence in him.

Innovation, improvement and sustainability

- The diagnostic team were proud that they had received awards for service innovations such as a fast track clinic for trans-ischemic attack (TIA/mini stroke) patients.
- A senior diagnostic manager was proud the trust maintained ISAS accreditation since being one of the first trusts to be awarded accreditation in 2011.
- The trust provided opportunities for staff to develop their improvement ideas. A member of MRI support staff described this as a formal meeting where they asked for support for an idea in front of senior trust members.

Outstanding practice and areas for improvement

Outstanding practice

- The porters' display of respect for the transport of the deceased to the mortuary especially in respect of baby deaths.
- The virtual fracture team who were dedicated to ensuring diagnosis of fractures was not missed in the emergency department (ED).
- The receptionist in ED providing CPR to a collapsed patient and summoning immediate assistance.
- Two consultant pediatricians learnt hypnosis to reduce the need for sedation in children requiring MRI or CT scanning.
- Trust performance against national audits was outstanding especially in the Sentinel Stroke National Audit Programme (SSNAP) and Myocardial Ischaemia National Audit (MINAP).
- Consultant paediatricians worked to provide access for patients. They set up outreach clinics in GP premises and held telephone clinics so that patients could stay in their own surroundings

- Staff who went the extra mile to drop off take-home medications or provide decaffeinated tea bags for a patient.
- The arrangement of a linked funeral service for the wife of the deceased who could not leave the hospital.
- The pharmacy service was excellent in providing take-home medications for patients.
- Additional support for critical care patients was provided by a follow-up nurse and a critical care outreach team, who also provided a cross-department education programme.
- In critical care, staff were encouraged and supported to undertake novel research projects, which they were able to present at national conferences as a knowledge-sharing strategy.
- Senior critical care staff had developed a robust five-year service plan in collaboration with unit staff, which was further evidence of the cohesive and supportive work culture we found.

Areas for improvement

Action the hospital MUST take to improve

- Review and ensure robust processes are in place to provide compliance with mixed sex accommodation regulations especially within CDU, critical care (in relation to level one patients) and recovery when it is utilised for stepdown from critical care.
- Review its 'Escalation Plan and Resuscitation Status' (EPARS) forms to ensure, specifically, that the Mental Capacity Act and Deprivation of Liberty Safeguards aspects are appropriate.
- Review its Mental Capacity Assessment, Deprivation of Liberty Safeguards and EPARS policies to ensure they are compliant with law and reflect good practice.
- Ensure a robust process for data management with regard to medical photography and comply with all information governance protocols including informed consent, data protection, tracking and tracing and appropriate audit systems implemented to ensure quality improvement.

Action the hospital SHOULD take to improve

- The trust should ensure that all staff understand and have access to incident reporting processes and ensure all investigations result in demonstrable learning.
- The trust should review the reporting of mortality and morbidity (M&M) discussions and learnings in surgery services to ensure consistent and effective documentation across the service.
- The trust should ensure staff compliance, across all staff groups, with mandatory and statutory training requirements.
- The trust should review referral to treatment times and aim to improve to ensure that surgical patients receive care within 18 weeks.
- The trust should ensure robust oversight of cancelled clinics and review theatre utilisation to support access to services and reduce patient treatment delays.
- The trust should ensure that the nutrition, hydration and toileting needs of patients are met when recovery is utilised as a step down area from CCU.

Outstanding practice and areas for improvement

- The trust should ensure the principles of infection control are appropriate and monitored within the critical care unit for caring for potentially infectious patients.
- The trust should ensure appropriate senior staffing support to promote patient safety, including midwifery support in the management of complex cases on labour ward, appropriate supervision for high dependency patients and appropriate level of supervision within outpatients.
- The trust should consider quality measurements such as local targets for induction of labour, assisted deliveries and return of women with perineal problems.
- The trust should have action plans where it is not reaching national standards in maternity.
- The antenatal and postnatal ward F11 should review the practice of overnight stays for all partners on the ward.
- The trust should review the succession planning and development for staff in seconded or interim roles within the maternity service.
- The trust should consider developing strategic planning arrangements including action plans to achieve service goals, a performance dashboard for children's services and a comprehensive transition policy to help all teenage patients adjust to adult health services.
- The trust should review the availability of staff with play specialist skills.

- The trust should review the options and nutritional value of food offered within the children's service.
- The trust should review medical staffing, particularly within maternity and end of life care services to ensure consultant cover meets recommended national guideline levels.
- The trust should ensure that nurse staffing levels for children meet recommended national guideline levels.
- The trust should include sepsis monitoring on the maternity dashboard for inpatient areas.
- The trust should consider midwifery staffing and specialist midwives roles to support vulnerable groups.
- The trust should review the way patients in the last days or hours of life have their needs holistically assessed and how this is documented.
- The trust should review it's specialist palliative care service for medical staffing and provision of a seven day service
- The trust should ensure that records management is secure and appropriate in all areas
- The trust should ensure a robust process for oversight and management of all policies and procedures.
- The service should ensure that risk scrutiny in governance meetings is robust and recorded so that there is assurance of management of risk.
- The trust should ensure dissemination of outcomes from audits and meetings is robust across all services.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Completion of Escalation Plan and Resuscitation Status (EPARS) forms was inconsistent and often did not match other documentation or had sections incomplete. At Newmarket Community hospital, not all forms, such as those relating to patients' wishes regarding resuscitation in the event of heart failure, were fully completed.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The trust's policy was inappropriate and misleading with regard to applying and following the principles of a Mental Capacity Assessment and Deprivation of Liberty Safeguards DoLS. Staff knowledge around the use and implementation of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was inconsistent.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Requirement notices

The trust was not compliance with mixed sex accommodation regulations especially within critical care (in relation to level one patients) and recovery when it is utilised for stepdown from critical care.