The Ipswich Hospital
NHS Trust

Our Passion, Your Care.

Quality Account 2017/18

Contents

Who was involved in the development of our Quality Account?

The Trust consulted with the following in the development of its Quality Account and the content within:

- our commissioners, Ipswich and East Suffolk Clinical Commissioning Group;
- Suffolk Health & Wellbeing Board;
- Healthwatch Suffolk; and
- staff, volunteers, carers and members of the public.

The Ipswich Hospital NHS Trust would like to thank those who contributed to the development and publication of this Quality Account.

Our front cover shows team members from the Reactive Emergency Assessment Community Team (REACT).

Part 1 - Statement on quality

Chief Executive's commentary

This is our account to you about the quality of services provided by The Ipswich Hospital NHS Trust in 2017/18. It looks back at our performance over the last year and gives details of our priorities for improvement in 2018/19.

What matters to patients is the care and compassion they receive in those moments when they most need it. There are hundreds of people who work behind the scenes to make sure that happens every day, making sure our buildings are safe and warm, and that care is delivered in the right place at the right time. People making sure our systems and processes work, and that patients are kept informed about their care. People who often go unnoticed but who are as important to the patients as the clinician in front of them.

This year has been one in which we have seen the organisation continue to deliver good performance despite some significant challenges. Our staff have once again demonstrated tremendous effort, motivation and energy to ensure we achieve our ambitions, and I thank them all for their hard work.

We remain an innovative forward-thinking organisation, always looking for ways to improve our services. In October 2017 we commenced a seven-year contract for NHS community services, which means we can continue to focus on patients in their home areas and at the same time tackle rising demands on doctors, nurses and health professionals' time. We have established an alliance in Ipswich and east Suffolk comprising Ipswich Hospital NHS Trust, Norfolk and Suffolk NHS Foundation Trust, Suffolk County Council and the GP Federation. The community services contract is the first important step for our health and social care system towards providing local people with simpler, seamless services and brings to life the vision detailed in the local Sustainability and Transformation Plan. The alliance enables us to provide seamless services giving professionals opportunities to work collaboratively while sharing good practice and avoiding duplication.

I continue to lead the local Sustainability and Transformation Plan (STP) for Suffolk and North East Essex. Over time, this will deliver the significant changes needed to allow the system to manage the increasing demand. The ambition of the STP process is to align services and resources so that by working differently, we will find a way to manage the increasing demand on health and care services. We will work together to improve safety and quality of care, and use technology to save patients and carers journeys to hospital when they can be seen more conveniently closer to home.

After many months of work we developed a business case which reviewed the various options available to Ipswich and Colchester hospitals in the future. The recommendation was that we form a single combined organisation with fully integrated clinical services. In August 2017 we held a meeting in public of the boards of The Ipswich Hospital NHS Trust and Colchester Hospital University NHS Foundation Trust to discuss how to take forward our partnership and hear the views of our community. Since then, we have held a number of meetings with local communities and staff giving people the opportunity to ask questions and raise any concerns about the merger they may have. The full business case (FBC) was considered by both Trust Boards at a joint Board meeting held in public in March 2018, where the FBC was approved to be taken forward. We are working towards a merger of the two organisations in July 2018. Subject to approval by NHS Improvement, the new Trust will be called the East Suffolk and North Essex NHS Foundation Trust. Further information about our partnership with Colchester can be found at www.colchesteripswich.org

The Trust is registered without conditions by the Care Quality Commission (CQC) from 1 April 2010 when the current system of regulation became law. The CQC visited the Trust between August and October 2017, and awarded the Trust an overall rating of 'Good'. More details on our inspection can be found on pages 25 and 26.

I remain grateful to our many partners for their contributions to the services we manage. We could not deliver the high quality of care of which we are rightly proud without the support of health, social care and voluntary organisations throughout the town and county.

To the best of my knowledge, the information contained in this Quality Account is accurate.

Nick Hulme
Chief Executive

Trust Services

We are an organisation with a proud history and one that has long adapted and responded to changes in health needs and circumstances. We are recognised by our patients and peers as a provider of good quality healthcare with a reputation for delivering caring and compassionate services. We provide a full range of acute services to the people of Ipswich and East Suffolk, and manage a range of community services including three local community hospitals.

Background

Every day over 3,000 patients rely on us to improve their lives. Our services include accident and emergency; critical care; planned medical and surgical care; consultant and midwifery-led maternity, neonatal and paediatric care; diagnostic and therapy services; community hospitals and specialist community services.

Ipswich Hospital has formed an alliance with Suffolk County Council, the Suffolk GP Federation and Norfolk and Suffolk NHS Foundation Trust to deliver community services from October 2017.

Two alliances have been set up to drive this work, which are made up of Ipswich Hospital in the east and West Suffolk Hospital in the west, with Suffolk County Council, Suffolk GP Federation and Norfolk and Suffolk NHS Foundation Trust spanning the whole county. These providers are working closely together to place the patient at the centre of care, share good practice and improve quality while making the best use of limited resources.

The older population in Suffolk continues to grow. This means it is vital to ensure patients receive the right care, at the right time and in the right place. Supporting people to remain at home rather than spend unnecessary time in hospital also makes them far more likely to maintain their independence, in turn reducing their reliance on health services in the future.

There are a number of examples of initiatives taking place across Suffolk to join up care more closely, support prevention work and tackle rising demand for healthcare services.

Admission Prevention Services

Reactive Emergency Assessment Community Team (REACT)
REACT is a new team dedicated to avoiding unnecessary admissions to Ipswich Hospital by making sure patients receive the right treatment to meet their needs in their own homes. REACT brings together staff based at the hospital and colleagues working within community healthcare with the aim of improving continuity of care for patients and reducing duplication.

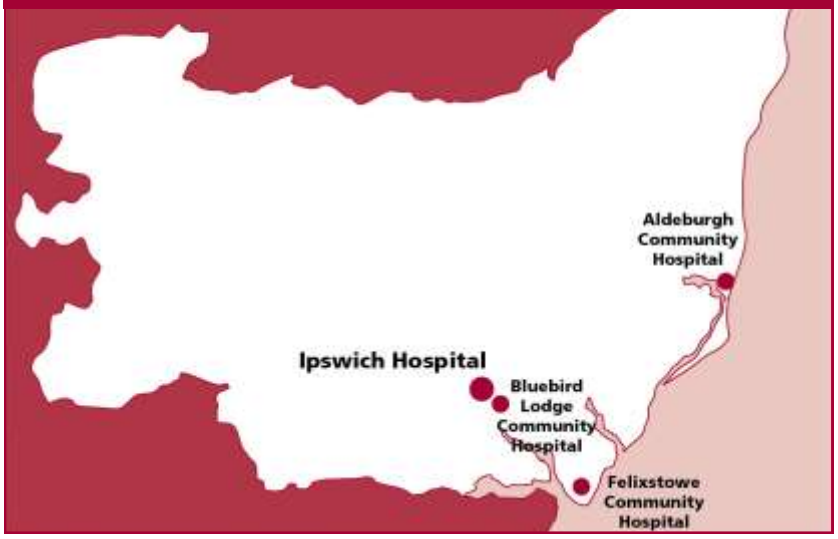
Operating 24/7, they work together to put the right care in place to prevent an admission to hospital, in turn helping to manage growing demand for health services. The team receives referrals from GPs and ambulance staff for patients who have reached crisis point. Staff then carry out a comprehensive assessment in the patient's own home with the aim of preventing them needing to be admitted to hospital.

They also assess patients in the hospital's emergency department and emergency assessment unit before putting appropriate support in place to allow them to be discharged, wherever possible. This includes up to five days of ongoing crisis management support, which will be provided by REACT to ensure continuity and the best possible patient experience.

The launch of this new team is another really good example of health and social care services, alongside the voluntary sector, working more closely together to further improve care for patients and their families.

Crisis Action Team (CAT)
Nurses and therapists work jointly with social care and the voluntary sector to avoid unnecessary hospital admission by supporting patients in the community in crisis to remain at home with multi-disciplinary team support, or supporting patients being discharged from the Emergency Department to go home with a range of health and social support to meet their needs.

Community Hospitals managed by Ipswich Hospital



Trust Services

Frailty Assessment Base (FAB)
Patients who are referred by GPs, or identified in the Emergency Department, are brought to the FAB as a "one-stop shop" and they will spend 3-4 hours having their complex needs addressed. Patients will have a heart tracing, blood tests performed and blood pressure taken lying and standing as part of the assessment. If needed, X-rays and scans may also be performed. Patients will receive a review from a consultant geriatrician, a therapist, a specialist nurse, a pharmacist and dietitian who will work together and look at each patient holistically in order to keep them active, healthy and at home. It is similar to a 'health MOT' for the older person.

FAB is a service unique to Ipswich Hospital, which has won a number of national awards:

- winner of the "Value and Improvement in Acute Service Redesign" award at the Health Service Journal Value and Healthcare Awards, 2016;
- winner in the category "FFT and Patient Insight for Improvement - Accessibility" at the Patient Experience Network National Awards, 2016; and
- winner in the category "Continuity of Care" at the Patient Experience Network National Awards, 2016.

Outpatient Parenteral Antimicrobial Therapy (OPAT) service
The OPAT team consists of an antimicrobial pharmacist, nursing staff, OPAT consultant and a microbiologist. Inpatients who are felt to be able to be treated at home with intravenous antibiotics are referred to the OPAT service and assessed by the team as to their suitability to have their intravenous antibiotics at home. Patients are followed up once a week by the OPAT nurses to check progress. This service has been very successful, helping patients to go home from hospital earlier, and saving around 2,500 bed days per year. The team can currently treat a maximum of 10-15 patients, most of whom are capable and willing to self-administer. OPAT covers all specialities, the only exclusion being where high risk antibiotics are required. Self-administration allows more patients to go home on either the 24 hour infusion devices or once daily antibiotics.

When patients are referred to the service by their Consultant, they are seen on the ward by a member of the OPAT team. They are risk assessed and consented as being willing to take responsibility for self-administration. Patients are taught how to self-administer on three separate occasions by a registered nurse before their competency is assessed. Patients have access to nurse support once they have been discharged, and are reviewed face-to-face every week to ensure all is on track and that patients are happy to continue self-administration.

Suffolk GP Federation
Suffolk GP Federation is a Community Interest Company (not-for-profit). It is a member of the alliance delivering community services to the people of Ipswich and East Suffolk. The GP Federation and Ipswich Hospital NHS Trust are providers of services, with the other partners influencing strategy development to improve access to services and deliver these services more efficiently.

Suffolk GP Federation services are sub-contracted through Ipswich Hospital and as well as the community services recently awarded, they have provided services in North East Essex and across the whole of Suffolk.

Under the banner of Suffolk Community Alliance, all organisations involved are committed to working together to maximise the partnership and work together to break down the existing organisational barriers and boundaries to improve the quality of the patient experience and meeting the challenges of rising demand and financial challenge.

The services provided by the Suffolk GP Federation are:

- Bladder and Bowel Service
- Falls Fracture Liaison (*west Suffolk only)*
- Minor Injuries Unit in Felixstowe
- Podiatry
- Stoma Service.

"My family and I would like to say a huge thank you to every staff member whatever their status who work on Sproughton ward. Our brother has very recently had a long stay on this ward and his care could not have been more exemplified. A great team retaining patient dignity, quality of care and compassion."

Patient comment posted on NHS Choices, June 2017

Part 2 - Priorities for improvement and statements of assurance

2017/18 quality improvement priorities
Progress against the priorities agreed

Patient safety priority: To continue to develop services to support patients who are elderly and frail.

Why was this a priority?
Older patients who require health services are often physically, cognitively or socially frail. By expanding services already in place we aim to keep patients well and reduce their dependency on health services by supporting them to maintain their independence and functional ability and so reduce the incidence of hospital-based deconditioning (the process of physiological or functional change as a result of inactivity or bedrest). The aim is to eliminate assessment waits to shorten hospital admissions and reduce the consequences of prolonged admission. Patients at risk of deconditioning need to be identified on admission, and expect zero tolerance of unnecessary delays to prevent deconditioning along with very proactive management, early mobilisation and prevention of unnecessary 'bed rest'.

Lead Director
Director of Operations.

2017/18 performance
Number of emergency admissions for patients aged 75 years and over = 12, 286 patients (12,840 patients in 2016/17, showing a decrease across the full year of 4.3%, bucking the national trend and despite increasing ED attendances).
DToC numbers = 9,689 total acute bed days occupied by patients who are medically stable but delayed either home with care or to another care setting.

What was our target?
- To achieve patients with a length of stay over 14 days, sustained at 105 patients.
- To reduce the number of admissions required.
- To expand service to become available seven days a week.
- To further integrate with community services and social services.

What did we do to improve our performance?
- Increased capacity of current FAB.
- Increased links with ED to enable more patients to benefit from a comprehensive geriatric assessment.
- Extended hours of cover for the emergency therapy team in ED and emergency assessment unit to 7 days a week, 8am - 8pm.
- Minimised deconditioning in hospital via re-ablement programme across the Trust, training over 500 staff.

How did we measure and monitor our performance?
- Monitored the number of patients referred to FAB and CAT services, and of those seen, monitored how many patients subsequently avoided admission to hospital.
- Monitored the length of stay of those patients who required admission following assessment by the FAB.
- Emergency admission levels.
- Patients in hospital over 7 and 14 days.
- % of patients discharged via Pathway Zero and Pathway One via Discharge to Assess model.
- Number of beds occupied in acute and community hospitals in accordance with detailed bed model.

Did we achieve our intended target?
- ✓ CAT and FAB services achieved 6 avoided admissions per day across the year, achieving the targets set.
- ✓ We achieved our target of reducing the number of emergency admissions required, with 3.2% reduction below plan for 2017/18.
- ✓ Patients in the hospital >7 & >14 days showed improvement over the 12 month period, but not quite sustaining the target of 105 patients over 14 days (see Stranded patient metrics in Key Achievements).
- ✓ We achieved our bed model predictions for 9 out of the 12 months. The 3 months where we exceeded bed occupancy against expected numbers was mainly due to the significant impact of flu, D&V and severe snow weather conditions causing complete disruption to patient discharges, from affected beds both in the hospital and care homes.

How and where was progress reported?
Reports and updates to: Portfolio Board, Emergency Care Programme Board, Quality Committee, Trust Board, system-wide Integrated Care Network.

Our key achievements
- ✓ Extended Therapy team cover, increasing the number of hours covered each day. Service also expanded to cover 7 days per week.
- ✓ Further continual improvements to the Frailty Assessment Base service including access to the service by the Emergency Department.
- ✓ Changes to internal ED processes, internal streaming and implementation of external review recommendations to improve patient flow through department.
- ✓ Changed the stroke patient pathway so that patients now go straight to CT Scan, bypassing the Emergency Department.
- ✓ Reduced the length of stay for patients aged 65 years and over on Lavenham ward. By using bedside 'huddles' to focus and agree individualised reablement goals, we have reduced the average length of stay from 9.1 days to 7 days, ensuring patients spend more time at their usual place of residence.
- ✓ 'Get up and Go' reablement project launched.
- ✓ CAT Plus and HomeFirst teams' expansion and integration between health and social care, working to jointly support patients' earlier discharge from hospital (Pathway 1 Discharge to Assess programme).
- ✓ Launch of REACT integrated service; a joint service amalgamating all teams involved in admission prevention.
- ✓ Launch and embedding of the Short Term Assessment, Reablement and Rehabilitation Centre (STARR Centre) at Bluebird Lodge community hospital.
- ✓ Delirium patient pathway launched, enabling patients with delirium to be cared for at Barking Hall nursing home, rather than having to stay in hospital.
- ✓ First in Midlands & East region for ED 4 hour performance across 2017/18, achieving 91.1%.
- ✓ Emergency admissions growth reduced; the admissions for the first nine months were lower than last year, and were 3.2% below plan at month 11.
- ✓ Emergency average length of stay for Medicine at 5.3 days, the lowest seen across an 18 month period.
- ✓ Stranded patient metrics dropped from 278 >7 days in February 2017 to 199 in February 2018; and 178 >14 days in February 2017 to 120 in February 2018.
- ✓ DToCs continue to reduce, from 1,050 bed days in February 2017 to 620 in February 2018.

2017/18 quality improvement priorities
Progress against the priorities agreed

Clinical effectiveness priority: To continue to improve our care to those at the end of their life and support patients who have limited treatment options.

Why was this a priority?
There is only one chance to get end of life care right. In the final stages of illness, care priorities shift with the focus often changing to palliative care for the relief of pain, symptoms, and emotional distress. Compassionate high quality care enables us to make a loved one's final weeks or days as comfortable as possible by offering the person at end of life, and those identified as important to them, choice around decisions concerning treatment and care wanted, and an individual plan of care tailored to the needs, wishes and preferences of the dying person; agreed, coordinated and delivered with compassion.

Lead Director
Director of Nursing.

2017/18 performance
We achieved our target of improving end of life care for patients and their families, as evidenced by the results from the national end of life care audit.

What was our target?
- To deliver high quality, compassionate and dignified end of life care for all patients.
- Patients will receive the right care in the right place.
- To increase the number of patients dying in the place of their choice.

What did we do to improve our performance?
- Recognised timely identification of patients in the last year of life.
- Facilitated patients and their families with making advance decisions and prioritising levels of care.
- Worked with system partners to improve end of life care at home provision.
- Recognised individual's needs and wishes to ensure they lived well until they died.
- Used national and locally recognised tools, ie the regional DNACPR form, the yellow folder, treatment options form and the individualised end of life care plan.
- Promoted co-ordinated care for discharge planning, enabling patients to die in their preferred surroundings, be that at home, hospital or hospice.
- Facilitated palliative and end of life care training and education for staff using innovative and creative approaches to learning.
- Provided access to specialist palliative care assessments, seven days a week.
- Improved bereavement support for families of patients who have died.

How did we measure and monitor our performance?
- Monitored themes from complaints relating to end of life care.
- Monitored results from DNACPR and national end of life audits to highlight themes for improvement.
- Audited use of individualised care plans to ensure best possible practice.
- Expanded post bereavement follow up service with families.

How and where was progress reported?
Regular reports and updates to:
End of Life Care Steering Group.

Our key achievements
- ✓ The 2017 CQC inspection rated end of care service as 'Good'.
- ✓ End of Life Care Strategy launched, with 4 workstreams of the End of Life Care Programme Board delivering key objectives.
- ✓ All complaints mentioning end of life care are reviewed by the End of Life Care Programme Board to enable service improvements and influence future education & training plans.
- ✓ DNACPR audits ongoing; audit of the use of the ICP in July 2017 showed 75% compliance (relates to ICP in place and completed appropriately).
- ✓ SPICT tool (identifies patients likely to be in the last year of life, with support to start discussions regarding 'My Care Wishes' and communicate this to GPs, and appropriate health care teams) piloted on Lavenham ward then rolled out across the Trust.
- ✓ 'Just in case' medicines community prescription chart now available on Evolve to ensure patients having end of life care outside of hospital have the correct paperwork to enable symptom control medicine to be given quickly.
- ✓ Dying Matters week, held in May 2017, was well received throughout the Trust.
- ✓ All refurbished wards have a side room to be used for end of life care with bespoke furniture and lighting to ensure a calming environment, with relatives able to stay with the patient overnight.
- ✓ 24hr chaplaincy service available.
- ✓ Trust involvement with the One Voice for Travellers Health Project to understand the needs of patients and family from the travelling community at end of life, and how healthcare professionals can support and work together to provide end of life care which meets the needs of the individual and their family.
- ✓ Refurbishment of the mortuary waiting and viewing rooms.
- ✓ Commencement of a relatives' bereavement survey to enable the Trust to learn from relatives' and carers' experiences of bereavement and support services.
- ✓ Funding for the Hospice and Trust to run a pilot whereby patients are assessed when they come into ED to support them to reach their preferred place of death.
- ✓ The palliative care team, and the mortuary team hosted a study day which included simulation training for caring for patients after death.
- ✓ Involvement of the end of life care team with the Trust's Schwartz rounds continues.
- ✓ Funding of consultant and nursing posts to support the Palliative Care team to achieve 7 day working, supported by Macmillan.

2017/18 quality improvement priorities
Progress against the priorities agreed

Patient experience priority: To avoid delays in transfers of care of a patient from hospital or community beds to other care environments.

Why was this a priority?
Delayed transfers, where patients are ready to return home or transfer to another form of care but still occupy a bed, are a symptom of a system failing to provide the right care, in the right place, at the right time. By ensuring patients are transferred from the ward environment as soon as they are medically stable to be discharged, improves wellbeing and gives them back their independence.

Lead Director
Director of Operations.

2017/18 performance
Number of delayed transfers of care from Ipswich Hospital wards = 9,689 bed days.

What was our target?
- To reduce the number of patients who have to stay in hospital beyond the date when they are medically stable for discharge. This is a high priority 'system-wide' urgent care project.
- To achieve and sustain DToC rate of 3.5%.
- Fully implement the system-wide Discharge to Assess model.
- To achieve and sustain number of patients with a length of stay over 14 days at 105.

What did we do to improve our performance?
Working with our commissioners, Social Services and other partners, we planned to improve our performance by:
- improving the current discharge model, with Ipswich Hospital and social services staff working together to provide multi-disciplinary team 'early supported discharge' to support patients to safely return to their home setting;
- Optimised utilisation of community beds, following detailed review and proposal around evidenced usage, forecasted growth and incorporation of impacts from:
  - reviewing the delirium/ dementia best practice pathways; and
  - delivering the Discharge to Assess model, including revised pathways for patients with delirium and non-weight-bearing patients.

How did we measure and monitor our performance?
Progress against this priority was measured by:
- reporting DToCs;
- reporting readmission rates;
- reporting the number of patients in the hospital with length of stay over 7 and 14 days; and
- reporting the % emergency admission rate for patients over 75 years.

Did we achieve our intended target?
Readmission rates are at 9% trust-wide and will require additional focus and scrutiny in 2018/19.

How and where was progress reported?
Regular reports and updates to: Patient & Carer Experience Committee, Quality Committee, Trust Board, Accountability Framework Oversight and Performance, Sustainability and Transformation Programme, Portfolio Board and Emergency Care Programme Board.

Our key achievements
- ✓ Launch and embedding of 'discharge to assess' programme, redesigning care pathways to support early and safe discharge including higher numbers going home without care, integration of health and social care to support patients at home, short term reablement and rehabilitation at Bluebird Lodge.
- ✓ Embedded twice-weekly focus on system-wide DToC reduction and clarity on escalation triggers, aiming to keep the number of DToC patients in hospital below 20 at any time.
- ✓ New patient pathway for patients requiring end of life care to enable them to spend their final days in their preferred place. The service is run by St Elizabeth Hospice, supporting domiciliary care needs for our patients to go home earlier.
- ✓ Introduced intravenous antibiotics self-administration programme, supporting patients going home, rather than having their antibiotics in hospital.
- ✓ Embedding 'Peer to Peer challenge' when a consultant, matron and senior therapist work together to independently visit a different ward to that where they normally manage, constructively challenging their peers on plans and next steps for every patient who has been in the hospital for more than 7 days.
- ✓ Continued planned and ad hoc 'Red to Green' periods.
- ✓ Warmer Homes project started, with weekly visits from Warmer Homes representatives, to support patients returning home with additional equipment/ support.
- ✓ Patient discharge workshop held, to share all of the schemes and tools relating to effective management of discharge planning.
- ✓ Additional consultant presence each weekend, performing further patient reviews to enable discharges across the weekend, with discharge co-ordinator support.
- ✓ Launch of 'Home Tomorrow, TTA's today' programme, bringing forward the preparation of medications to ensure they are ready in time for the patient's expected discharge.

2017/18 quality improvement priorities
Progress against the priorities agreed

Patient experience priority: To continue to expand our dementia-friendly environment.

Why was this a priority?
Each year the number of people living with dementia is growing and this number is expected to double during the next 30 years. It is estimated that over 40% of people aged over 65 in general hospitals have a dementia diagnosis or a cognitive impairment. Being in an unfamiliar environment such as a hospital can be very frightening and distressing, and can reduce the person's level of independence.

Lead Director
Director of Nursing.

2017/18 performance
Creatively refurbished two adult acute wards, designed to be dementia-friendly. Continued to create a dementia-friendly environment in community inpatient areas.

What was our target?
We achieved our target to increase the number of dementia-friendly wards in the hospitals managed by The Ipswich Hospital NHS Trust.

What did we do to improve our performance?
- Creatively refurbished two further wards to provide a shared clinical and social environment using The Kings Fund's Enhancing the Healing Environment and other existing research in the design process.
- Shared the learning from creative refurbishments with other areas.

How did we measure and monitor our performance?
- Tracked progress of works to improve ward environments to ensure all work was completed within the agreed timescale.
- Measured the numbers of incidents of violence and aggression in these areas.
- Patient, carer and staff experience findings.

How and where was progress reported?
Regular reports and updates to: Patient & Carer Experience Committee, Quality Committee and Trust Board.

Our key achievements
- ✓ Stradbroke ward (colorectal ward) refurbished and is now a dementia-friendly environment.
- ✓ Key performance indicators to measure and monitor improvements in the patient, carer and staff experience following the refurbishment such as complaints, incidents and general feedback.
- ✓ Brantham ward and emergency assessment unit both refurbished and now have dementia-friendly environments.
- ✓ Reconfiguration of Brantham ward and assessment area which has enabled the following:
  - ✓ Creation of a safer, accessible area for people who may require a calm, quiet space for their clinical assessments.
  - ✓ Quiet rooms available for private discussions with patients and their families.
  - ✓ Improvements to the ambulance entrance to the assessment unit.
  - ✓ Additional consultation rooms.
  - ✓ Direct access corridor from Emergency Department to Brantham assessment unit to improve patient transfers, reducing the noise and throughput of patients through Brantham ward.
  - ✓ Created additional chair spaces for patients who do not require a bed maintaining independence, privacy and dignity. #fit2sit
  - ✓ Creation of a bay on Brantham ward for those patients requiring more intensive short-term monitoring and assessment.

The new dementia-friendly Stradbroke and Brantham wards which opened in the autumn.

2017/18 quality improvement priorities
Progress against the priorities agreed

Patient experience priority:
Work with all clinical partners to identify the most appropriate service for children and young people needing unplanned medical advice or care.

Why was this a priority?
The local population is rising at around 1% per annum, with a large rise in the number of children aged 5-9 years. An increasing challenge is the rising number of patients coming to the Emergency Department (ED) with medical conditions, some of whom attend because they feel unable to access other forms of advice. The challenge is to ensure they can access the right care in the right place.

This age group is the only patient cohort which showed an increased admission rate in 2016/17 compared with 2015/16, (having taken into account the ED attendance growth). In comparison, all other age groups showed significant decreases in admission rates when comparing the same period, hence why a focus on children and young people admission rates is a key priority for 2017/18.

Lead Director
Director of Nursing.

2017/18 performance
- Number of attendees to ED aged 18 and under = 18,419
- Number of emergency admissions of patients aged 18 and under = 5,448 *(of which 2,946 were aged 16 and under)*

This highlights that whilst we have seen a reduction in ED attendances over the previous year, there has been an increase in admissions to the Paediatric Assessment Unit (PAU) from 2,765 in 2016/17, in part due to the pressure to move people on from the Emergency Department to a more appropriate environment. We believe this is indicative of more appropriate attendance to the Emergency Department.

What was our target?
To reduce the number of under 18s attending ED by 5% by 2022, against a growing population. This target was achieved.

What did we do to improve our performance?
- Education of parents/ guardians/carers by health visitors on managing minor childhood illness.
- Work in partnership to produce information leaflets for parents about minor childhood illness.
- Work with the Alliance to better meet the needs of this patient group.

How did we measure and monitor our performance?
- Monitor the number of attendances in ED by children and young people.

Did we achieve our intended target?
We achieved our target to reduce the number of patients aged 18 and under attending ED, however the number emergency admissions for patients aged 18 and under increased slightly when compared to 2016/17.

How and where was progress reported?
Regular reports and updates to: Children's Services Project Board.

Our key achievements
- ✓ 'Common illnesses' booklet given to new parents/ guardians/carers by health visitors and on attendance at the Emergency Department if felt to be appropriate.
- ✓ Any baby aged under 28 days who attends the Emergency Department, is now referred directly to the Paediatric Assessment Unit.
- ✓ Dedicated paediatric nursing team based in the Emergency Department, which enables the ED team to better manage those children attending ED, and to signpost them to alternative services if appropriate.
- ✓ GP streaming service adjacent to the Emergency Department has enabled a number of patients attending the Emergency Department to be seen by a more appropriate service.
- ✓ Promotion of self-management for certain conditions such as respiratory illness.
- ✓ Piloting of a community mental health crisis action team service for under 18s.
- ✓ Condition-specific audits (eg bronchiolitis, feverish illness) of attendances to ED and admissions have taken place and resulting actions addressed.
- ✓ Collaborative work with Public Health to better understand the reasons patients have attended ED, where patients live and time of their arrival to enable a focus on key themes.

Quality improvement priorities for 2018/19

Qualitative information from a number of sources including patient surveys, staff surveys, complaints, compliments and the views of users and user groups has helped inform the Trust's priorities for 2018/19.

Patient safety priority: To improve compliance with the Sepsis Six care bundle.

Why is this a priority?

The Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. It was developed in 2006 by a group of physicians and nurses working on an educational programme to raise awareness and improve the treatment of patients with sepsis.

The management of sepsis after admission to hospital usually involves three treatments and three tests, known as the 'Sepsis Six'. These should be initiated by the medical team within an hour of diagnosis.

Treatment involves:

- giving intravenous antibiotics
- giving fluids intravenously if clinically required
- giving oxygen if levels are low

Tests will include:

- taking blood to identify the type of bacteria causing sepsis
- taking a different type of blood sample to assess the severity of sepsis
- monitoring urine output to assess severity and kidney function

Many centres throughout the world have adopted the Sepsis Six, which has been associated with decreased mortality, decreased length of stay in hospital, and fewer intensive care bed days.

Lead Directors

Medical Director and Director of Nursing.

2017/18 performance

Timely treatment of sepsis in ED and Acute inpatient settings:
Q1 = 71%
Q2 = 70%
Q3 = 66%
Q4 = 67%

What is our target?

Commence treatment of sepsis according to Sepsis Six pathway; complete all within 60 mins = 90%

To increase the number of clinical staff having received sepsis training:
Q1 = 50% of clinical staff trained
Q2 = 75% of clinical staff trained
Q3 = 80% of clinical staff trained
Q4 = maintain 80% of clinical staff trained.

What will we do to improve our performance?

- Implement clinical Sepsis Six tool to guide screening and treatment
- Implement mandatory training (e-learning programme) for all clinical staff
- Enable the prescribing of intravenous fluids by nursing staff to manage the early treatment of sepsis
- Increase awareness of the signs and symptoms of sepsis for healthcare professionals and the public through education
- Bespoke training sessions for ward-based staff.

How will we measure and monitor our performance?

- Audit timely identification and treatment of sepsis
- Monitor compliance with staff training for doctors, registered nurses, and healthcare assistants
- Compliance with CQUIN for identification and treatment of suspected sepsis

How and where will progress be reported?

Regular reports and updates to: Quality Committee, Trust Board, Deteriorating Patient Group.

Clinical effectiveness priority:

To improve access to psychiatric liaison services for hospital inpatients.

Why is this a priority?

The mental health five year forward view ensures patients receive equitable and prompt access to both mental and physical health care.

Nationally, there is evidence that 25-33% of people admitted to acute hospitals also have a mental health condition; with 5% of all Emergency Department (ED) admissions having a primary mental health concern.

Working in partnership and providing effective mental health support to patients, and expertise to staff, we can provide rapid assessment, care planning and intervention, and can minimise the time a patient needs to stay in an acute hospital environment.

Training and guidance to help identify, support and refer when needed, patients who have mental health or psychological needs.

Lead Director

Director of Operations.

2017/18 performance

Level of ED breaches attributed to Psychiatric Liaison for the hours the Psychiatric Liaison service operates (0700 to 2100) = 5.17%.

What is our target?

To meet the 95% target for patients attending ED needing psychiatric intervention (review within one hour).

To provide patients with access to mental health review during their admission in the acute hospital (review within same day or 24 hours).

Quality improvement priorities for 2018/19

What will we do to improve our performance?
In partnership with the Ipswich & East Suffolk Clinical Commissioning Group and the Norfolk & Suffolk NHS Foundation Trust, we have co-written and co-commissioned an enhanced psychiatric liaison service.

Within the enhanced psychiatric liaison service we have also included training and education for healthcare providers to support increased awareness and referral when required.

To monitor our key performance indicators against the criteria set to ensure we are consistently achieving a sustainable service.

How will we measure and monitor our performance?
Review and regular monitoring of KPIs.

Development of a dashboard to capture and collate information and performance.

How and where will progress be reported?
Regular reports and updates to: Trust Performance Boards; Joint Operational Board (Ipswich Hospital, Norfolk & Suffolk NHS Foundation Trust and our Commissioners); and Quality Committee.

Reporting by exception to: Mentally Healthy Communities Board; Integrated Care Network; and East Alliance Partnership Board.

Patient experience priority:

To continue to improve our care to those at the end of their life and support patients who have limited treatment options.

Why is this a priority?
There is only one chance to get end of life care right. In the final stages of illness, care priorities shift with the focus often changing to palliative care for the relief of pain, symptoms, and emotional distress. Compassionate high quality care enables us to make a loved one's final weeks or days as comfortable as possible by offering the person at end of life, and those identified as important to them, choice around decisions concerning treatment and care wanted, and an individual plan of care tailored to the needs, wishes and preferences of the dying person; agreed, coordinated and delivered with compassion.

Lead Directors
Director of Nursing and Medical Director.

2017/18 performance
DNACPR compliance:
January 2017 = 78%
June 2017 = 94%
September 2017 = 92%
February 2018 = 94%

Number of complaints relating to end of life care = 14

What is our target?
- To deliver high quality, compassionate and dignified end of life care for all patients.
- Patients will receive the right care in the right place.
- To increase the number of patients dying in the place of their choice.

What will we do to improve our performance?
- Pilot processes to promote early/prompt recognition of patients in the last year of life.
- Facilitate patients and their families with making advance decisions and prioritising levels of care.
- Work with system partners to improve end of life care at home provision.
- Recognise individual's needs and wishes to ensure they live well until they die.
- Promote better use of national and locally recognised tools, eg the regional DNACPR form, the yellow folder, Supportive and Palliative Indicators Tool (SPICT), treatment options form and the individualised end of life care plan.
- Promote co-ordinated care for discharge planning, enabling patients to die in their preferred surroundings, be that at home, hospital or hospice.
- Facilitate palliative and end of life care training and education for staff using innovative and creative approaches to learning.
- Provide access to specialist palliative care assessments, seven days a week.

How will we measure and monitor our performance?
- Monitored themes from complaints relating to end of life care.
- Monitored results from DNACPR and national end of life audits to highlight themes for improvement.
- Audited use of individualised care plans to ensure best possible practice.
- Assessment of surveys of bereaved relatives.
- Service assessment reviews of new initiatives.
- Review of processes and policy for end of life care.

How and where will progress be reported?
Regular reports and updates to Quality Committee, Trust Board.

Quality improvement priorities for 2018/19

Patient experience priority:

Work with all clinical partners to identify the most appropriate service for children and young people needing unplanned medical advice or care. This is the second year of a two year priority.

Why is this a priority?

The local population is rising at around 1% per annum, with a large rise in the number of children aged 5-9 years. An increasing challenge is the rising number of patients coming to the Emergency Department (ED) with medical conditions, some of whom attend because they feel unable to access other forms of advice, and young adolescents requiring mental health care. The challenge is to ensure they can access the right care in the right place at the right time.

This age group is the only patient cohort which showed an increased admission rate in 2016/17 compared with 2015/16, (having taken into account the ED attendance growth). In comparison, all other age groups showed significant decreases in admission rates when comparing the same period, hence why a focus on children and young people admission rates is a key priority for 2017/18 and 2018/19.

Lead Directors

Director of Community Services and Director of Nursing.

2017/18 performance

- Number of attendees to ED aged 18 and under = 18,419 (a 1.4% decrease when compared with 2016/17)
- Number of emergency admissions of patients aged 18 and under = 5,448 *(of which 2,946 were aged 16 and under)*

What is our target?

To reduce the number of under 18s attending ED by 5% by 2022, against a growing population.

What will we do to improve our performance?

- Education of parents/ guardians/carers by health visitors on managing minor childhood illness.
- Work with the Alliance to better meet the needs of this patient group.
- Development of a Children's Board to drive improved performance by auditing patterns of attendance to ED, allowing a focus on the key issues highlighted to take targeted actions to improve performance further.
- Collaborative working with Norfolk & Suffolk NHS Foundation Trust to ensure consistent patient pathways for all children who attend in crisis.
- Work in partnership with Public Health and Primary Care to produce further information leaflets for parents about minor childhood illness.
- Continue our multi-agency approach.

How will we measure and monitor our performance?

Monitor the number of attendances in ED and admissions from ED by children and young people.

Review of audit data to shape key priorities.

How and where was progress reported?

Regular reports and updates to: Children's Board.

Provided and sub-contracted services

Provided and sub-contracted services

During 2017/18 The Ipswich Hospital NHS Trust provided and/or sub-contracted 110 relevant health services.

The Ipswich Hospital NHS Trust has reviewed all the data available to them on the quality of care in 110 of these relevant health services.

The income generated by the relevant health services reviewed in 2017/18 represents 100% of the total income generated from the provision of relevant health services by The Ipswich Hospital NHS Trust for 2017/18.

The data reviewed covers the three dimensions of quality: patient safety, clinical effectiveness and patient experience. All relevant data has been reviewed and a number of contract monitoring systems are in place.

Commendation winners

Ipswich Commendation is a staff recognition scheme which says thank you to colleagues who live the hospital values. The nominations are judged by a panel of colleagues and patients.

Two physiotherapists who organised a 24-hour specialist physio rota to help a very ill baby won a Commendation for the care they provided. Charlie Martin and Ali Angell were part of a multidisciplinary paediatric team caring for a young baby with a dangerous chest infection.

Determined to help the child, Ali and Charlie thought quickly, rallied their small team and set up a 24/7 physiotherapy service, making sure the baby received a complex chest physio treatment every four hours. This was on top of their daily jobs and for some of the team meant balancing caring for their own small children at home. This dedicated care went on for a week and a half, night and day, until the baby's illness improved.

Ali and Charlie were presented with their commendations by Managing Director Neill Moloney, watched by team members on the children's ward.

Participation in clinical audit

During 2017/18, 33 national clinical audits and 3 national confidential enquiries covered relevant health services that The Ipswich Hospital NHS Trust provides.

During 2017/18 The Ipswich Hospital NHS Trust participated in 96.97% of the national clinical audits and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that The Ipswich Hospital NHS Trust was eligible to participate in during 2017/18 are as follows:

Clinical Audits	
Heart and Circulatory System	
1	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
2	Cardiac Rhythm Management (CRM)
3	Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions
4	National Cardiac Arrest Audit (NCAA)
5	National Heart Failure Audit
Acute	
6	Case Mix Programme (CMP) - Intensive Care
7	Falls and Fragility Fractures Audit Programme (FFFAP)
8	Fractured Neck of Femur (care in emergency departments)
9	Major Trauma Audit (TARN)
10	National Emergency Laparotomy Audit (NELA)
11	National Joint Registry (NJR)
12	Pain in Children (care in emergency departments)
13	Procedural Sedation in Adults (care in emergency departments)
Women and Children	
14	Diabetes (Paediatric) (NPDA)
15	National Maternity and Perinatal Audit (NMPA)
16	National Neonatal Audit Programme - Neonatal Intensive and Special Care
Older People	
17	National Audit of Dementia
18	Sentinel Stroke National Audit programme (SSNAP)
Long Term Conditions	
19	BAUS Urology Audits - Nephrectomy audit
20	BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL)
21	Inflammatory Bowel Disease (IBD) Programme/IBD Registry
22	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
23	National Diabetes Audit - Adults
24	UK Parkinson's Audit: (incorporating Occupational Therapy, Speech & Language Therapy, Physiotherapy, Elderly Care and Neurology)
Cancer	
25	Bowel Cancer (NBOCAP)
26	National Audit of Breast Cancer in Older People (NABCOP)
27	National Lung Cancer Audit (NLCA)
28	National Prostate Cancer Audit
29	Oesophago-gastric Cancer (NAOGC)
Haematology	
30	National Comparative Audit of Blood Transfusion Programme
31	Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme
Other	
32	Elective Surgery (National PROMs Programme)
33	National Ophthalmology Audit

National Confidential Enquiries	
1	Child Health Clinical Outcome Review Programme (chronic neurodisability)
2	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)
3	Medical and Surgical Clinical Outcome Review Programme

Participation in clinical audit

The national clinical audits and national confidential enquiries that The Ipswich Hospital NHS Trust participated in during 2017/18 are as follows:

The national clinical audits and national confidential enquiries that The Ipswich Hospital NHS Trust participated in, and for which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

* **Inflammatory Bowel Disease (IBD) Programme Registry**
Unfortunately the Trust did not have internal resources.

	Clinical Audits	Cases submitted	Cases expected	%
Heart and Circulatory System				
1	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	370	370	100
2	Cardiac Rhythm Management (CRM)	500	500	100
3	Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions	400	399	99.8
4	National Cardiac Arrest Audit (NCAA)	76	76	100
5	National Heart Failure Audit	633	633	100
Acute				
6	Case Mix Programme (CMP) - Intensive Care	812	812	100
7	Falls and Fragility Fractures Audit programme (FFFAP)	493	493	100
8	Fractured Neck of Femur (care in emergency departments)	50	50	100
9	Major Trauma Audit (TARN)	396	396	100
10	National Emergency Laparotomy Audit (NELA)	204	204	100
11	National Joint Registry (NJR)	719	719	100
12	Pain in Children (care in emergency departments)	100	100	100
13	Procedural Sedation in Adults (care in emergency departments)	58	58	100
Women and Children				
14	Diabetes (Paediatric) (NPDA)	195	195	100
15	National Maternity and Perinatal Audit (NMPA)	3,585	3,585	100
16	National Neonatal Audit Programme - Neonatal Intensive and Special Care	34	34	100
Older People				
17	National Audit of Dementia	89	89	100
18	Sentinel Stroke National Audit programme (SSNAP)	622	622	100
Long Term Conditions				
19	BAUS Urology Audits - Nephrectomy audit	54	54	100
20	BAUS Urology Audits - Percutaneous Nephrolithotomy	19	19	100
21	Inflammatory Bowel Disease (IBD) Programme Registry	0*	0*	0*
22	National Chronic Obstructive Pulmonary Disease (COPD)	466	466	100
23	National Diabetes Audit - Adults	3,715	3,715	100
24	UK Parkinson's Audit: (incorporating Occupational Therapy, Speech & Language Therapy, Physiotherapy, Elderly Care and Neurology)	40	40	100
Cancer				
25	Bowel Cancer	238	238	100
26	National Audit of Breast Cancer in Older People	350	350	100
27	National Lung Cancer Audit	202	202	100
28	National Prostate Cancer Audit	341	341	100
29	Oesophago-gastric Cancer	144	144	100
Haematology				
30	National Comparative Audit of Blood Transfusion	43	43	100
31	Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	15	15	100
Other				
32	Elective Surgery (National PROMs Programme)	1,292	1,845	70
33	National Ophthalmology Audit	2,788	2,788	100

	National Confidential Enquiries	Cases submitted	Cases expected	%
1	Child Health Clinical Outcome Review Programme (chronic neurodisability)	7	7	100
2	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)	22	22	100
3	Medical and Surgical Clinical Outcome Review Programme	12	12	100

Participation in clinical audit

The reports of 33 national clinical audits were reviewed by the provider in 2017/18 and The Ipswich Hospital NHS Trust intends to take the following actions to improve the quality of healthcare provided:

BTS Adult Asthma Audit (British Thoracic Society)
The audit has been carried out in 2011, 2012 and 2016, and focuses on hospital admissions with acute asthma, specifically looking at initial assessment, management and follow-up. Ipswich Hospital results are generally above the national average. This is due to implementation of the Asthma Care Bundle. Nonetheless, there are areas for improvement including writing a written action plan and arranging hospital follow-up.

Sample and data collection method
Cases admitted with acute asthma to the adult acute medicine service between 1 September and 31 December 2016 were included. Ipswich submitted 28 cases; a minimum of 20 cases was requested from each participating unit.

National Recommendations
The comparative report currently available on the BTS website does not include national recommendations. It is anticipated that a report will be made available on the website within the next few months containing general recommendations.

Local recommendations
- Provide education to doctors to ensure follow-up is arranged.
- Provide education to junior doctors to ensure all assessments are conducted, findings acted upon within the action plan, with counselling and education to patients.
- A discharge checklist sticker is introduced for asthma patients.

National Breast Cancer in Older Patients (NBCOP) 2017 Annual Report
The National Audit of Breast Cancer in Older Patients was commissioned to evaluate the quality of care provided to women aged 70 years or older by breast cancer services in England and Wales. It was established to explore why older women with breast cancer appear to have worse outcomes than younger women, and to investigate apparent differences in the patterns of care delivered to older women. The audit started on 1 April 2016.

The results of the audit's work during its first year are described in the annual report. The main components have been:
- An analysis of existing national hospital datasets to provide comparative background information on patterns of breast cancer treatment in England and Wales.
- An organisational audit to examine the structures of breast cancer services in England and Wales.
- A series of case vignettes to explore which patient factors are most important for breast cancer clinicians in determining treatment options for older patients.
- Developing a set of process and outcome indicators for the prospective patient-level audit.

Sample and data collection method
All NHS breast cancer units in England and in Wales were invited to participate in and to evaluate the structure and range of breast cancer services available, with particular emphasis on those services with greatest relevance for older patients.

Findings
90% of women aged 50 to 74 years diagnosed with invasive breast cancer had surgical resection. The proportion of women undergoing surgery decreases with age, with 50% of women aged 90+ years having surgery for invasive breast cancer. There is regional variation in treatment patterns for older women in types of breast and axillary surgery; in duration of post breast cancer surgical hospital stay; and in tools/methods of formal assessment of older patients. Teams caring for the older patients were rarely involved in the formal management of breast cancer patients.

National recommendations relevant to Ipswich Hospital
Breast cancer units should review the results for their organisation to ensure care is consistent with the recommendations in clinical guidelines on the management of older patients with breast cancer, such as those published by the International Society of Geriatric Oncology (SIOG) and European Society of Breast Cancer Specialists (EUSOMA). Units should review whether patients and carers feel they are involved adequately in decision making and receive sufficient information on treatment options.

Local protocols should be developed and implemented:
1. to improve the formal assessment of older patients' health in order to guide decision making about treatment, and
2. to improve the identification of patients who could benefit from access to Teams Caring for the Older Person.

Clinicians and hospital managers should review their hospital length of stay figures. The variation described in this report suggests there is scope for greater consistency and efficiency among hospitals. Providers should regularly monitor the completeness and accuracy of data submitted to the national cancer registration services.

Participation in clinical audit

Actions taken

- Ipswich Hospital has led the Elderly Breast Cancer Care programme in East Anglia, has reported to SIOG and presented a paper covering our care and outcomes. The Trust is compliant with all measures.
- All patients are offered all treatments, and patients and carers are involved in treatment planning. Ipswich has the highest surgical intervention rate in the region >75%.
- When needed we access other care providers for advice and management both in Primary care and Secondary care.
- We have excellent day case figures for all. Longer-stay care ie overnight is only indicated for those who live alone and is pre-planned from clinic.

Areas of good practice
We provide an excellent service with no age discrimination. Treatment planning is individualised and patients are always involved in decision making. There is complete data for a cohort of patients >70 years of age from 2009-2011 with all outcomes recorded. This is a group of >700 patients.

Areas for improvement/local recommendations
The service is compliant in all areas and exceeds the recommendations.

The breast team continues to work on the 5 year+ survival data and can demonstrate that surgery has a huge impact on survival and cancer free survival compared to those who do not proceed with surgery.

Myocardial Ischaemia National Audit Project (MINAP)
MINAP measures the processes and outcomes of care of every patient diagnosed with heart attack, from their call to the emergency services or self-presentation to an Emergency Department, to the prescription of preventative medications on discharge from hospital. Largely this reflects hospital care, but often includes diagnosis and treatments before arrival at hospital. The audit describes aspects (process measures) of the quality of care of hospitals and of ambulance trusts, and is based on analyses of data that has been directly submitted by the participating organisations.

The MINAP audit assesses care against the Quality Standards and Clinical Guidelines issued by NICE: QS68 Acute coronary syndrome in adults, CG172 Myocardial infarction: cardiac rehabilitation and prevention of further cardio-vascular disease, CG167 Myocardial infarction with ST-segment elevation: acute management. The audit findings were published in June 2017.

Sample and data collection method
Data was routinely collected by designated Trust staff. 370 cases were submitted during 2015/16.

Audit findings
Ipswich Hospital does not currently provide primary Percutaneous Coronary Interventions. Local patients with STEMI suitable for immediate reperfusion are taken directly by ambulance to other centres.

Management of patients admitted to hospital with nSTEMI

	nSTEMI seen by Cardiologist	Admitted to cardiac ward	Out of	Had angiography before discharge	Out of
2015/16 - England	**96.2**	**55.8**	**47,039**	**83.6**	**39,082**
2015/16 - Ipswich	**98.4**	**64.3**	**370**	**99.2**	**240**
2014/15 - England	94.3	55.6	45,910	77.9	38,676
2014/15 - Ipswich	9.7	60.7	440	61.2	387

Performance of hospitals with respect to prescription of secondary prevention medication at time of discharge home to patients with either STEMI or nSTEMI. Performance is not reported when there are fewer than 20 eligible patients. Patients are excluded if they were transferred to another hospital or if they died in hospital.

	Patients received all secondary medication for which they were eligible	Number of patients eligible
2015/16 - England	**91.1**	**58,993**
2015/16 - Ipswich	**95.6**	**320**
2014/15 - England	88.3	57,301
2014/15 - Ipswich	93.9	325

National recommendations

- Continue to ensure the data provided to MINAP is high quality, accurate and timely, as outlined in the MINAP Minimum Data Standard.
- Interrogate the data on a regular basis (quarterly), and use the data to facilitate quality improvement initiatives aimed at targeting MINAP identified limitations in the care provision of people with STEMI and nSTEMI.

Findings for the Trust: Areas of good practice and comment
Ipswich performed very well in 2015/16. For each criteria for management of nSTEMI and secondary prevention, Ipswich results were better than the national average/median. Ipswich's length of stay has increased slightly since last year, but compares well to other local trusts receiving few STEMI cases (West Suffolk Hospital and Colchester Hospital). Audit results were presented at the Divisional audit/governance meeting in December 2017.

Participation in clinical audit

The reports of the 162 local clinical audits were reviewed by the provider in 2017/18 and The Ipswich Hospital NHS Trust intends to take the following actions to improve the quality of healthcare provided:

MRI scan of Internal auditory meatus (IAM) - Request for Screening of Vestibular Schwannoma
Although vestibular schwannoma (acoustic neuroma) is a rare finding (approx. 1 per 100,000 person-years), a large number of MRI scans are requested to screen for this. Over-investigation leads to wasting of resources and can increase patient anxiety.

The aim of the audit was to ensure that requests for MRI IAM for screening of vestibular schwannoma follow agreed current guidelines. An additional objective of collecting the data was to conclude which staff groups should be targeted for education, to reduce unnecessarily requested MRI scans.

Conclusions
Between 1 August 2017 and 9 October 2017 there were 177 MRI IAM scans requested for the screening of vestibular schwannoma. Only 2 (1.12%) scans had a positive finding for this pathology.

Of the 67 selected audiograms which represented the basis for imaging investigations requested, 29 did not comply with the agreed standard.

The majority of wrongly requested scans were made by a Locum Specialty Doctor or Middle Grade Doctor (11, 37.93%), followed by training Specialist Registrars (10, 34.48%). GPs with special interest in ENT requested 4 (13.79%) and Consultants and Specialty Doctors 2 (6.89%) each.

One of the reasons that led to the findings may be the fear of the clinician not to miss a diagnosis; hence the cautious approach of requesting a large number of investigations. Another reason may be related to education; 93.11% of the requests identified as unnecessary according to agreed guidelines were placed by ENT trainees and grades more junior than Consultant.

Last but not least, the findings can be due to the lack of unanimity in agreeing upon a single guideline or standard to be followed when requesting MRI IAMs for the screening of vestibular schwannoma.

Action Plan
The following actions were taken:

- Incorporate British Academy of Audiology guidelines into local guidelines as the standard for MRI IAM requests to rule out vestibular schwannoma.
- Hearing threshold values are entered for each frequency separately in a table format below the graphic audiogram for quicker and more accurate calculation of interaural difference in hearing sensitivity by the clinician. In the absence of recordable bone conduction thresholds, air conduction thresholds should be considered instead.
- Re-audit in 12 months to ensure that the changes have improved the results and that the improvements are sustained.

Oxycodone prescribing and administration
Oxycodone is a potent opioid, useful in the treatment of chronic and acute pain. The British National Formulary notes that it has an efficacy and safety profile similar to that of morphine. In the Trust, it is often used as an adjunct in the treatment of palliative patients, but its use is broad and can be used in many different types of nociceptive cases.

The aim of this audit is to review and optimise the use of oxycodone at Ipswich Hospital NHS Trust. This includes identifying why errors are made when prescribing or administering different forms of oxycodone, and potential ways to minimise such errors. This audit differs from its predecessors in that it targets a particular opioid (oxycodone) as opposed to the whole class.

Such errors are not exclusive to Ipswich Hospital NHS Trust, with patient safety incidents involving oral oxycodone (both standard and modified release) previously reported to the National Reporting and Learning System (NRLS). While the majority of incidents reported were ‘near misses’ 801 (10.8%) incidents reported a degree of harm to the patient.

Recommendations were made in a Rapid Response Report issued by the NPSA in 2008 highlighting opioid prescribing errors nation-wide, and a 6-point checklist produced which aimed to reduce errors.

Participation in clinical audit

The following recommendations were made:

- To instil the importance of using reference sources in prescribing, administering and dispensing oxycodone by issuing a newsletter detailing the resources available and how to use them.
- Increase awareness of patient factors by noting them in a newsletter detailing what symptoms to look out for.
- Monitoring and managing the side effects of oxycodone (and naloxone), to be detailed a medication safety update newsletter.
- To heighten awareness of appropriate dosage regimen and active ingredients in oxycodone brands by including this in a medication safety update.
- Awareness of which preparations are long acting and short acting by including this in a medication safety update.
- Presentation of results to the Medication Safety Committee.
- Presentation of results to Nursing and Midwifery Board.
- Inclusion in junior doctor induction.

Further medicine safety updates would be beneficial and more information given informally at multidisciplinary team ward meetings is considered a suitable method of disseminating this kind of information. Future audits will further aim to develop and enhance the ability of healthcare professionals to prescribe and administer oxycodone with greater ease and skill.

Actions:

- Prepare a suitable drug safety newsletter which follows the recommendations made in the Rapid Response Report.
- Present results to the Medication Safety Committee.
- Present results to the Nursing and Midwifery Board.

Commendation winner

Assistant practitioner Kim Swan received a surprise when she was awarded a Commendation.

Kim, who works for the Crisis Action team (CAT), was presented with the award from managing director Neill Moloney.

She joined the team when it was formed last year and works above and beyond regularly to make sure patients are able to leave hospital on the day they are scheduled to, giving those patients their lives back at home and freeing up bed space.

Kim has also been instrumental in training and inducting no fewer than 13 CAT generic workers, supporting them as they all completed their Care Certificate.

Line manager Hannah Beardmore said: “I can honestly say that Kim has been my rock through some very difficult and trying times we have had in developing this new service and, as an assistant practitioner, I truly know that she has gone well beyond what is expected of her at this level.”

Kim Swan was presented with her Commendation by Managing Director Neill Moloney

Participation in clinical research

Commitment to research as a driver for improving the quality of care and patient experience.

The number of patients receiving relevant health services provided or sub-contracted by The Ipswich Hospital NHS Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 2,526. Of the 2,526, 1,216 were involved in industry sponsored studies. We were successful in recruiting the first patient globally into a complex cancer commercial study.

The Department of Health is committed to offering patients the opportunity to take part in robust, peer-reviewed research. The organisation remains dedicated to supporting clinical research in order to improve the quality of care we offer and to making our contribution to wider health improvement. We actively seek to attract high quality research to help develop our research portfolio.

The Ipswich Hospital NHS Trust was involved in conducting 79 clinical research studies during 2017/18, across 19 clinical units, examples of which include:

PITCHES is a **P**hase III trial in **I**ntrahepa**T**ic **CH**olestasis (ICP) of pregnancy to **E**valuate ur**S**odeoxycholic acid (UDCA) in improving perinatal outcomes. ICP or obstetric cholestasis (OC) is a liver disorder which occurs during pregnancy. It affects 1 in 150 pregnancies each year in the UK, but the causes of ICP are not fully understood. It can cause itching, mainly on the hands and feet and may lead to marks on the skin from scratching. ICP can be very uncomfortable.

The question the research hopes to answer is "if a woman has ICP, what are the consequences for the baby if she is treated with UDCA or placebo?"

Professor Lucy Chappell, PITCHES Chief Investigator, and the PITCHES Trial Team in Oxford have praised Ipswich Hospital for their consistent recruitment to the trial over the past 24 months with 26 participants already randomised to date.

PERFECTED - Enhancing recovery of patients admitted to acute settings with hip fracture who are identified as experiencing confusion.

Hip fracture has a significant impact on the health and independence of patients and their families. Older people who fracture their hip can become confused whilst in hospital. For people with prior memory difficulties, the risk of confusion is greater, and can have a more serious impact on their daily life. The PERFECTED study aims to see if care of patients who fracture their hip and who experience confusion can be delivered more effectively. To do this we are comparing acute care wards using an intervention enhanced recovery pathway against wards delivering standard care, across 11 Hospital sites in England and Scotland. Ipswich Hospital was randomised to the trial as an active site, meaning that it was charged with implementing the PERFECTED Enhanced Recovery Pathway Intervention on a designated orthopaedic care ward. Following a 3-month lead-in period, where key members of the site staff ensured that the study ward's intervention adherence score was achieved, Ipswich Hospital officially began recruiting to the study in November 2016.

During the course of the following 15-month recruitment period, Ipswich Hospital was one of the top-three recruiting sites on the study. Recruitment to the study closed on 31 January 2018, by which time Ipswich had recruited 68 study participants, consisting of 34 patients and 34 suitable informants - who provided essential proxy information about each patient. The study team at the University of East Anglia (UEA) commended the quality of the Ipswich team quoting "throughout the recruitment window, Ipswich Hospital was constantly one of the most consistent recruiters and it is a testament to their hard work and dedication to the study that they managed to achieve such an impressive overall total on what is a very difficult to recruit to complex interventional study".

65 Trial - Recent evidence suggests that aiming for a lower blood pressure may be beneficial for patients, particularly those aged 65 years or older.

Ipswich Hospital is one of 65 UK Centres running this multicentre trial comparing treatment using a lower target for blood pressure (Group one: aiming for a blood pressure in the range of 60 to 65 mmHg), with treatment that is currently used in the NHS (Group two: usual care). We have this year recruited 29 patients (at a high rate of 4.2 patients per month). Ipswich has been congratulated by the sponsor for this great achievement of recruitment and ensuring screening and recruitment have been incorporated into usual practice within the critical care unit, helping to ensure a high number of eligible patients are picked up each month.

Participation in clinical research

VESPA - **V**ariations in the organisation of **E**arly pregnancy assessment units in the UK and their effect on clinical, **S**ervice and **PA**tient-centred outcomes.

Ipswich Hospital has been one of the participating UK Centres for this multicentre trial to collect information from women and staff from early pregnancy units. The aim is to better understand how to improve the ways in which early pregnancy care is delivered and how to make sure that women's needs and expectations are met. We collected data for 150 women and recruited 112 women to the questionnaire arm of this study, which collected information about the journey of women through our early pregnancy unit, what investigations they had and the number of women admitted to hospital because of early pregnancy complications. In addition, we asked women to share their thoughts about the care they received and the impact on their health and sense of wellbeing, as well as feedback from staff. The Trust was the largest recruiting site in the East of England.

The Trust's employees have demonstrated the vibrancy and innovative practice of a research active organisation in the last twelve months by producing conference abstracts and publications in high quality academic journals. 141 articles and abstracts were produced.

These examples demonstrate that a commitment to clinical research leads to better treatments for patients.

Leading Consultants appointed to professorships

Two of our senior Consultants have been appointed as honorary professors.

Professor Gerry Rayman, a consultant at Ipswich since 1993, took up his role with the University of East Anglia (UEA) in August, in recognition of the major contribution he has made to diabetes research and education, for the support he has given to the UEA's medical school for the past decade and his role supervising doctors completing higher degrees.

At the same time, he has become the diabetes clinical lead for a national project called Get It Right First Time (GIRFT). In this role, Professor Rayman will visit trusts across the country to identify and share best practice while making suggestions which will improve efficiency and the care people with diabetes receive.

Professor Rayman, who leads the hospital's Diabetes Research Team and is also a visiting professor with the University of Suffolk said, "I decided to specialise in diabetes after I started helping people to understand and manage the condition, which I found very empowering. I also developed a particular interest in diabetes education and research, both of which can make a real difference to people with diabetes. The professorship is an endorsement of not only my research work, but also of the excellent clinical and research team we have in place at Ipswich, without who this would not have been achieved. It is nice to receive that recognition."

"I am excited by the GIRFT project, which will focus on improving the quality of diabetes services across the country. We have done tremendous things in East Suffolk for diabetes care. Sharing this best practice, learning from other teams across the country and finding ways to support others to implement service changes and innovations in their own trusts will be a stimulating and rewarding challenge. I also hope to bring back ideas from elsewhere which could improve the services we provide locally still further."

Professor Richard Watts has been awarded an honorary professorship for his work in the Trust, as well as his academic achievements at UEA. Professor Watts joined Ipswich as a consultant rheumatologist in 1994 and was appointed a clinical senior lecturer at the Norwich Medical School in 2005. He was Research & Development director at the Trust between 2004 and 2016, and chaired the Norfolk and Suffolk Clinical Research Network.

Having written and edited several text books and lectured to thousands, Professor Watts remains as committed as ever to the continuous development of treatment for patients with various types of arthritis, and explained that the long-term care of his patients was his key motivation. "I have an inherent curiosity of my field and want to develop, improve and gain new knowledge. There is still plenty of scope for research of rheumatic diseases over the next 20 to 30 years. My key motivation is the continuous long-term follow-up of patients, as it is a chronic disease speciality. I see patients over a very long time and patient care is the fun part of my job."

He served as Editor-In-Chief of Rheumatology between 2002 and 2008 and added: "I have been working academically most of my career and I think this award reflects the academic work I have done over many years, both within the Trust and UEA. Ninety-five per cent of my role is looking after outpatients though and that reflects a dramatic improvement in the treatment of patients with rheumatoid disease over the last 20 to 30 years."

Monitoring quality

When we talk about quality care we mean care that is safe, responsive to people's needs and contributes to a positive patient experience.

Our vision reflects our position as a provider of healthcare for both local people and the wider population and we provide care in many ways and locations. To deliver this ambition we know that we will always seek to improve the healthcare we provide and we will be flexible and responsive to future demands so that we can make sure patients get great care when and where they need it.

In order to ensure we consistently deliver high quality care, we monitor and regularly report on a wide range of quality indicators at all levels within the organisation. This information is displayed for the public on noticeboards in ward and clinic areas, on the website and on the staff intranet site. Our performance on quality is discussed at staff meetings and at each meeting of the Trust Board, as well as being reported to a number of groups and assurance committees, such as the Quality Committee, Finance & Performance Committee and Audit Committee (sub-committees of the Trust Board), and our user groups including the over-arching user group, Ipswich Hospital User Group (IHUG). Close monitoring of quality enables us to take action to make improvements if this is required. Monitoring of community-based services is managed via a joint board with West Suffolk Hospital.

Quality Metrics

Our approach to quality monitoring in clinical areas links to the Trust accountability framework providing a view of quality and performance at both Trust and clinical area level. Review of existing, and the addition of more relevant specialised quality metrics, takes place annually.

Use of the Commissioning for Quality and Innovation (CQUIN) payment framework

The CQUIN payment framework enables our commissioners to reward excellence and innovation of national and locally-agreed quality improvement goals reported to NHS England and our local Clinical Commissioning Group.

The Ipswich Hospital NHS Trust's income in 2017/18 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because the agreed goals formed part of a block contract agreement.

Further details of the agreed goals for 2017/18 and for the following 12 month period are available electronically at: https://www.england.nhs.uk/wp-content/uploads/2016/11/cquin-2017-19-guidance.pdf

With regards to compliance with CQUIN 2b (timely treatment of sepsis in ED and Acute inpatient settings), we have not fully met our target, achieving 71% in Q1, 70% in Q2 and 66% in Q3. This CQUIN is linked to a patient safety quality priority for 2018/19 (see page 11).

We did not achieve CQUIN 4a (improving services for people with mental health needs who present to ED), but did improve from 10% in Q1 to 50% in Q3. We now have an established system-wide forum which is developing system-wide care plans.

Table 1 overleaf demonstrates the actual performance for the CQUIN indicators for 2017/18 for The Ipswich Hospital NHS Trust.

Commendation winner

We said thank you to trainee doctor Foyzur for being an NHS hero. Foyzur is currently caring for our Obstetrics and Gynaecology patients and was surprised with an award while working on the Stour Centre.

Foyzur was singled out for the brilliant care he gave an emergency patient and their family. The family was distressed and anxious and Foyzur showed 'over and above' levels of professionalism and kindness to support them.

Foyzur Miah was presented with his Commendation by Managing Director Neill Moloney

Monitoring quality

Table 1 – Actual performance for the CQUIN indicators for 2017/18

CCG	Scheme	Sub-scheme		Q1	Q2	Q3	Q4
1	Improving Staff Health and Wellbeing	a	Improving staff health and wellbeing				
		b	Healthy food for staff, visitors and patients				
		c	Flu vaccination uptake for frontline staff				
2	Reducing the impact of serious infections (Antimicrobial resistance and sepsis)	a	Timely identification of sepsis in ED and Acute inpatient settings				
		b	Timely treatment of sepsis in ED and Acute inpatient settings				
		c	Antibiotic review				
		d	Reduction in antibiotic consumption for 1,000 admissions				Not available
4	Improving services for people with mental health needs who present to ED	a	Improving services for people with mental health needs who present to ED				
6	Offering advice and guidance	a	Offering advice and guidance				
7	NHS e-referrals	a	NHS e-referrals				
8	Supporting proactive and safe discharge	a	Supporting proactive and safe discharge				

Specialist Commissioning Scheme						
Scheme	**Sub-scheme**		**Q1**	**Q2**	**Q3**	**Q4**
Hospital Medicines Optimisation	1	Adoption of best value generic/biologic products in 90% of new patients within one quarter of guidance being made available.				
	2	Improving drugs MDS data quality to include dm+d as drug code in line with ISB0052 by June 2017 or in line with agreed pharmacy system upgrade as well as all other mandatory fields.				
	3	Increase use of cost effective dispensing routes for outpatient medicines.				
	4	Improving the turnaround time for infection testing within NICU to meet NICE CG149				
	5	Improving data quality associated with outcome databases in agreed format fully, accurately populated in agreed timescales.				
Nationally Standardised Dose Banding for Adults (SACT)	2	Local Drugs and Therapeutics committee have agreed and approved principles of dose standardisation and dose adjustments required.				
	3	Targets to be agreed for end of year achievement in relation to the % of doses standardised per drug (number of SACT doses given of selected drugs that match to the standardised doses/number of SACT doses given of selected drug); including confirmation of transition from local previously agreed QIPP arrangements (if any) such as legacy gain share.				
	4	Trust agreement and adoption of standard product descriptions (where these are available) for individual chemotherapy drugs.				
Palliative Chemotherapy	2	Review of current practice in relation to 30 day mortality reviews ensuring that monthly 30 day mortality review meetings are in place to review all deaths within 30 days of chemotherapy and that consultant specific 30 day mortality data is feedback on a regular basis to individual consultants.				
	3	Documented improvement plan against all aspects of triggers 1 and 2 agreed and shared. Including % targets set for improvement in relation to number of cases where a documented peer discussion takes place prior to commencement of continuation of treatment within the patient cohorts defined above.				
Spinal Surgery	1a	Continued working of the Regional Spinal Network on a 4-6 monthly rota. Minutes to be available and must follow the National template.				
	1b	Continued working of the Sub-Network Clinical Governance Group with meetings every 2-4 months. Minutes to be available and must follow the National template.				
	1c	Update the Regional Policy to manage spinal emergencies including transfer if required				
	1d	Update the Regional Policy for emergency imaging if required.				

Key

Green	Amber	Red	Grey
Standard achieved	Standard partially achieved	Standard not achieved	Development, implementation or not deliverable for this Quarter

How healthcare is regulated

The Ipswich Hospital NHS Trust is required to register with the Care Quality Commission (CQC) and its current registration status is full registration.

The Ipswich Hospital NHS Trust has the following conditions on registration - no conditions.

The Care Quality Commission has not taken enforcement action against The Ipswich Hospital NHS Trust during 2017/18.

The Ipswich Hospital NHS Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

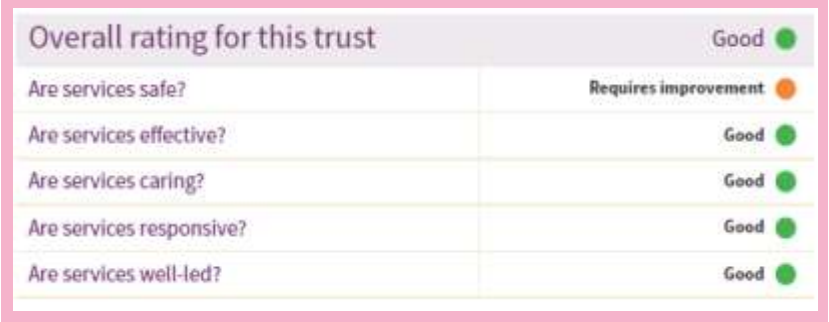
The CQC undertook unannounced inspections of the Trust's acute and community services on 30 & 31 August 2017, 19-21 September 2017 and announced inspections on 12 & 13 October 2017 for the Well-led domain, and 18 October 2017 for Use of Resources.

CQC monitoring and inspection process

The CQC's surveillance model is built on a suite of indicators which relate to the five key questions - are services **safe, effective, caring, responsive, and well-led**?

The indicators are used to raise questions about the quality of care but are not used on their own to make final judgements. Judgements will always be based on a combination of what is found at inspection, national surveillance data and local information from the Trust and other organisations. The judgement is based on a ratings approach using the following categories:
Outstanding
Good
Requires Improvement
Inadequate

Inspections are carried out using an expert team of inspectors over several days. The following areas



are assessed during an inspection:

- Urgent & emergency services;
- Medical care, including older people's care;
- Surgery;
- Critical Care;
- Maternity;
- Services for Children & Young People;
- End of Life Care;
- Outpatients; and
- Community health inpatient services.

In addition there were inspections of the Well-led domain and Use of Resources.

Inspections by the Care Quality Commission (CQC)

The CQC regulates and regularly inspects healthcare service providers in England. Where there is a legal duty to do so, the CQC rates the quality of services against each key question as outstanding, good requires improvement or inadequate. Healthcare service providers can be re-inspected at any time if services fail to meet the Fundamental Standards of Quality and Safety, or if any concerns are raised.

Following the unannounced inspections of the Trust's acute and community services in August and September 2017, and announced inspections in October 2017, the Trust received a rating of '**Good**'.

The report of this inspection, published on 18 January 2018, details a number of recommendations for improvement. The Trust has developed an action plan to address these recommendations, with progress monitored monthly by the Quality Committee.

The CQC found areas for improvement including two breaches of legal requirements the Trust must address. There were 22 recommendations that the Trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality. The CQC issued two requirement notices to the Trust, which means the Trust has to send the CQC a report saying what action would be taken to meet these requirements. This action related to breaches of legal requirements at a trust-wide level and in a number of core services. The CQC will ensure the Trust takes the necessary action to improve its services. The CQC will monitor the safety and quality of services through its continuing relationship with the Trust and the regular inspections. The full report can be viewed on the CQC website at http://www.cqc.org.uk/provider/RGQ

Areas for improvement from the Trust's inspection by the CQC

Action the Trust must take to improve:
The CQC issued the Trust with two requirement notices. For further information see page 42 of CQC report detailing what action the Trust must take.

Actions the Trust must take to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services. This action related to two services (urgent & emergency care, and children & young people's services), and the Trust overall.

How healthcare is regulated

For the overall Trust:

- ensure staff are up to date with mandatory training in accordance with their role, specifically basic, intermediate and advanced life support.
- ensure all staff are up to date with safeguarding training to a level in accordance with their role and that safeguarding documentation/ flowcharts make reference to the different aspects of potential abuse.
- ensure there are effective processes in place for equipment maintenance and servicing. Oversight of action plans for Electrical & Biomedical Engineering department should continue to ensure the environment is fit for purpose.
- ensure the recently established senior management oversight of the discharge lounge continues.

Urgent & emergency services:

- undertake a formalised assessment process to ensure that the area in majors used for mental health assessments is safe and suitable for use.
- ensure staff are competent and documentation is accurate in relation to the modified early warning score (MEWS) within the emergency department.
- ensure there are effective processes in place to manage the electrical safety testing for all electrical equipment.
- ensure there are processes in place to manage effective equipment checks for example all resuscitation equipment is checked daily.
- ensure staff complete the required mandatory training.

Children & young people's services:

- ensure all relevant staff are up to date with safeguarding children level three training.
- ensure the first hour of care documentation is completed by medical staff for all babies admitted to the neonatal unit.

The CQC found examples of outstanding practice in medical care, end of life care, children & young people's services and urgent & emergency care:

- The emergency department works collaboratively with the frailty assessment base to identify patients with frailty needs. These patients are moved to a specialist assessment ward within the Trust.
- The 2016 National Diabetes Inpatient Audit measured the quality of diabetes care provided to people with diabetes when they are admitted to hospital whatever the cause, and aims to support quality improvement. The audit identified 86 inpatients with diabetes at the Trust. The overall results indicate the Trust is in the best performing 25% of trusts in England.
- The frailty assessment base provides an alternative to acute admission and enables instant advice for GPs or community teams and same or next day assessment by a dedicated MDT.
- The children and young people's service achieved recognition in nominations for national awards with Voice4Change young people's group and the research and development team.
- Within the children's service there is innovative use of various techniques, such as sensory equipment and animal handling for stimulation, distraction and comfort for children with differing needs.
- The chaplaincy team provide a responsive supportive role throughout the Trust. They carry a trauma bleep to enable them to be available to offer emotional support to relatives of critically ill patients. They also offer emotional support to staff and have developed a resilience training programme.
- The Trust has a 'carers cabin' which is run in partnership with Suffolk Family Carers, a local charity. The cabin is situated outside the main hospital building, and is open from Monday to Friday, offering carers free refreshments and the chance to drop in for emotional support and signposting to services.

Ratings for Ipswich hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↓ Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Good ↓ Jan 2018	Good ↓ Jan 2018	Good ↓ Jan 2018
Medical care (including older people's care)	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018
Surgery	Requires improvement Jan 2015	Good Jan 2015	Good Jan 2015	Good Jan 2015	Good Jan 2015	Good Jan 2015
Critical care	Good Jan 2015	Good Jan 2015	Good Jan 2015	Good Jan 2015	Good Jan 2015	Good Jan 2015
Maternity	Good Jan 2015	Good Jan 2015	Good Jan 2015	Requires improvement Jan 2015	Good Jan 2015	Good Jan 2015
Services for children and young people	Requires improvement →← Jan 2018	Good ↑ Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Good ↑ Jan 2018	Good ↑ Jan 2018
End of life care	Good →← Jan 2018	Requires improvement →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018
Outpatients	Good Jan 2015	Not rated	Good Jan 2015	Good Jan 2015	Good Jan 2015	Good Jan 2015
Overall*	Requires improvement →← Jan 2018	Good ↑ Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health inpatient services	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018
Overall*	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018

Statements relating to the quality of relevant health services provided

NHS number and General Medical Practice Code validity

The Ipswich Hospital NHS Trust submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

- 99.69% for admitted patient care;
- 99.85% for outpatient care; and
- 98.8% for accident and emergency care.

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

- 99.63% for admitted patient care;
- 94.07% for outpatient care; and
- 98.32% for accident and emergency care.

Information Governance Toolkit attainment levels

The Ipswich Hospital NHS Trust Information Governance Assessment Report overall score for 2017/18 was 84% and was graded satisfactory (Green).

Clinical coding

The Ipswich Hospital NHS Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission*. However, an external clinical coding audit was carried out in January 2018 to satisfy the requirements of the Information Governance Toolkit.

* The clinical coding functions noted above and previously undertaken by the Audit Commission are now under the guidance of NHS Improvement.

Data Quality

The Ipswich Hospital NHS Trust will be taking the following actions to improve data quality:

Data Quality Indicator	Update
Consolidation and Co-ordinating Commissioner sign off of the reporting into the Provider's Accountability Framework including the source data file.	**20/6/17 IHT** - Awaiting feedback from CCG. **15/8/17 CCG** - Part of overall review of reporting requirements - CCG Internal review - Ongoing.
Joint review of accuracy of dataflow following implementation of NHS Digital national data services.	**20/6/17 IHT** - Awaiting feedback from CCG with regards to timeframe. **15/8/17 CCG** - a) Move to non-sus to Data Landing Portal & b) ECDS Progress IHT currently report will meet 1/10 start date - Ongoing.
Child safeguarding - revised template to be agreed by the Provider and Co-ordinating Commissioner and submitted.	**20/6/17 IHT** - Currently under review by IHT, but Child Safeguarding Lead has expressed concerns that need to be addressed. **15/8/17 CCG** - Request for Child safeguarding template escalated within CCG - Ongoing.
The Provider shall publish median waiting times for first and follow up outpatient appointments by specialty on their website and to inform the Co -ordinating Commissioner.	**20/6/17 IHT** - Requires further discussion. - Ongoing. **15/8/17 CCG** - CCG request. **04/10/17 IHT** - the August Median OP Waiting Times were published on the Ipswich Hospital internet website at the end of September. This will be updated on a monthly basis.
SEND Reporting.	**20/6/17 IHT** - Requires further discussion. - Ongoing.
Data Sharing Requirements to support development of Urgent and Emergency Care Dashboards.	**20/6/17 IHT** - Trust IG Manager agreed a Data Sharing Agreement with I&ES CCG and this wasn't included at the time, so CCG should engage with Trust IG Manager to take this forward.

Core Quality Indicators

The data given within the Core Quality Indicators is taken from the Health and Social Care Information Centre Indicator Portal (HSCIC), unless otherwise indicated.

Please note that HSCIC is now known as NHS Digital.

Indicator: Summary Hospital-Level Mortality Indicator (SHMI)

SHMI is a hospital-level indicator which measures whether mortality associated with a stay in hospital was in line with expectations. SHMI is the ratio of observed deaths in a Trust over a period of time divided by the expected number given the characteristics of patients treated by the Trust. SHMI is not an absolute measure of quality, however, it is a useful indicator to help Trusts understand mortality rates across every service provided during the reporting period.

The data made available to the Trust by the HSCIC with regard to:	Reporting period	Ipswich score	National average	Highest score	Lowest score	Banding
The value and banding of the SHMI for the Trust for the reporting period	**Oct 14 - Sept 15**	0.983	1	1.177	0.652	2
	Oct 15 - Sept 16	0.983	1	1.164	0.692	2
	Oct 16 - Sept 17	1.044	4	1.247	0.727	2
The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period *(the palliative care indicator is a contextual indicator)*	**Oct 14 - Sept 15**	11.7	26.5	53.5	0.2	-
	Oct 15 - Sept 16	14.6	29.7	56.3	0.4	-
	Oct 16 - Sept 17	21.5	31.5	59.8	11.5	-

The Ipswich Hospital NHS Trust considers that this data is as described for the following reason:

- The Trust is banded as a '2' which is 'as expected' mortality. This correlates with the information gained from local morbidity & mortality meetings.

The Ipswich Hospital NHS Trust is taking the following actions to improve this score, and so the quality of its services, by:

- The Trust now follows the national mortality review programme and is prospectively reviewing any patient groups flagged through Dr Foster via the structured judgement review process.
- Ongoing surgical improvement audit to reduce mortality associated with emergency and elective surgical care.
- Ongoing learning is occurring through newly established regular divisional 'learning from death' meetings, feeding back to the Mortality Review Group.

Commendation winners

Lavenham ward sisters Fiona and Naomi have won a staff award after their staff described them as 'hard working and professional' and said they 'would love them to know how grateful we are'. Here they are pictured with matron Lindsey and Director of Nursing Lisa.

Fiona Rawson and Naomi Gunton pictured with matron Lindsey Mazur (left) and Director of Nursing Lisa Nobes (right).

Core Quality Indicators

Indicator: Patient Reported Outcome Measures (PROMs) scores

PROMs measures a patient's health-related quality of life from the patient's perspective using a questionnaire completed by patients before and after four particular surgical procedures. These questionnaires are important as they capture the extent of the patient's improvement following surgery.

The data made available to the Trust by the HSCIC with regard to:	Reporting period	Ipswich score	National average	Highest score	Lowest score
The Trust's patient reported outcome measures scores for groin hernia surgery during the reporting period	**2015/16**	0.491	0.573	8.0	0.02
	2016/17	0.636	0.575	7.58	0.01
	2017/18	Data expected to be published summer 2018.			
The Trust's patient reported outcome measures scores for varicose vein surgery during the reporting period	**2015/16**	0.335	0.327	1.918	0.020
	2016/17	0.258	0.349	3.366	0.21
	2017/18	Data expected to be published summer 2018.			
The Trust's patient reported outcome measures scores for hip replacement surgery during the reporting period	**2015/16**	0.646	0.869	12.87	0.153
	2016/17	1.00	0.85	4.66	0.164
	2017/18	Data expected to be published summer 2018.			
The Trust's patient reported outcome measures scores for knee replacement surgery during the reporting period	**2015/16**	0.736	0.963	7.730	0.035
	2016/17	0.947	0.944	5.54	0.18
	2017/18	Data expected to be published summer 2018.			

The Ipswich Hospital NHS Trust considers that this data is as described for the following reason:

- The scores show significant improvement from earlier scores. One reason would be a higher incidence of laparoscopic surgery for varicose vein and groin hernia surgery.
- The PROMs score for knee replacement is 0.003 below the national average for the first time. We can find no reason for this change.

The Ipswich Hospital NHS Trust has taken the following actions to improve this score, and so the quality of its services, by:

- More recently, a greater number (>50%) of varicose vein and groin hernia surgery has been carried out laparoscopically by Consultant grade clinicians.
- The data will be reviewed in the next round of scores being published summer 2018 and if scores unchanged or worse we will attempt to review the raw data.

Core Quality Indicators

Indicator: Readmission rates

The percentage of patients readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.

In the absence of national data being made available by NHS Digital, the Trust has presented locally calculated metrics:	Reporting period	Ipswich score	National average	Highest score	Lowest score
% of patients aged 0-15 years readmitted within 30 days NOTE: Data runs from 1 February 2017 - 31 January 2018	**2015/16**	10.7%	No data available.		
	2016/17	10.8%			
	2017/18	10.8%			
% of patients aged 16 years or over readmitted within 30 days NOTE: Data runs from 1 February 2017 - 31 January 2018	**2015/16**	7.8%	No data available.		
	2016/17	7.4%			
	2017/18	7.9%			

The Ipswich Hospital NHS Trust considers that this data is as described for the following reason:

- As national data for readmissions within 28 days has not been made available through NHS Digital, the Trust has provided the local metric for readmission rates within 30 days. This is monitored at both a divisional level and Trust level through the Accountability Framework.

The Ipswich Hospital NHS Trust has taken the following actions to improve this score, and so the quality of its services, by:

- Ensuring every child and their parents/carers are given both written and verbal information on their condition, with self-management instructions. Children with chronic conditions such as Cystic Fibrosis, oncology or respiratory conditions are able to attend under 'open access' arrangements, and these patients are counted in our readmission figures.
- Enhanced admission prevention services in place to prevent patients reaching crisis point before needing admission.
- From 1 April 2018 we will be bringing historically separate services together to deliver a more integrated approach across acute and community services.

Indicator: Responsiveness to the personal needs of patients during the reporting period

The data made available to the Trust by the HSCIC with regard to:	Reporting period	Ipswich score	National average	Highest score	Lowest score
The Trust's responsiveness to the personal needs of its patients during the reporting period	**2015/16**	68.1	69.6	86.2	58.9
	2016/17	66.9	68.1	85.2	60.0
	2017/18	Publication due August 2018.			

The Ipswich Hospital NHS Trust considers that this data is as described for the following reason:

- Care rounding is used in all appropriate clinical areas. It is regularly audited to ensure practice is embedded.

The Ipswich Hospital NHS Trust has taken the following actions to improve this score, and so the quality of its services, by:

- The nurse in charge on each ward is identifiable with a large red 'Nurse in Charge' badge.
- Plan to further develop the HELP line, helping to empower loved ones and patients to raise and resolve concerns at ward level.
- Improving recruitment and retention of all care staff using the learning from the NHS Improvement Retention Collaborative.

Core Quality Indicators

Indicator: Staff recommendation (Friends and Family Test)
Taken from Question 21d of the NHS staff survey

The data made available to the Trust by the HSCIC with regard to:	Reporting period	Ipswich score	National average	Highest score (best)	Lowest score (worst)
The % of staff employed by or under contract to the Trust during the reporting period who would recommend the Trust as a provider of care to their family and friends.	**2015**	76%	69%	89%	46%
	2016	75%	69%	91%	48%
	2017	77%	71%	93%	42%

The Ipswich Hospital NHS Trust considers that this data is as described for the following reason:

- Responses to the NHS Staff Survey are independently reviewed.
- The 2017 survey was a census rather than responses from a random sample of staff.

The Ipswich Hospital NHS Trust is taking the following actions to improve this score, and so the quality of its services, by:

- In collaboration with staff and external stakeholders, we have developed and will be delivering our People, Organisation and Development Strategy.
- Further development of our Staff Experience Group and our Equality, Diversity and Inclusion Group.
- Improving the experience for appraisals and personal development conversations by delivering a number of appraisal training sessions entitled High quality workplace conversations.
- Improved communication by launching a new weekly staff briefing.

Indicator: Patient recommendation (Friends and Family Test)

The data made available to the Trust by the HSCIC with regard to:	Reporting period	Ipswich score	National average	Highest score (best)	Lowest score (worst)
All acute providers of adult NHS funded care, covering services for inpatients and patients discharged from A&E (types 1 and 2)					
Inpatients	**2015/16**	95.82%	95.4%	100%	83.3%
	2016/17	95.87%	95.39%	100%	75.55%
	2017/18*	97.22%	95.75%	100%	71.88%
A&E	**2015/16**	79.04%	87.69%	98.9%	49.3%
	2016/17	74.56%	86.16%	100%	47.8%
	2017/18*	77.26%	88.27%	98.6%	53.3%

The Ipswich Hospital NHS Trust considers that this data is as described for the following reasons:

- Results are monitored by the Information Department, Divisions, Patient & Carer Experience Committee and Trust Board using the Integrated Performance Report; and any outlying scores trigger a review.

The Ipswich Hospital NHS Trust has taken the following actions to improve this score, and so the quality of its services, by:

- Reviewing results within the relevant CDG and Divisional meetings and at Patient & Carer Experience Committee meetings, and any actions required to improve responses are taken.
- Teams working with wards and clinics to review feedback to make improvements - see 'You said, we did' on page 64.
- Emphasising the importance of submission of good returns and the satisfactory outcome scores achieved in multidisciplinary team meetings.

*Data relates to the period April 2017 - February 2018 (the latest published data)

Core Quality Indicators

Indicator: Risk assessment for venous thromboembolism (VTE)					
The data made available to the Trust by the HSCIC with regard to:	**Reporting period**	**Ipswich score**	**National average**	**Highest score (best)**	**Lowest score (worst)**
% of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	**2015/16**	94.1%	95.7%	100%	75%
	2016/17	81.5%	95.5%	100%	73%
	2017/18 Q1 - Q3 (most recent data available at time of publishing)	88.1%	95.2%	100%	66.4%

The Ipswich Hospital NHS Trust considers that this data is as described for the following reason:

- The Ipswich Hospital NHS Trust switched to electronic VTE risk assessment in 2016. Although we have largely maintained our performance in the appropriate prescription of thrombo-prophylactic medication, we have performed less well in our risk stratification assessment of VTE risk. The move to the electronic Nervecentre system for risk stratification brought an additional task to perform in the VTE risk stratification. We have tried hard to improve performance, but after discussion with clinicians and nursing staff, have now moved to a paper based risk stratification as part of a new drug chart. We intend in the longer term to look to an e-prescribing solution whereby VTE risk assessment will be a gateway to the inpatient prescription pathway.

The Ipswich Hospital NHS Trust is taking the following actions to improve this score, and so the quality of its services, by:

- The thrombosis group and medical director have decided to revert to using the paper VTE assessment on the drug chart from 1st May 2018. The overall plan is to include VTE risk assessment with e-prescribing when this is implemented. We would expect compliance to improve, since rates of assessment were high on previous paper VTE risk assessments prior to switching to electronic assessment.

Indicator: *Clostridium difficile* infection rate					
The data made available to the Trust by the HSCIC with regard to:	**Reporting period**	**Ipswich score**	**National average**	**Highest score (worst)**	**Lowest score (best)**
The rate for 100,000 bed days of cases of *Clostridium difficile* infection reported within the Trust amongst patients aged 2 or over during the reporting period	**2015/16***	20.1	14.9	66.0	0
	2016/17**	18.6	29.9	62.0	0
	2017/18**	10.4	13.9	95.1	0

The Ipswich Hospital NHS Trust considers that this data is as described for the following reasons:

- The accuracy of the data is checked thoroughly before submission.
- Data is cross-checked with laboratory data and is subject to external assurance by the Ipswich & East Suffolk Clinical Commissioning Group.
- Post infection reviews now carried out at a local level, ensuring more robust investigation to highlight areas of learning to share with all clinical areas.

The Ipswich Hospital NHS Trust has taken the following actions to improve this score, and so the quality of its services, by:

- Purchased a Vaporised Hydrogen Peroxide decontamination system for environmental decontamination of single rooms including equipment, and the Trust is planning to review how this equipment could be utilised more widely across all clinical areas.

* Includes *Clostridium difficile* cases at community hospitals managed by The Ipswich Hospital NHS Trust from 1 October 2015 to 31 March 2016.
** Includes *Clostridium difficile* cases as community hospitals managed by The Ipswich Hospital NHS Trust.

Core Quality Indicators

Indicator: Patient safety incident rate									
The data made available to the Trust by the HSCIC with regard to:	**Reporting period**	**Ipswich Score**		**National average**		**Highest score**		**Lowest score**	
		Number	**Rate**	**Number**	**Rate**	**Number**	**Rate**	**Number**	**Rate**
the number and rate of patient safety incidents reported within the Trust during the reporting period ***(please note that the reporting period changed to 'per 1,000 bed days' in April 2014)***	**October 14 - March 15**	2,664	26.67	4,538	37.1	12,784	82.21	443	3.57
	April 15 - September 15	2,954	32.90	4,125	38.25	12,080	74.67	1,559	18.07
	October 15- March 16	3,331	38.68	4,817	39.6	3,426	75.91	2,394	18.19
	April 16- September 16	3,486	35.44	4,955	40.76	3,620	71.81	2,305	21.15
	October 16- March 17	4,049	36.77	5,122	41.1	3,300	68.97	3,227	26.29
	April 17- September 17	4,630	44.44	5,226	42.84	10,016	111.69	3,085	23.47
	October 17- March 18	Data not available at time of publishing.							
the number and percentage of such patient safety incidents that resulted in severe harm or death during the reporting period	**Reporting period**	**Ipswich Score**		**National average**		**Highest score**		**Lowest score**	
		Number	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
	October 14 - March 15	12	0.4	22.5	0.5	128	1.53	2	0.02
	April 15 - September 15	21	0.7	17	0.14	89	1.12	0	0.03
	October 15- March 16	19	0.5	19.4	0.4	94	1.3	1	0
	April 16- September 16	27	0.77	18.5	0.37	98	1.73	1	0.02
	October 16- March 17	22	0.5	19.2	0.4	92	1.1	1	0
	April 17- September 17	24	0.5	18.38	0.4	121	2.0	0	0
	October 17- March 18	Data not available at time of publishing.							

Continued...

Core Quality Indicators

Indicator: Patient safety incident rate

The Ipswich Hospital NHS Trust considers that this data is as described for the following reasons:

Our ambition for 2017/18 was to increase our incident reporting rate and we have achieved a 20 percent increase; particularly of 'no harm' and 'low harm' categories. This proactive and open reporting ensures that all patient safety incidents are reviewed and investigated to ensure lessons are learned to safeguard future patient care. Patient safety incidents (irrespective of the level of harm) are uploaded to the NRLS, to enable NHS-wide learning.

We have reported performance of 0.5 percent in respect of the 'percentage of patient safety incidents that resulted in 'severe harm or death' indicator which benchmarks similar to our peer group. The nature of the process for investigating patient safety incidents and assessing the severity means that the severity of a case may be amended following the initial upload of the details to the national database. The national database has data freeze points during the year which prevents any amendments post these points in time being reflected in the published data. Five of the reported severe harm or death patient safety incidents were subsequently re-graded to lower harm levels following investigation which is not reflected in the published data. As a result, the published figure of 24 has subsequently changed and using most up to date data would give a percentage of patient safety incidents resulting in severe harm or death for April-September 2017 as 0.37 percent which is consistent with peer organisations.

41% of our patient safety incidents resulting in severe harm or death were related to patient falls leading to injuries requiring medical interventions. The Trust continues to focus on the prevention of falls and will continue to work with health and social care colleagues locally to support the elderly and frail members of our community. See pages 42 and 43 for the improvements we intend to make.

The Ipswich Hospital NHS Trust is taking the following actions to improve this score, and so the quality of its services, by:

The Trust Board has stated a commitment to improving our reporting rate, with the ambition stated within our strategy to be in the top 25% of reporters on the NRLS database by 2022.

We will continue to engage our staff to report all types of incidents to enable learning and changes to our service models to reduce the risk of adverse events for our service users.

Commendation winner

Critical Care Outreach nurse Sue Chatterton
Sue is part of our Critical Care Outreach team and supports very unwell patients on the wards, often before or after a stay in the Critical Care Unit.

Alongside her day job caring for patients, Sue has been leading a project to collect and analyse useful data for her team's patients. It means the team can provide a safer service.

Sue Chatterton with her commendation certificate

Part 3 - Other information

Patient safety

Infection prevention and control

Infection prevention and control is a high priority for the Trust, our patients and visitors. Limiting the spread of infection can be as simple as making sure everyone washes their hands, uses the antibacterial hand gel, does not visit hospital when feeling unwell and everything is clean, to caring for patients who need complex clinical care.

What is MRSA bacteraemia?

MRSA stands for meticillin resistant Staphylococcus aureus. It is a strain of the Staphylococcus aureus family of bacteria, which cause a number of infections, some of which are serious. The reason that MRSA is such a problem for hospitals, and why it has become known as a superbug, is that it is resistant to common antibiotics.

Bacteraemia is when there is bacteria present in the bloodstream such as MRSA. MRSA can enter the normally sterile bloodstream either from a local site of infection (wound, ulcer, abscess) or, for example, via an intravenous catheter (placed there for the patient's medical care).

MRSA screening

As per the Department of Health paper *Implementation of modified admission MRSA screening guidance for NHS*, published in 2014, the Trust screens patients in high risk areas such as Critical Care, Oncology, Orthopaedics and Neonates, and screens high risk patients such as renal patients and past MRSA-positive patients, but does not routinely screen medical patients, emergency admissions or day cases. This targeted approach to screening is national practice.

- Patients identified as colonised with MRSA will be offered decolonisation treatment as appropriate.
- Patients currently colonised with MRSA will be cared for using precautions to stop transmission.

Learning from MRSA bacteraemia cases

- Improved recording of insertion and removal of peripheral intravenous catheters.

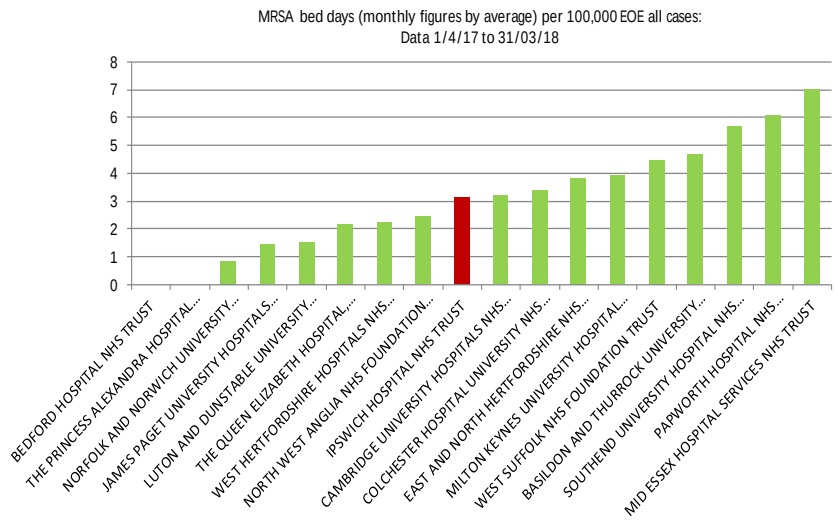
MRSA bacteraemia

Chart 1 shows our performance in rates of MRSA bacteraemia compared with the other hospitals in the East of England. The last case of MRSA bacteraemia assigned to the Trust was May 2017.

The rates are calculated using the total number of cases from 1 April 2017 to 31 March 2018, the average daily number of available and occupied beds and expressed as rates per 100,000 bed days.

Year	Number of cases of MRSA bacteraemia	Target
2015/16	0	Zero cases
2016/17	0	Zero cases
2017/18	1	Zero cases

Chart 1 – The performance of Ipswich Hospital in rates of MRSA bacteraemia, compared with the other hospitals in the East of England region for 2017/18



Patient safety
Infection prevention and control

Clostridium difficile

Chart 2 shows our performance in rates of *Clostridium difficile* compared with the other hospitals in the East of England. The rates are calculated using the total number of cases from 1 April 2017 to 31 March 2018, the average daily number of available and occupied beds and expressed as rates per 100,000 bed days.

Each case of *Clostridium difficile* is subject to a post-infection review. If all care is in place and appropriate, the Infection Prevention and Control lead for the commissioners may designate a case as 'non-trajectory'.

14 of the 23 cases were identified as non-trajectory by commissioners. The table below shows the total number of cases, both apportioned to The Ipswich Hospital NHS Trust (trajectory) and those where all care had been appropriate and there was nothing further that could have been done to prevent the infection (non-trajectory), such as the patient's need for antibiotics being greater than the risk of developing a *Clostridium difficile* infection.

Two themes have emerged as learning from *Clostridium difficile* infections: the benefits of both timely isolation and sampling lead to reduced risk of transmission and more prompt giving of treatment.

What is *C.difficile*?

C.difficile is an abbreviation of *Clostridium difficile* and it is the major cause of antibiotic-associated diarrhoea and colitis, an infection of the intestines. It is part of the Clostridium family of bacteria, which also includes the bacteria that cause tetanus, botulism and gas gangrene. It is an anaerobic bacterium (it does not grow in the presence of oxygen) and produces spores that can survive for a long time in the environment. It most commonly affects elderly patients with other underlying diseases.

Year	Target	Total number of cases of *Clostridium* difficile
2015/16	No more than 18 cases	32+5 cases from the three community hospitals (October 2015 onwards)
2016/17	No more than 18 (trajectory) cases	9 trajectory 20 non-trajectory
2017/18	No more than 18 (trajectory) cases	9 trajectory 14 non-trajectory

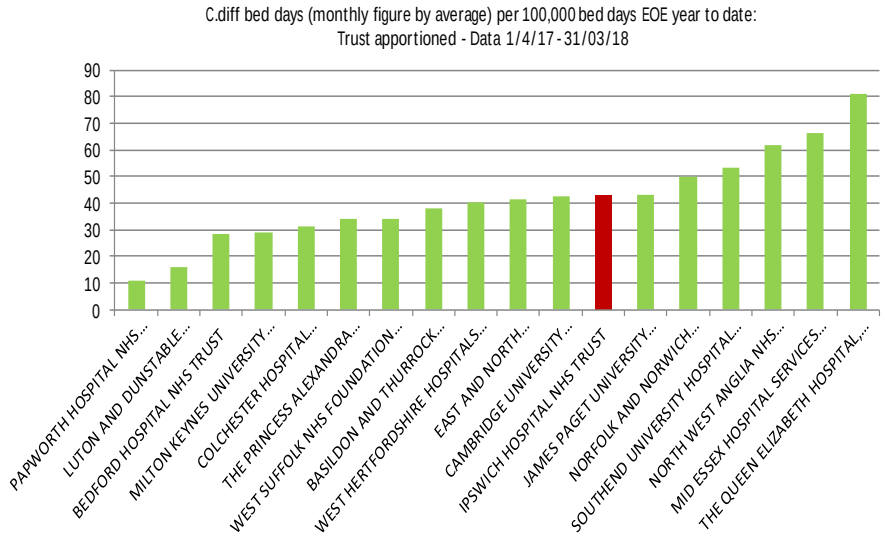


Chart 2 – The performance of Ipswich Hospital in rates of *Clostridium difficile*, compared with the other hospitals in the East of England region for 2017/18 (reference: Public Health England, 2018)

Patient safety
Infection prevention and control

Norovirus

Norovirus is measured in number of outbreaks rather than the number of cases. This is because of its ability to affect the optimal management of a hospital (outbreaks may cause ward or hospital closures).

There were 10 outbreaks of Norovirus during 2017/18, which resulted in two complete ward closures and eight partial ward closures to minimise transmission to other patients and visitors. Visitors can help to stop the spread of norovirus by not visiting the hospital if they feel unwell or have vomiting and/or diarrhoea.

Number of outbreaks of Norovirus at Ipswich Hospital NHS Trust	
2015/16 (includes community services from October 2015)	6
2016/17 (includes community services)	8
2017/18 (includes community services)	10

Influenza

There were 3 outbreaks of Influenza A in the Trust during 2017/18. One ward was completely closed as a consequence, and two wards were partially closed.

Preventing healthcare associated Gram-negative bloodstream infections

There is an NHS-wide ambition to reduce the number of healthcare associated Gram-negative blood stream infections by 50% by 2021, and reduce inappropriate antimicrobial prescribing by 50% by 2021.

As an organisation, we will be focussing across our acute and community services on reducing the number of e-coli bloodstream infections as this represents 55% of all Gram-negative bloodstream infections.

Appropriate use of antibiotics for possible urinary tract infections and keeping patients hydrated may contribute to a reduction in e-coli bloodstream infections.

Commendation winners

The IT team

The NHS Cyber Attack brought IT systems in hospitals up and down the country to a halt back in May. While our hospital's computers systems weren't infected, our IT and Information teams had to work extraordinarily hard behind the scenes. Not only did they pull out all the stops to protect our hospital's systems and ensure patient care could continue as normal, they also travelled in numbers down the A12 to Colchester Hospital to help out where they were more heavily affected.

Members of the Trust's IT Team, receiving their commendation certificate from Managing Director Neill Moloney and Chief Executive Nick Hulme

Patient safety
Prevention and treatment of pressure ulcers

What is a pressure ulcer?

A pressure ulcer is damage that occurs on the skin and underlying tissue.

Pressure ulcers are caused by three main things:

- pressure - the weight of the body pressing down on the skin;
- shear - the layers of the skin are forced to slide over one another or over deeper tissues, for example when you slide down, or are pulled up, a bed or chair or when transferring to and from a wheelchair; and
- friction - rubbing the skin.

How do you recognise a pressure ulcer?

The first sign that a pressure ulcer may be forming is usually discoloured skin, which may get progressively worse and eventually lead to an open wound.

Where do you get a pressure ulcer?

The most common places for pressure ulcers to occur are over bony prominences (bones close to the skin) like the bottom, heel, hip, elbow, ankle, shoulder, back and the back of the head.

The development of a pressure ulcer is usually the result of a number of factors including health conditions which make it difficult to move, especially those confined to lying in a bed or sitting for prolonged periods of time, sensory impairment, poor nutrition, dehydration and incontinence.

We have a clinical specialist team whose remit is to:

- encourage 'gold standard' practice across the hospital to reduce the number of pressure ulcers that occur during hospital inpatient stays;
- support community staff who regularly visit patients in their own home to assess, educate and offer pressure relieving equipment and guidance to patients to reduce the high occurrence of pressure ulcers that develop in this patient group;
- provide education and training to multidisciplinary staff to improve and standardise practice across all areas including community staff and other support services;
- support education opportunities to care home staff to encourage 'gold standard' practice in all care environments in the community.
- develop policies and pathways in line with national guidance and best practice;
- recommend use of correct equipment for individual needs;
- develop the wound care product formulary; and
- ensure the Trust is providing current, evidence-based care.

Our key achievements

- ✓ Expansion of the senior tissue viability team to provide enhanced support to all clinical areas.
- ✓ Led the development of the Tissue Viability Alliance for Suffolk.
- ✓ Purchased additional bariatric equipment such as pressure-relieving cushions and wheelchairs.
- ✓ Responded to the increasing requirement for enhanced levels of tissue viability prevention equipment, as part of the organisation's seasonal planning.
- ✓ Tissue viability links with the University of Suffolk to improve levels of knowledge for pre-registration healthcare students.
- ✓ Focussed training provided tailored to individual departmental needs.
- ✓ Provision of support to ward managers and clinical teams when undertaking root cause analysis of pressure ulcer development to ensure lessons are learnt and disseminated widely.
- ✓ Thematic review of pressure ulcers has provided a framework for key actions to reduce the occurrence of avoidable pressure ulcers.
- ✓ The Quality Committee continues to provide support to the tissue viability service to drive improvements in patient safety.
- ✓ Increasing use of vacuum dressings which enable patients to be discharged from hospital sooner and receive further treatment at home.
- ✓ Continue to trial new and innovative equipment to meet the individual needs of our patients and encourage reablement.

Aims for 2018/19

- Review the provision of equipment available for use on wards, reducing the delay of essential equipment being available.
- Strengthen local leadership for tissue viability to include pressure ulcer management.
- Develop the provision of an enhanced service to include outpatients.
- Standardise a wound care formulary Suffolk-wide.
- Provide training days for care home staff.

Patient safety

Prevention and treatment of pressure ulcers

How pressure ulcers are graded European Pressure Advisory Panel (EPUAP) Classifications

Grade 1
Non-blanchable erythema of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness may also be used as indicators, particularly on individuals with darker skin.

Grade 2
Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion or blister.

Grade 3
Full thickness of skin involving damage to, or necrosis of, subcutaneous tissue that may extend down to but not underlying fascia - the skin may be unbroken.

Grade 4
Extensive damage, tissue necrosis or damage to muscle, bone or supporting structures with or without full thickness skin loss.

Commendation winner

Anna Kruczek has been awarded a Commendation for acting compassionately and quickly to help two end of life patients get home to die. Anna is the discharge coordinator for Washbrook and Woodbridge wards but was on a night duty overtime shift as a healthcare assistant when she stepped in to help the patients and their families.

There is only one chance to get end of life care right and Anna acted with kindness, respect and professionalism to get both patients safely discharged, with care arranged at home, the following morning. One of the patients died in the comfort of her own home, as was her wish, the day after. Without Anna voluntarily using her discharge skills while on an HCA shift the lady would have died in hospital. Anna was also applauded for the rapport she built with the patients' families and the arrangements she made with the day staff to make sure the discharges went ahead.

Anna was surprised with the award at a ward Board Round by Managing Director Neill Moloney.

Anna Kruczek, pictured with colleagues and Managing Director Neill Moloney

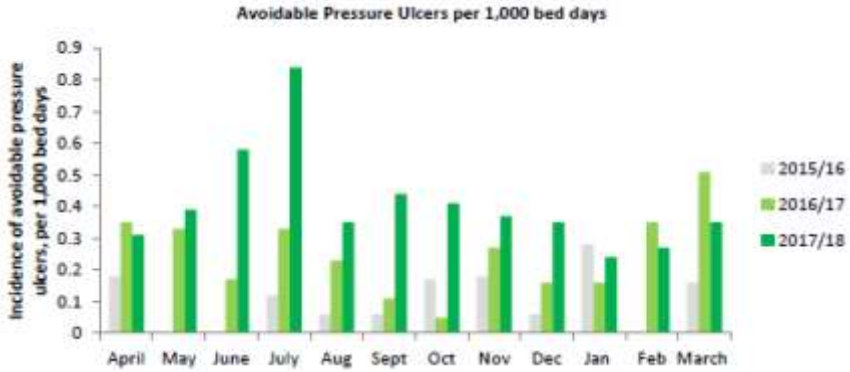


Chart 3 – Our performance over the last three years: Avoidable pressure ulcers per 1,000 bed days

Patient safety
Learning from Incidents, SIRIs and Never Events

Reporting incidents helps us to learn from them and decide whether we need to change the way we do things to improve patient safety, as well as identifying areas where we need to focus resources, such as training. We report our patient safety incidents to the National Reporting and Learning System (NRLS) so that information can be reviewed nationally for trends or problems.

Learning from incidents

All reported incidents are investigated and lessons that can be learnt are shared by Clinical Delivery Group governance meetings, at Divisional Board meetings, at morbidity & mortality meetings and discussed at the Trust's Risk Oversight Committee.

It is important that when serious incidents occur, they are reported and investigated in a timely manner, not only to ensure that the correct action can be taken, but to enable the Trust to learn from the incident to prevent it happening again and to reassure the patient involved that such incidents are taken seriously and thoroughly investigated.

The higher level incidents are categorised as Serious Incidents Requiring Investigation (SIRIs) and are reported to the Ipswich & East Suffolk Clinical Commissioning Group. These incidents are investigated, a comprehensive report written and actions implemented, and the learning shared both within the organisation and with the patient and/or their family.

The number of pressure ulcers recorded during 2017/18 has increased due to reporting changes to now include the reporting as SIRIs of all avoidable and unavoidable pressure ulcers.

Changes we have made as a result of lessons learnt:

- ✓ Removal of non radio-opaque small cotton swabs from use within theatres.
- ✓ Introduction of the national Invasive Procedure Policy which sets out the standards for checking of patients undergoing invasive procedures outside the operating theatre, such lumbar punctures.
- ✓ Anaesthetic Pre-operative Investigations in Adults guideline updated and incorporated into a comprehensive overarching guideline to ensure patients with suspected acute kidney injury are managed correctly.
- ✓ Sepsis e-learning programme for new FY1, FY2 and registered nurses launched to highlight the signs and symptoms of sepsis (Sepsis Six).
- ✓ Formalised process introduced so that patients being transferred between departments now require formal identification between staff undertaking the transfer.
- ✓ Modification to the incident reporting system to ensure fields relating to whether a patient safety incident has safeguarding implications are now mandatory.
- ✓ Introduction of new processes around the management of patients with glaucoma, particularly patients with raised intraocular pressure.
- ✓ Updated protocols in place to agree referral criteria and required response times (such as 'urgent', 'soon', 'routine') for appointments within Diagnostic Imaging.

Duty of Candour

Open and honest communication with patients is at the heart of healthcare.

Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 sets out some specific requirements which providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

As part of the Trust's process, patients or their relatives are informed of any such incidents. The Trust continues to work to improve the timeliness of follow up letters to patients, their families or carers and to work with the families to individualise the level of engagement.

Failure to meet this regulatory standard may result in financial penalty. The Trust has not been subject to any penalties relating to Duty of Candour.

What have we done to make improvements?

- ✓ Availability of an information leaflet to be given to patients or their relatives who have been the subject of a serious incident (SIRI). The leaflet explains the process for investigating a SIRI and how patients and their families can get involved.
- ✓ Formalisation of a family liaison officer role to support those patients and their relatives during the SIRI investigation process.

Patient safety
Learning from Incidents, SIRIs and Never Events

Table 2 – Adverse events and SIRIs reported

For the year 2017/18, there have been the following adverse events (categorised as no harm to severe harm) reported on the Datix risk management computer system. The adverse events recorded below are all adverse events, not only those related to patients.

Type of adverse event	No. of adverse events
Abusive, violent, disruptive or self-harming behaviour	222
Access, Appointment, Admission, Transfer, Discharge	1,860
Accident that may result in personal injury	2,246
Anaesthesia	19
Clinical assessment (investigations, images and lab tests)	1,105
Consent, Confidentiality or Communication	435
Diagnosis, failed or delayed	85
Financial loss	3
Implementation of care or ongoing monitoring/review	2,636
Infrastructure or resources (staffing, facilities, environment)	550
Labour or Delivery	442
Medical device/equipment	405
Medication	1,299
Other - please specify in description	309
Patient Information (records, documents, test results, scans)	438
Security	63
Treatment, procedure	264
Totals:	**12,381**

Of these adverse events, 162 were reported during 2017/18 as Serious Incidents Requiring Investigation (SIRIs) on the national Strategic Executive Information System (StEIS):

Type of adverse event	No. of SIRIs
Adverse media coverage or public concern	0
Allegation against staff	4
Diagnostic incident including delay meeting SI criteria	14
Infection control incident meeting SI criteria	5
Information Governance breach	2
Maternity/Obstetric incident meeting SI criteria (mother/baby)	3
Medication incident meeting SI criteria	3
Pressure ulcers Grade 3 or 4 meeting SI criteria	91
Screening issues meeting SI criteria	0
Slip/trip/fall meeting SI criteria	18
Suboptimal care of the deteriorating patient meeting SI criteria	5
Surgical/Invasive procedure incident meeting SI criteria	6
Treatment delay meeting SI criteria	11
Totals:	**162**

Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

The list of Never Events for 2017/18, as defined by NHS Improvement (Revised Never Events Policy and Framework, 2015), are:

1 Wrong site surgery
2 Wrong implant/prosthesis
3 Retained foreign object post-procedure
4 Mis-selection of a strong potassium containing solution
5 Wrong route administration of medication
6 Overdose of insulin due to abbreviations or incorrect device
7 Overdose of Methotrexate for non-cancer treatment
8 Mis-selection of high strength midazolam during conscious sedation
9 Failure to install functional collapsible shower or curtain rails
10 Falls from poorly restricted windows
11 Chest or neck entrapment in bedrails
12 Transfusion or transplantation of ABO-incompatible blood components or organs
13 Misplaced naso- or oro-gastric tubes
14 Scalding of patients

There are exclusions to each Never Event.

Never Events at The Ipswich Hospital NHS Trust

2015/16	2016/17	2017/18
5	4	1

Regrettably there was one Never Event during 2017/18 when a foreign object was retained post procedure. The patient has suffered no ill effects.

Patient safety

Prevention of patient falls

What are patient slips, trips and falls?

There will always be a risk of falls in hospital given the nature of the patients that are admitted, and the injuries they may sustain could be serious.

However, there is much that can be done to reduce the risk of falls and minimise harm, whilst at the same time properly allowing patients freedom, mobilisation and rehabilitation during their stay in hospital and beyond discharge.

What can contribute to the cause of patient slips, trips and falls?

- badly fitting or no footwear;
- not using the correct walking aids, if needed;
- cluttered areas;
- problems with vision, hearing or balance;
- loss of muscle strength;
- dehydration;
- medication;
- not calling for assistance;
- confusion;
- acute medical illness.

Prevention of patient falls

Preventing falls must be balanced with patients' rights to dignity, privacy, independence, rehabilitation and their choice about the risks they are prepared to take. **A ward where no patient falls is likely to be a ward where no patient can regain their independence and return home.** This does not stop the Trust from wanting to provide the best quality and safest care for our patients.

There has been a changing demand on community hospitals, with an ever increasing cohort of frail patients. There is a concerted effort to tackle these challenges whilst continuing to maintain patient safety. Ward staff continue to assess falls risk and manage patients who repeatedly fall using individualised care plans. We continue to investigate innovative and collaborative ways of working with other organisations to streamline resources.

What are we doing to make improvements?

Our focus has been on reablement and giving patients the confidence to move safely, which stops their muscles deconditioning (wasting) giving them strength to mobilise and not lose their balance. Loss of strength can make the difference between dependence and independence.

For patients who have acute confusion or delirium, evidence of frailty and are at risk of falling, we have implemented a delirium care plan and continence care plan to optimise these parts of their care. Delirium and continence are often major pre-cursors for falling.

Our key achievements

- ✓ Supporting patients to help themselves so that they do not lose confidence in mobilising.
- ✓ Launched an enhanced reablement training programme for all nursing, therapy and support staff, with 2-3 reablement champions on each ward. Led by therapists, the training helps staff to recognise those patients most likely to fall.
- ✓ Launch of 'Get up and Go' initiative (see page 43).
- ✓ Participation in the national #EndPJparalysis campaign
- ✓ Launch of the Short Term Assessment, Reablement and Rehabilitation (STARR) Centre at Bluebird Lodge community hospital. The facility helps patients who are not safe to return home immediately after a stay in hospital to go back to their own homes within two weeks, thanks to a course of intensive rehabilitation and reablement. Patients will be able to plan their recovery while being helped by staff with everyday tasks such as walking, dressing and cooking to help them regain their independence and increase their strength.

Chart 4 – Our performance over the last three years: Falls per 1,000 bed days

Patient safety

Prevention of patient falls

- ✓ Participated as one of 20 Trusts invited to be part of an East of England 100 day challenge to get all of our appropriate patients up and dressed on the wards to promote their independence and prevent deconditioning. We accepted the challenge as it links with our Get Up and Go campaign and the reablement training programme. In 100 days, the 20 trusts together aimed to get 100,000 patient days where patients are up, dressed and moving in their own clothes, rather than wearing hospitals gowns or pyjamas.
- ✓ Implemented the continence assessment and the delirium care plan.
- ✓ Reducing our length of stay where possible for frail patients, who are the group of patients most likely to fall, to attempt to keep patients independent.

The "Get Up and Go" initiative reminds staff of the importance of keeping all patients, especially those who are frail and elderly, active so they do not lose strength, balance and mobility. By doing so, they can retain a good quality of life and live as independently as possible after discharge from hospital.

Evidence shows spending 10 days in a hospital bed causes the equivalent of 10 years' ageing in the muscles of people aged 80 and over. In addition, prolonged bed rest can also lead to depression, reduced appetite, urinary tract infections, incontinence, confusion and pressure ulcers.

Penny Cason, professional lead occupational therapist, said: "This campaign reminds our staff to keep life as normal as possible for patients by empowering them to get up, get dressed and carry on with as many of their usual activities as they can. By doing so, they will reduce the risk of developing pressure ulcers and other complications while also retaining the strength in their muscles so that they can return home and be as independent as possible.

"Hospitals across the country tend to inadvertently over-prescribe care by bringing everything to the patient's bedside and not encouraging them to be active. Although we may think we are being helpful, this can actually have a negative impact and could mean they cannot fulfil as many activities as they did before their admission when they do return home.

"Where clinically possible, we want every single patient to stay as close to their usual routine as they can by getting up and dressed, staying hydrated, eating their meals in a chair and walking to the toilet so that they can enjoy a good quality of life when they are discharged."

Staff training is taking place, while a patient booklet is also being produced which includes exercises people can do in their chairs as well as space to note down their daily goals, such as walking to the toilet.

A variety of initiatives are already in place at the hospital to encourage activity, such as static cycles on Lavenham ward to reduce the risk of muscle wastage.

Commendation winner

Senior occupational therapist Clare Cunnell

Patients who spend a week in bed will lose 10% of their strength. Team leader Clare has been instrumental in the hospital's 'Get Up and Go' campaign which focuses on getting patients out of bed, dressed and active so they do not lose strength, balance and mobility. Clare is on a mission to make sure as many staff as possible get specialist training, showing a real passion for patient care.

Clinical effectiveness
Emergency care

Waiting a long time for treatment may impact on clinical outcomes and does not result in a good patient experience.

Since 2002, the measure for successful and timely treatment of patients who need emergency care has been the 4 hour target. This can only be achieved if Emergency Department (ED) capacity matches demand; beds and length of stay are sufficient; and patients are not delayed leaving hospital when they no longer need acute hospital care. Achievement of this standard is a barometer for how the hospital is functioning across all services.

National achievement of this target has consistently fallen below 95% since 2012. The NHS in England has been set a target to again achieve 95% by March 2018. It is recognised that the whole system needs to be well resourced and organised to achieve safe and timely care for our patients. These same national pressures are felt in Ipswich Hospital, and since 2016 achievement of this standard has fallen below 95%.

To address this, a number of changes have been made to improve our processes so that we can once again achieve this target. These changes have started to improve care for patients in ED, elsewhere in the hospital and in the local community, helping patients to avoid or delay the need for acute care.

This work is reported through the Emergency Care Programme Board Integrated Care Network who coordinate the actions needed to make improvements. Those involved in this work include Ipswich Hospital, Ipswich & East Suffolk CCG, Adult Community Services, Norfolk & Suffolk NHS Foundation Trust, East of England Ambulance Service and voluntary groups.

In February, a new handover procedure was introduced in the region's hospitals to help ambulance crews hand over patients within 15 minutes, enabling the crews to be available for new emergency calls as quickly as possible, without putting patient safety at risk.

Chart 5 – Our performance over the last three years: 4 hours to discharge from Emergency Department

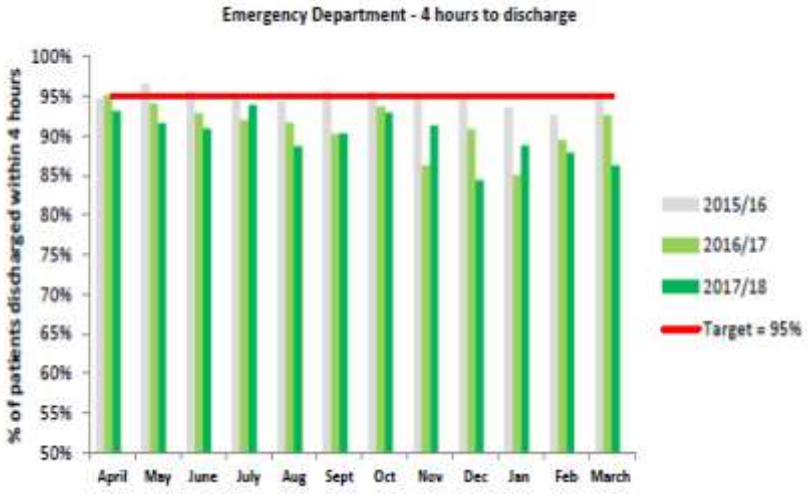
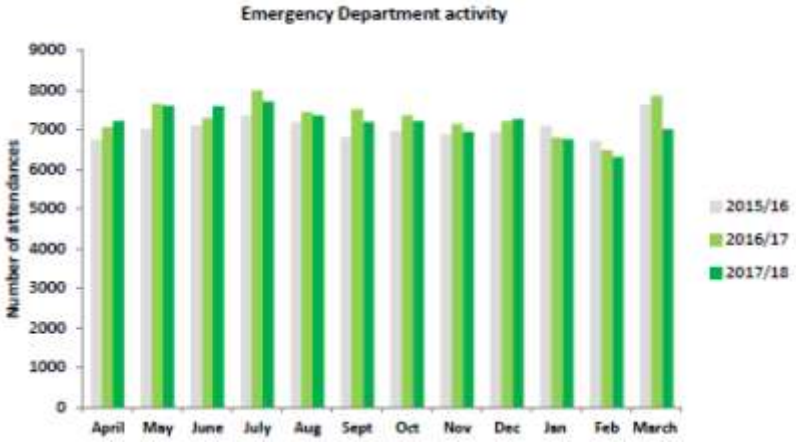


Chart 6 – Our performance over the last three years: Emergency Department activity



At Ipswich, we increased the number of trolleys in ED and created more triage areas. There are also new screens to be able to divide bigger bays when necessary. A 'Fit to Sit' area has been created for patients who do not need to be lying down. The 'Majors' area has 24/7 reception cover and a dedicated handover nurse in place to cover peak times.

Elsewhere in the hospital, teams have increased capacity for direct referrals from GPs to specialty teams in an attempt to avoid ED being used for inappropriate attendances where the patients should be going straight to specialty clinics.

Clinical effectiveness
Summary Hospital-level Mortality Indicator (SHMI)

What is SHMI?

The Summary Hospital-level Mortality Indicator is a ratio of the observed number of deaths to the expected number of deaths for a trust. The SHMI differs from some other measures of mortality by including both in-hospital deaths and deaths of patients occurring within 30 days of discharge from hospital.

Why is SHMI important?

We need to know what our ratio of actual deaths against expected deaths is, in order to assess and measure how good the care and treatment is.

How does SHMI work?

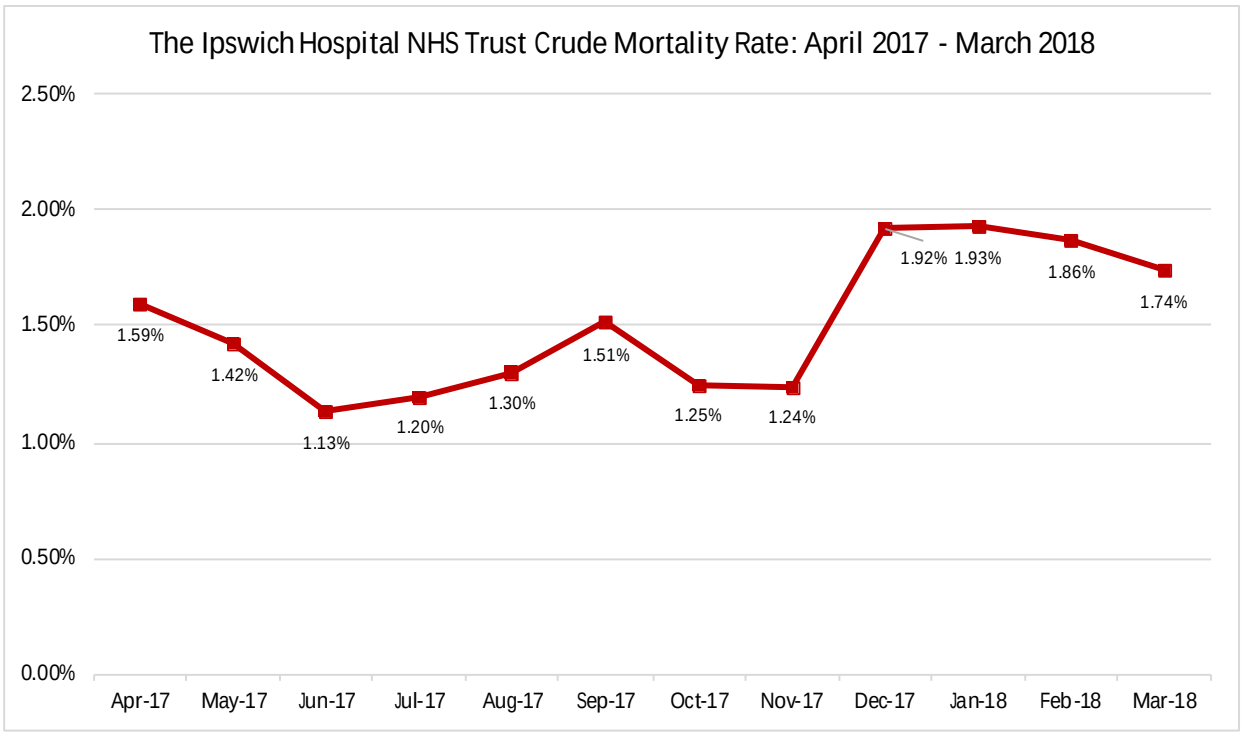
SHMI, like the HSMR, is a ratio of the observed number of deaths to the expected number of deaths. The calculation is the total number of patient admissions to hospital which result in a death either in-hospital or within 30 days of discharge. Like all mortality indicators, the SHMI shows whether the number of deaths linked to a particular hospital is more or less than expected, and whether that difference is statistically significant.

What is HSMR?

The Hospital Standardised Mortality Ratio is the ratio of observed deaths to expected deaths for a basket of 56 diagnosis groups, which represent approximately 80% of in-hospital deaths.

Chart 7 - Crude mortality: March 2017 - March 2018

Crude mortality continues to show an expected seasonal variation with winter months higher than the summer in line with the national picture. The crude mortality rate continues to remain one of the lowest in the region. For more information about our performance with regard to SHMI, please see the SHMI Core Quality Indicator on page 28.



Clinical effectiveness

Summary Hospital-level Mortality Indicator (SHMI)

The monitoring of in-hospital and post-discharge mortality is a key component of safe and effective health care. By using a range of indicators, the Trust can be assured there are no significant areas of unexpectedly high mortality and continue to provide care to a high standard.

The Mortality Review Group has overseen the establishment of the national mortality review programme as laid out by NHS England.

The Mortality Review Group meets every month to review the mortality statistics and oversee the review of patient deaths.

HSMR analysis: Rolling 12 months (December 2016 - November 2017)

The Trust's HSMR is 111.6 and is within the 'higher than expected' range.

Other gastrointestinal disorders
This is a varied group of patients and flagged as a risk in January, May and June 2017. On review of a sample of these cases, this was a very heterogeneous group with no thematic learning. Due to the nature of data, this will continue to flag until June 2018.

Acute cerebro-vascular accident
Flagged in April and July 2017. Our relative risk remains higher than expected as does our long term crude mortality rate. Prospective review of these patients has been commenced.

Table 3 - Results summary for December 2016 - November 2017

In-hospital mortality, for all in-patient admissions to The Ipswich Hospital NHS Trust for the period December 2016 - November 2017 has been reviewed. The SHMI is updated and rebased quarterly.

Metric	Result
HSMR	111.6 'higher than expected' range.
HSMR position vs. East of England peers	The Trust is 1 of 5 within the peer group of 16 that sit within the 'higher than expected' range.
HSMR outlying groups	Other gastrointestinal disorders Acute cerebro-vascular accident Fractured Neck of femur Pneumonia
HSMR Weekday/ Weekend Analysis	There is now a significant difference between the weekday and weekend HSMR for emergency admissions. Weekday admissions are no longer 'higher than expected'.
SHMI (July 2016 to June 2017)	102.01 'as expected' (band 2).

Fractured Neck of femur
Flagged in January and again in October 2017. Overall mortality rate remains within expected limits. Prospective review of a sample group of these patients has been commenced.

Pneumonia
Rolling 12 month relative risk remains higher than expected. A sample of these cases has been reviewed with further ongoing prospective review occurring. No significant thematic issues have been identified at present with the care of these patients being judged to be good. Issues within the coding of pneumonia have been identified which may go some way to identify the higher than expected mortality as reported by Dr Foster.

References

SHMI
The SHMI is like the HSMR, a ratio of the observed number of deaths to the expected number of deaths. However, this is only applied to non-specialist acute providers. The calculation is the total number of patient admissions to the hospital which resulted in a death either in-hospital or within 30 days post discharge. Like all mortality indicators, the SHMI shows whether the number of deaths linked to a particular hospital is more or less than expected, and whether that difference is statistically significant.

HSMR
The Hospital Standardised Mortality Ratio is the ratio of observed deaths to expected deaths for a basket of 56 diagnosis groups, which represent approximately 80% of in hospital deaths. It is a subset of all and represents about 35% of admitted patient activity.

Clinical effectiveness

Summary Hospital-level Mortality Indicator (SHMI)

Weekday vs Weekend mortality for emergency admissions

Weekday HSMR (Emergency Admissions) = **107.1** (99.9 - 114.6) 'as expected'

Weekend HSMR (Emergency Admissions) = **123.5** (110.9 - 137.1) 'higher than expected'

The difference between the two has led the Board to focus on development of an integrated 'hospital at night' service and to move towards meeting the NHS England key criteria for 7 day working in order to ensure safe and sustainable patient care at all times.

Chart 8 - Weekday vs Weekend admissions, emergency only

12 months rolling trend, December 2016 - November 2017

Weekday HSMR (Emergency Admissions) = **107.1** 'as expected'
Weekend HSMR (Emergency Admissions) = **123.5** 'higher than expected'

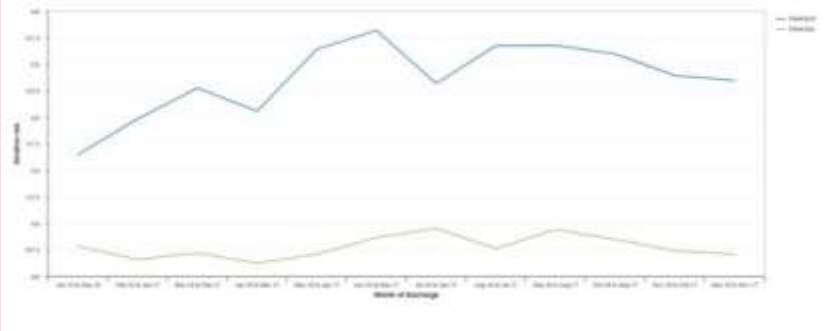
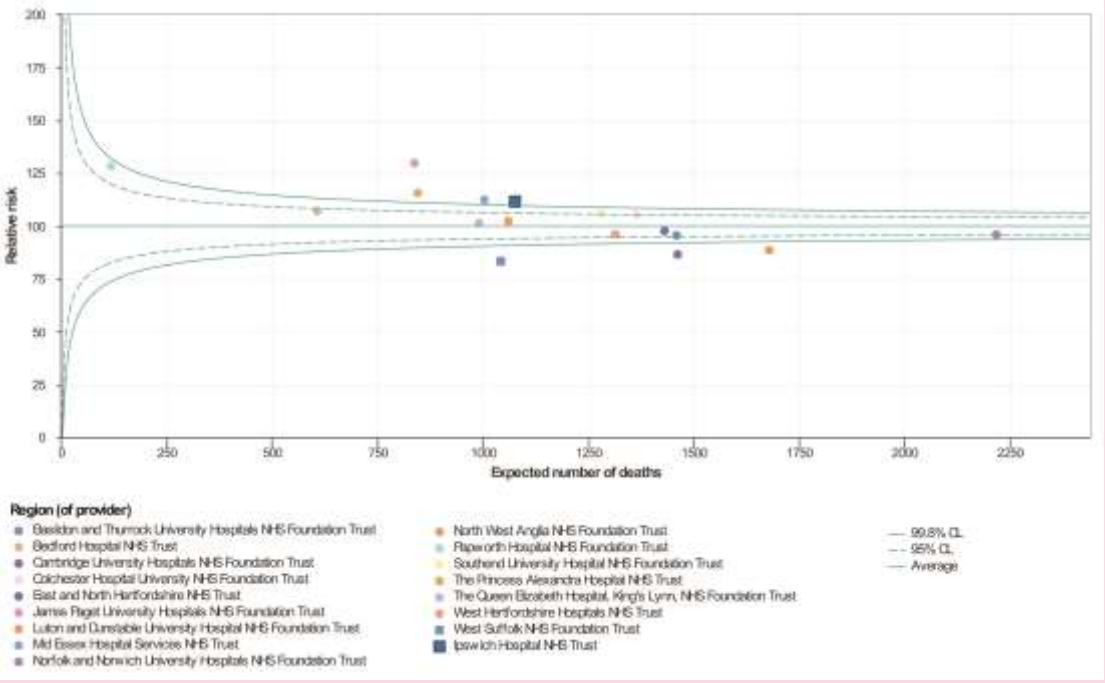


Chart 9 – HSMR peer comparison



Clinical effectiveness

Summary Hospital-level Mortality Indicator (SHMI): Review of hospital deaths

Review of Hospital deaths

The Ipswich Hospital NHS Trust is committed to ensuring robust processes are in place and working effectively, so that we continuously identify areas for improvement in the care and treatment we provide to our local population.

There is a trust-wide approach to the implementation of the national learning from deaths guidance, which is communicated and available to all staff. It sets out the procedures for identifying, recording, reviewing and investigating the deaths of people who die in hospital by providing a framework for clinical staff who participate in mortality reviews. The Trust supports those who have been bereaved by a death in hospital, and also how they should expect to be informed about and involved in any further action taken to review and/or investigate the death. The Trust also supports staff who may be affected by the death of someone in the Trust's care.

The Mortality Review Group has overseen the establishment of the national mortality review programme as laid out by NHS England. The Group meets monthly to review the mortality statistics and oversee the review of patient deaths.

The monitoring of in-hospital mortality is a key component of safe and effective health care. By using a range of indicators, the Trust can be assured there are no significant areas of unexpectedly high mortality and continue to provide care to a high standard. The Trust's Learning from Deaths policy sets out how the Trust will learn from the care provided to patients who die, as part of its work to continually improve the quality of care it provides to all its patients.

Key findings from mortality reviews

The mortality reviews have overall demonstrated high levels of care in all groups of patients.

Whilst we continue to provide high quality care to patients at the end of their lives once in hospital, we are not recognising that some patients are in the last weeks and months of life, and are appropriate for palliative care prior to the point of acute admission to hospital, often out of hours. We should be more proactive in having discussions with patients and their families/carers in regards to the extent of treatment and escalation of care including DNACPR decisions. Our palliative care coding rates are now in line with the national average.

The reviews have shown a very low number of deaths that have been felt to have been preventable due to care. This may well be a reflection of the low crude rate of mortality within the trust. Reviews have highlighted the need for earlier recognition of patients who are dying and the need for palliative care, along with discussions around DNACPR. Significant efforts have been made to improve the awareness of and need for specialist palliative care. This has seen our rates palliative care increase from 2.5% in 2016/17 to 4.1% in 2017/18 to now be in line with the national average.

Coding of the admitting diagnosis has sometimes reflected the symptoms rather than the overall diagnosis, leading to sometimes spurious results in mortality data such as data from Dr Foster.

What we are doing to make improvements

- Feedback to clinical groups through the Mortality Review Group and the Learning from Deaths/Mortality and Morbidity meetings to highlight the need for proactive referral and involvement with the palliative care team.
- Divisional reports from Learning from Deaths two-monthly meetings to the Mortality Review Group and Clinical Audit and Effectiveness Committee, with identification of departmental and corporate areas for system improvement. These will link with quality improvement projects wherever necessary.
- We have already seen a significant improvement in palliative care referral rates, which are now in line with the national average.
- The importance of discussing with patients and their families the escalation of care, treatment options and DNACPR continues to be fed back to clinical teams.
- We now have clinical involvement in coding of treatment and diagnosis, and improvement in documentation which now allows the diagnosis on admission to be reconfirmed 48 hours after admission and also retrospectively as part of the mortality review process, all with approval of the coding auditors. This will improve the quality and accuracy of our coding, enabling us to be more confident in how we are performing with different patient groups.
- We continue to increase consultant engagement into the use and meaning of mortality data, which helps to guide ongoing quality improvement in services.

Please note: During 2017/18 the method and process of mortality review substantially changed at the end of Q2 to bring the process in line with the National Learning from Deaths Framework. During Q1 and Q2, all reviewed patients had a notes review with the reviewer indicating whether they believed the death was more likely than not due to problems in care. If so, there was a more detailed second review if the patient's care was not already subject to a serious incident investigation (to avoid duplication of the case review). From Q3 the initial reviewing clinician was no longer asked to rate care, but only to allocate cases for review as laid out in the learning from deaths policy, which required a SJR. Hence the significant change in number of reviews between Q1/ Q2 and Q3/Q4.

	Number of deaths	Case note review including screening review	Investigation or Structured Judgement Review (SJR)	Case note review and investigation	% of deaths judged to be more likely than not to have been due to problems in the care provided.
Q1	338	258	2	258	0.8%
Q2	318	187	1	187	0%
Q3	363	302	28	302	0.2%
Q4	449	189	10	189	0%
Total	1,468	936	41	936	1%

Patient experience
Improving the patient and carer experience

Key achievements

- ✓ Expansion of 'Kissing it Better' activities.
- ✓ Transformation of an additional two wards, Brantham and Stradbroke, into dementia-friendly wards.
- ✓ Launch of the Learning Disability Action Group.
- ✓ Launch of the Liver Disease Action Group.
- ✓ Pam Talman, Patient Experience Coordinator, was 'Highly Commended' for the 'Living the Values' #TeamIpswich staff award.
- ✓ Publication of the Baby Guide, which is available for all parents-to-be.
- ✓ Joined the Patient Experience Collaborative, working with colleagues from Northumbria Healthcare NHS Foundation Trust, and the Patient Experience Network to drive forward improvements in data analysis.
- ✓ Finalists in the PENNA awards.
- ✓ Critical Care ran a second service user engagement event.
- ✓ Changing Places toilet in the main Outpatient Department to give people with multiple learning and physical disabilities, such as spinal injuries, muscular dystrophy and multiple sclerosis, the extra space and equipment they need to ensure their safety and comfort. It includes a hoist, adult-sized changing table and shower, along with space for both the individual and their carer.

Follow up clinics for Critical Care patients

A follow-up clinic to help former Critical Care patients with their recovery was launched at our hospital this year.

The Critical Care Follow-up Clinic offers patients who were on a ventilator in Critical Care for more than four days, appointments at two, six and 12 months after their discharge. Patients can experience any of a number of symptoms following their stay on the Critical Care Unit (CCU), including post-traumatic stress disorder, mobility issues, or problems eating or sleeping.

The first monthly clinic was held in September and patient Valerie Pitchers was the first patient to attend. Each clinic is run by a Critical Care consultant and an outreach nurse. GPs can also refer appropriate patients to the clinic.

Critical Care lead nurse Roz Yale, said: "We are very excited about the launch of the new Critical Care Follow-up Clinic and this valuable opportunity to meet our patients again and improve their journey of recovery.

"The transition for the patient from CCU to a ward and then, from a ward to home, can be underestimated. It can be very challenging for them emotionally and psychologically and this service is helpful on their road to recovery. The clinic can also be very helpful to family members and people close to the patient."

National Institute of Health and Care Excellence (NICE) guidelines recommend that CCU patients should be offered such a service and was highlighted at a service user feedback session.

Back row: Nikki Benmore (Critical Care Outreach team practice educator), Roz Yale (lead nurse, Critical Care).

Front row: Lynn Bolton (radiographer and Valerie Pitchers' daughter), Valerie Pitchers, Dr Paul Carroll (consultant intensivist).

Patient experience
Improving the patient and carer experience

Patient Experience Network National Awards (PENNA)

The Trust was again a finalist in three award categories:

Measuring, Reporting and Acting

- Lavenham Ward Supporting Family Carers & Frailty Initiative

Support for Caregivers, Friends and Family

- Lavenham Ward Supporting Family Carers & Frailty Initiative

The Trust has created a holistic frailty-focussed culture with an emphasis on the identification and support of family carers as central to supporting patients; especially around a sustainable discharge. Led by nursing teams on Lavenham (an acute surgical ward) this is the first initiative of its kind nationally. Ward Sisters have striven for ambitious results. All areas of the multidisciplinary team are involved and actively encouraged for their opinion and ideas for innovation. Work to clearly identify initial focus areas enabled a decrease in length of stay for patients; improved satisfaction from patients and carers - better informed, involved, motivated to be mobile and less likely to suffer deconditioning. The ward sisters, ward team and Frail older person nurse consultant are motivated and enthusiastic to strive for excellence, ensuring that all initiatives are achievable and sustainable not only on Lavenham but across the Trust.

The results have been regionally and nationally recognised for the nurse-led approach on a surgical ward, as opposed to a care of the elderly ward.

Strengthening the Foundation

- Involving patient leaders in human factors training

The initiative is believed to be the first in the country to utilise a patient/staff collaborative approach to human factors training. The simulation suite manager and the IHUG Chair have built a solid and trusting understanding which has enabled them to lead the different aspects of the training. The success of the project has been tangible, demonstrated by the feedback from participants who appreciated the value of 'real' patient participation, as well as patient feedback measures indicating improvements on the wards. The training aimed to provide a sustainable change of behaviour on the wards and in the participants.

IHUG identified that they, as patient leaders, would have a unique contribution to make to staff training by utilising their 'expert by experience' insights. By working collaboratively with IHUG as actors for the scenarios planned for the sessions, they thought the impact of 'real' patients/relatives might be increased for those staff attending the training. IHUG members gave unbiased feedback as to how they had felt during the sessions. This is something unable to be captured by other means.

During the training, staff were able to see the IHUG members as real relatives and patients, making the impact of the learning far more significant, and comments such as "Now I understand" and "I had never considered relatives as a resource before" were made.

The biggest impact was unexpected, with one staff member discovering through IHUG feedback that in stressful situations such as resuscitation, relatives' overwhelming desire was to stay in the room and quietly observe what was happening to their loved one, whereas the instinct of staff was to remove the relative, believing this was kinder. IHUG feedback clearly showed relatives' stress levels were far higher when they were taken away and imagining the worst. Involving IHUG literally changed the thought process of staff. At the end of the courses, there was a statistically significant sustained improvement from the patient's perspective. There was also huge personal benefit reported by IHUG members, as they were also learning.

Before, during, immediately after and again six weeks after the course, staff and IHUG members were sent questionnaires to identify if the impact of the course could be seen on the wards. Staff reported improvements in their recognition of the concepts, of how patients/carers felt and improved team sense.

#TeamIpswich finalists at the PENNA awards (Left to Right)
Lavenham ward and Suffolk Family Carers workers supporting family carers, and IHUG and Simulation Suite collaboration

Patient experience
Improving the patient and carer experience

Kissing it Better (KiB)

Kissing it Better is recognised nationally and their vision of constantly exceeding a patient's expectation of their care environment - simple ideas, small acts of kindness, harnessing the energy and goodwill of the community, mirrors the Trust's own values.

The aim is to provide a range of compassionate caring services over and above traditional healthcare. For example; music, art, theatre, reminiscence, social visiting, hairdressing, manicures, make-up etc. The services are provided in partnership with organisations such as local colleges, charities and societies. Kissing it Better allows the Trust to create a programme which sets it apart from others - with a focus on the patient as a person and the hospital being truly a part of the community.

All students conduct themselves with charm, grace and dignity. Patients respond and, time and again we see patients that had looked withdrawn, open up in their company. The students not only provide a treatment but also a welcome distraction from other worries, and it is a confidence boost for the students, many of whom are nervous about working in a hospital. Students are always accompanied by their tutors and hospital staff.

- **Better patient experience**
  Addresses patient needs, including emotional needs, in a holistic way, and responds to patient feedback that it is the small things which matter and make a difference. Visitors and family carers can also take part.
- **Better staff experience**
  Improves staff morale by enabling staff to do something with and alongside patients over and above the traditional healthcare interaction which facilitates a shared experience; enhancing empathy and compassion.
- **Better quality of care**
  Enhances the whole patient experience.
- **Partnerships**
  Mobilising students from colleges and universities to bring in their skills to benefit patients, providing professional development alongside kind, compassionate care; and increasing joint working with community partners such as the Co-op and Suffolk Artlink.

Who has been involved this year?

- ✓ Suffolk New College beauty therapy students visit to provide hand massage and manicures.
- ✓ Ipswich High School drama and music students sing, act and read poetry.
- ✓ Ipswich Hospital Community Choir take part in supportive singing on the wards. #suppertimesinging
- ✓ Suffolk New College hairdressing students visit to provide hair treatments.
- ✓ Stowupland High School students visit wards to chat and reminisce.
- ✓ Applied Science students visit wards to chat and reminisce.

Kissing it Better






Patient experience
Improving the patient and carer experience

Carers Week

Carers Week is an annual campaign held in June to raise awareness of caring, highlight the challenges carers face, and recognise the contribution they make to families and communities throughout the UK. The campaign is brought to life by thousands of individuals and organisations who come together to organise activities and events throughout the UK, drawing attention to just how important caring is.

The Trust is committed to ensuring a partnership approach to working with family carers is adopted, in which the family carer's role, expertise and understanding of the patient's needs are recognised and taken into account when planning the patient's care, treatment and discharge. The Trust also recognises the needs of family carers to access support, advice and information.

Music around the hospital!
ActivLives' Keep on Rockin' choir singing outside the Carers Cabin (above), and PopChorus performing in our South Wards reception area (below), both during Carers Week

Support for carers

Debbie Reeve and Mandy King are support workers employed by local charity Suffolk Family Carers (SFC) but are based at Ipswich Hospital. They walk the wards each day in search of family carers or patients themselves who may be family carers, who might need help. Their message is "Don't struggle alone." Debbie and Mandy provide awareness raising and education opportunities for staff both 1:1 and on the wards.

SFC also provided a young carers information stand along with a visit from their bus for Carers' Rights Day in November 2017 and for Young Carers Day in January 2018.

497 family carers have been supported directly by Debbie and Mandy during the year.

708 people have visited the Carers Cabin over the year.

Number of family carers supported	
Q1	128
Q2	107
Q3	172
Q4	90

Mandy and Debbie provide support and information to family carers as needed.

Family Carer Support - case study

Suffolk Family Carers Support Worker Debbie supported Janet (not her real name) who is a family carer and was due to be admitted to Ipswich Hospital for a planned procedure. She was very concerned about her partner whom she cares for; how would they cope whilst she was in hospital? The partner was over 85 and experiencing short term memory loss and was at risk of falling.

Debbie worked with the multi-disciplinary team including the nurse specialist to create a plan of care with emergency planning if needed. She ensured the ward was aware that the patient is also a family carer and worried about her partner. Debbie visited the ward when Janet was in to provide reassurance and additional support. Plans were put in place to have neighbours go in and help the partner, and the Crisis Action Team and community healthcare team telephone numbers were given to the nurse specialist in case of an emergency with Janet's partner while she was in hospital. A referral was made to the Red Cross for assistance with shopping on discharge from hospital.

Outcome/impact
Planning prior admission with the assistance of the nurse specialist assisted in a smooth transition, enabling Janet to feel reassured and less anxious about her partner, also knowing that in an emergency situation a plan had been put in place for her partner. The ward was also able to ensure that Janet met all her goals before discharge. Janet said she felt extremely reassured about her partner and was able to concentrate on her recovery after her operation.

Patient experience
Caring for people with dementia

Helping Aldeburgh patients reminisce

Aldeburgh Community Hospital has a new interactive touch screen system - packed full of old movies, TV programmes and songs, as well as activities, games such as bingo and exercise routines - aimed at improving the experience of their older patients, including those with dementia. Purchased for £6,000 by the Aldeburgh League of Friends, the digital reminiscence therapy system can reduce a patient's stress levels and, as a result, can reduce the number of falls they have.

Dementia-friendly environment

Stradbroke ward, specialising in gastroenterology, and Brantham ward (medical admissions ward) were refurbished to dementia-friendly standards in the autumn with money from a £1.5m legacy left to the hospital by former patient Peter Gibbons. These wards were chosen as patients with a dementia are admitted to any of our wards according to their clinical need. As part of the project, social areas and calming artwork were added, lighting was improved, bed areas were decluttered and pictorial signs and colour-coded walls were introduced to help patients find their way.

The emergency medical assessment unit adjacent to Brantham ward was also refurbished to create a dementia-friendly environment. Additional building work took place to reconfigure the entire area to create an environment focussed on the needs of the patient. The work carried out included a new entrance from the Emergency Department to reduce the footfall through the ward area enabling the ward to remain calm; a new ambulance entrance for patients who require emergency medical assessment; and provision of additional fully equipped seated assessment areas, designed around patient and carer needs.

Sensory garden for Aldeburgh Community Hospital

The garden includes an exercise area, pavilion, a listening bench designed to stimulate conversation and interaction amongst patients with dementia, and scented, textured and edible plants.

The Aldeburgh League of Friends-funded project has cost over £30,000 and is designed to be an outdoor extension of the hospital's facilities to aid rehabilitation and recuperation of patients and as a resource for the community. It has been transformed into a place to be enjoyed by all, but also offers areas of privacy for solace and stimulation.

One of the garden's main features is a horseshoe-shaped listening seat which has statements and questions designed to spark conversation.

Research indicates that patients who can enjoy green spaces recover more quickly and can return home more rapidly. They also need less pain relief during their recovery. Michelle Fletcher, Aldeburgh Community Hospital matron, said: "This project has been three years in the making and has finally come to fruition."

Pictured above, from left, landscape gardener Tony Crisp, matron Michelle Fletcher and League of Friends volunteer Anne Parsons.

Patient experience
Caring for people with a learning disability

Learning Disability Liaison Nurse
Research suggests that people with learning disabilities often have specialist requirements when attending hospital. Ipswich Hospital employs a full-time learning disability liaison nurse to assist people with learning disabilities or autism who visit the hospital. The learning disability liaison nurse works directly with family carers and hospital staff to improve the experience of being in hospital.

Staff Training
The learning disability liaison nurse trains all Trust staff how to effectively work and care for people with learning disabilities. All staff receive mandatory learning disability training and more in-depth training is available where requested. Training includes autism, profound and multiple learning disabilities, mental health, and communication training.

Reasonable Adjustments
Reasonable adjustments are changes to the work environment or working practices which allow people with disability to be safely cared for. Under the Equality Act (2010) staff will assess the individual reasonable adjustments required for all inpatients with a learning disability and use this assessment to inform the care each the patient receives.

All practicable reasonable adjustments that can be made to facilitate a good stay for a person will be taken.

Familiar carers
It is sometimes possible for a patient with complex needs to be funded for a familiar carer to be present during the hospital stay to have the assistance they require. Support from known carers can be of benefit to a patient with a learning disability as it is a 'familiar face' in unfamiliar surroundings.

Individualised care pathways
All patients with complex medical requirements and learning disabilities are given bespoke day plans for their procedure or visit to ensure a smooth multidisciplinary approach for the patient. The plans are produced in collaboration with the patient, their family carers, doctors, GP and community staff.

Accessible information
The Accessible Information Standard was introduced by the government in 2016 to ensure people with a disability or sensory loss receive information in a way they can understand.

Ipswich Hospital is committed to giving information to people with a learning disability in a way they understand. Where requested, all information can be simplified to meet individual requirements.

"The professional approach and collaborative working from your team was outstanding."
(Care Agency 2017)

"The competency of your team was inspiring. The work you do is so very important for people with learning disabilities, and work with such dedication and expertise."
(Family member 2017)

"From start to finish an absolute success, and from our perspective best practice at its absolute best. Perhaps your example is something others could learn from in developing practices that enhance the quality of care offered to people with learning disabilities and other groups"
(Family member 2017)

The learning disability action group (LDAG) consists of people with learning disabilities or autism who use the hospital. LDAG meets regularly to consult on how the hospital can improve services. A user group for parents and carers met for the first time in March 2018. The group has a Chairperson who feeds back to IHUG.

Roger Blake, learning disability liaison nurse, pictured with LDAG members at a recent meeting.

Patient experience
Patient Experience Collaborative

Patient Experience Collaborative

What is the Collaborative?
12 trusts across the UK have come together to work with Northumbria Healthcare NHS Foundation Trust and the Patient Experience Network (PEN) for 12 months to trial the use of the Northumbria model for gathering patient experience feedback and applying quality improvement ideas and methodology.

The focus of the collaborative is to identify, develop, share and embed ideas and processes for improving patient experience, sustaining that improvement and providing a measurement framework to evidence improvement.

What is the Northumbria Model?
Real time surveying of at least 50% of patients on a ward using a set survey covering key aspects of care and experience which are considered to have the strongest relationship to patients' overall satisfaction (Picker Institute 2009).

The following are recognised as the priority areas for assessing patient experience of acute hospital inpatient care:

- Consistency and coordination of care;
- Treatment with respect and dignity;
- Involvement in decisions;
- Doctors;
- Nurses;
- Cleanliness; and
- Pain control.

Surveys, covering these areas are undertaken and reported on as close to real time as possible enabling immediate action to improve. This is then monitored over time to map and show the improvements.

How are Ipswich and Colchester hospitals involved?
Working as one overall team from both Ipswich and Colchester hospitals, six core team members have been identified to take the project forward on both sites, which will involve eight patient wards and departments across the sites.

The core team members will attend five learning events during the year and there will be a real time measurement uploaded twice a month giving robust evidence on impact and change.

The core team will have additional membership to create a 'steering group' to guide and support the programme, including the wider multidisciplinary team

In addition several data collectors have been identified to undertake the surveys, upload and share the data with the wards/steering group. The Northumbria team visited both sites in November 2017 to train the data collectors and core team in the methodology, with the first data being collected the same month.

Wards:
Ipswich Hospital
Martlesham
Needham
Saxmundham
(all trauma & orthopaedic wards)

Colchester Hospital
Aldham (Orthopaedics)
Brightlingsea (ENT, General Surgery)
Layer Marney (General Medicine)

Patient experience
Measuring and reporting the patient experience

National Patient Surveys

Patients are asked to answer questions about different aspects of their care and treatment. Based on their responses, each NHS trust is given a score out of 10 for each question (the higher the score the better). The question scores presented here have been rounded up or down to a whole number. There is no single overall rating for each NHS trust. This would be misleading as the survey assesses a number of different aspects of people's experiences (such as care received from doctors and nurses, tests, views on the hospital environment eg cleanliness) and performance varies across these different aspects.

Each trust also receives a rating of 'Above', 'Average' or 'Below'.

- Above (Better): the trust is better for that particular question than most other trusts that took part in the survey.
- Average (About the same): the trust is performing about the same for that particular question as most other trusts that took part in the survey.
- Below (Worse): the trust did not perform as well for that particular question as most other trusts that took part in the survey.

National Inpatient Survey

The results from the CQC survey of inpatient experiences of acute trusts 2017 were published on 13 June 2018.

This survey looked at the experiences of 72,778 people who received care at an NHS hospital in July 2017.

Between August 2017 and January 2018, a questionnaire was sent to 1,250 recent inpatients at each trust. Responses were received from 543 patients at The Ipswich Hospital NHS Trust. The national response rate was 41%.

Table 4 - Based on patients' responses to the Care Quality Commission's National Inpatient Survey, this is how Ipswich Hospital compared with other Trusts

The Emergency/A&E Department (answered by emergency patients only)	8.7 / 10	WORSE ABOUT THE SAME BETTER
Waiting lists and planned admissions (answered by patients referred to hospital)	8.7 / 10	WORSE ABOUT THE SAME BETTER
Waiting to get to a bed on a ward	7.6 / 10	WORSE ABOUT THE SAME BETTER
The hospital and ward	7.8 / 10	WORSE ABOUT THE SAME BETTER
Doctors	8.6 / 10	WORSE ABOUT THE SAME BETTER
Nurses	7.7 / 10	WORSE ABOUT THE SAME BETTER
Care and treatment	7.9 / 10	WORSE ABOUT THE SAME BETTER
Operations and procedures (answered by patients who had an operation or procedure)	8.3 / 10	WORSE ABOUT THE SAME BETTER
Leaving hospital	7.1 / 10	WORSE ABOUT THE SAME BETTER
Overall views of care and services	4.7 / 10	WORSE ABOUT THE SAME BETTER
Overall experience	8.0 / 10	WORSE ABOUT THE SAME BETTER

People were eligible for the survey if they were aged 16 years or older, had at least one overnight stay in hospital as an NHS patient, and were not admitted to maternity or psychiatric units.

The National Inpatient Survey 2017 results for Ipswich Hospital show the hospital as being About the same as all other hospitals overall.

The full report can be found at www.cqc.org.uk/provider/RGQ/surveys

Patient experience
Measuring and reporting the patient experience

National Emergency Department Survey

The results from the CQC survey of Emergency Department experiences of acute trusts 2017 were published on 17 October 2017.

The survey sought the views of more than 45,000 people aged 16 years and older who attended emergency and urgent care departments at 137 acute and specialist NHS trusts during September 2016. The questionnaire was sent to 1,250 people who had used emergency department services at Ipswich Hospital, with responses received from 424 people.

The following patients were excluded from the survey: anyone who had a planned attendance at an outpatient clinic run within the emergency department (such as a fracture clinic); patients attending primarily to obtain contraception (for example, the morning after pill), patients who suffered a miscarriage or another form of abortive pregnancy outcome while at the hospital, and patients with a concealed pregnancy.

Nationally, the survey findings show that 75% of people who had attended a major consultant-led accident and emergency department said they 'definitely' had confidence and trust in the doctors and nurses treating them; 78% felt they were treated with respect and dignity 'all of the time', and that they 'definitely' had enough time to discuss their medical problem with staff (73%). However, nationwide, responses to questions about waiting times, access to pain relief and discharge arrangements were less positive.

The results for Ipswich Hospital show the hospital as being 'about the same' as all other hospitals overall. The full report can be found at www.cqc.org.uk/provider/RGQ/surveys

Table 5 - Based on patients' responses to the Care Quality Commission's National Emergency Department Survey, this is how Ipswich Hospital compared with other Trusts

Arrival at the emergency department	8.0 / 10	WORSE ABOUT THE SAME BETTER
Waiting times	5.8 / 10	WORSE ABOUT THE SAME BETTER
Doctors and nurses (answered by all those who saw a doctor or nurse)	8.5 / 10	WORSE ABOUT THE SAME BETTER
Care and treatment	8.2 / 10	WORSE ABOUT THE SAME BETTER
Tests (answered by those who had tests only)	8.5 / 10	WORSE ABOUT THE SAME BETTER
Hospital environment and facilities	8.6 / 10	WORSE ABOUT THE SAME BETTER
Leaving the emergency department (answered by those who went home or went to stay with a friend or relative or went to stay somewhere else)	6.8 / 10	WORSE ABOUT THE SAME BETTER
Respect and dignity	9.0 / 10	WORSE ABOUT THE SAME BETTER
Experience overall	8.1 / 10	WORSE ABOUT THE SAME BETTER

Actions to address the findings of the survey

- Waiting times are displayed in the waiting room, and are regularly updated by reception staff.
- New vending machines for snacks and drinks have been provided in the waiting area.
- Increased involvement by Red Cross volunteers, providing snacks and drinks for patients, and offering support to patients and their families as required.
- Additional touchscreens available in the Emergency Department to increase patient feedback of the service.
- Volunteers speak with patients to gain 'soft intelligence' on the service within the Emergency Department.

Patient experience

Measuring and reporting the patient experience

National Children and Young People's Survey

The results from the CQC survey of Children and Young People's experiences of acute trusts 2016 were published on 28 November 2017.

The survey looked at the experiences of 34,708 children and young people under the age of 16 who received inpatient or day case care during October, November and December 2016. Between February and June 2017, a questionnaire was sent to a maximum of 1,250 recent patients at Ipswich Hospital, with responses received from 283 patients.

Children and young people, and their parents and carers were asked to answer questions about different aspects of their care and treatment. Based on their responses, each NHS Trust has been given a score out of 10 for each question (the higher the score the better). Each trust also receives a rating of 'Better', 'About the same' or 'Worse'.

- Better: the trust is better for that particular question compared to most other trusts that took part in the survey.
- About the same: the trust is performing about the same for that particular question as most other trusts that took part in the survey.
- Worse: the trust did not perform as well for that particular question compared to most other trusts that took part in the survey.

Section scores not available: Where the number of answers received was too low (less than 30 respondents) the CQC does not report results. If results for children say 'Not applicable' this is because too few children answered the question.

Table 6 - Based on patients' responses to the Care Quality Commission's National Children and Young People's Survey, this is how Ipswich Hospital compared with other Trusts

Going to hospital	**No overall score available**	
Choice of admission date	3.3/10	About the same
Change of admission date	9.6/10	Better
The hospital ward	**No overall score available**	
Things to do	7.0/10	About the same
Food	6.5/10	About the same
Sleep	5.6/10	About the same
Privacy	9.1/10	About the same
Play	Not applicable	
Suitability of ward	6.7/10	Worse
Play for younger children	7.8/10	About the same
Enough things for younger children	8.5/10	About the same
Food for young children	5.9/10	About the same
Privacy for younger children	8.9/10	About the same
Type of ward stayed on	10/10	Better
Appropriate equipment or adaptions	9.0/10	About the same
Cleanliness	8.9/10	About the same
Hospital staff	**No overall score available**	
Speaking with staff	9.9/10	Better
Understanding what staff say	8.7/10	About the same
Able to ask questions	9.7/10	About the same
Questions being answered	9.7/10	About the same
Involvement	5.9/10	About the same
Support when worried	9.2/10	Better
Talking to a doctor or nurse alone	Not applicable	
Staff introducing themselves	8.8/10	About the same
Communicating with young children	7.9/10	About the same
Conflicting information	8.3/10	About the same
Parents and carers feeling listened to	8.9/10	About the same
Explanations parents and carers could understand	9.3/10	About the same
Keeping parents and carers informed	8.5/10	About the same
Parents and carers able to ask questions	9.1/10	About the same
Planning care	9.5/10	About the same
Parent and carer involvement	8.4/10	About the same
Information	9.0/10	About the same
Children's medical history	7.5/10	About the same
Individual or special needs	8.5/10	About the same
Help when needed	8.3/10	About the same
Staff working together	9.0/10	About the same
Confidence and trust	9.2/10	About the same

continued

Patient experience
Measuring and reporting the patient experience

The Trust did better than other organisations in a number of questions such as:

- Not changing the date of admission;
- Suitability of the ward environment;
- Availability of staff to speak with;
- Support from staff when worried;
- Use of distraction techniques during an operation or procedure;
- Availability of information for parents/carers after an operation or procedure;
- What to do in case of having further concerns abut your child;
- Advice on self care; and
- Information to take home following discharge from hospital.

Actions to address the findings of the survey

- Improve access to food for parents and guardians whilst their child is in hospital.
- Improve the facilities and suitability of the ward environment for older children who are transitioning between children's and adult services.

The full report can be found at www.cqc.org.uk/provider/RGQ/surveys

Facilities for parents and carers	**No overall score available**	
Access to hot drinks	8.5/10	About the same
Food preparation	4.0/10	About the same
Facilities for staying overnight	7.4/10	About the same
Pain management	**No overall score available**	
Pain management	9.2/10	About the same
Parent and carer's views on pain management	8.9/10	About the same
Operations and procedures	**No overall score available**	
Information before an operation or procedure	9.5/10	About the same
Information after an operation or procedure	8.5/10	About the same
Information for parents and carers before an operation or procedure	9.4/10	About the same
Answers to questions before an operation or procedure	9.5/10	About the same
Distracting a child during an operation or procedure	8.5/10	Better
Information for parents and carers after an operation or procedure	9.3/10	Better
Medicines	**No overall score available**	
Information about medicines	9.5/10	About the same
Leaving hospital	**No overall score available**	
What to do in case of further concerns	8.8/10	Better
Information about next steps	8.0/10	About the same
Advice on self care	9.1/10	Better
What to do if concerned about their child	8.9/10	About the same
Parents & carers being given information about next steps	8.2/10	About the same
Advice on caring for child	9.0/10	About the same
Information to take home	9.3/10	Better
Overall experience	**No overall score available**	
Friendliness	9.5/10	About the same
Being well looked after	9.3/10	About the same
Parents and carers feeling staff were friendly	9.2/10	About the same
Parents view of child being well looked after	9.3/10	About the same
Dignity and respect	9.2/10	About the same
Parent and carer being well looked after	8.5/10	About the same
Parents view of child's overall experience	8.8/10	About the same

Patient experience
Measuring and reporting the patient experience

National Maternity Survey

The results from the CQC survey of maternity experiences of acute trusts 2017 was published on 30 January 2018.

This survey looked at the experiences of 18,426 women who gave birth in February 2017.

During the summer of 2017, a questionnaire was sent to all women who gave birth in February 2017. Responses were received from 126 patients at The Ipswich Hospital NHS Trust.

Exclusions: women whose baby had died during or since delivery; women who had a stillbirth (including where it occurred during a multiple delivery); women who were in hospital or whose baby was in hospital at the time the sample was drawn; women who had a concealed pregnancy; women whose baby was taken into care (foster care or adopted); and women who gave birth in a maternity unit managed by another provider or in a private maternity unit or wing.

The full report can be found at www.cqc.org.uk/provider/RGQ/surveys

Survey results

Following the last national maternity survey, the Maternity team completed a comprehensive action plan which has resulted in key improvements reflected in the 'green' (better) status of a number of the questions within this survey.

Information and explanations
Receiving the information and explanations they needed after the birth

8.7 / 10	BETTER

Partner involvement
Partners being involved as much as they wanted

9.9 / 10	BETTER

Advice at the start of labour
Receiving appropriate advice and support

9.3 / 10	BETTER

Actions to address the findings of the survey

- Information to be provided to women in order to offer choices of where to have their baby.
- All women to be told how to contact their midwife (community and ward telephone numbers).
- Enable women to move around and choose a comfortable position in labour - active birthing equipment ordered.
- Ensure discharge process is streamlined to avoid delays.
- Women to be given a choice of where postnatal care can take place, with postnatal clinics to be set up in more community locations.
- To provide information about emotional changes post-natally, and ensure women know who to contact for advice regarding postnatal emotional changes.

Table 7 - Based on patients' responses to the Care Quality Commission's National Maternity Survey, this is how Ipswich Hospital compared with other Trusts

Labour and birth	9.2 / 10	WORSE / ABOUT THE SAME / BETTER
Staff during labour and birth	8.9 / 10	WORSE / ABOUT THE SAME / BETTER
Care in hospital after the birth	8.1 / 10	WORSE / ABOUT THE SAME / BETTER

Patient experience
Measuring and reporting the patient experience

Friends and Families Test (FFT)

There is a strategic key performance indicator for patient experience which is to achieve more than 97% FFT recommenders by 2022.

Inpatients FFT (including daycase patients)
30% return rate target was agreed as part of our contract with commissioners. This was consistently exceeded throughout the year. The 'recommender rate' has been circa 95%.

Emergency Department FFT
20% return rate target was agreed as part of our contract with commissioners. Both the 'return rate' and 'recommender rate' have fluctuated throughout the year. Analysis shows this is often related to times of peak activity.

Outpatients FFT
The percentage return rate has generally been above 10%. The percentage of patients recommending the hospital has stayed circa 96%.

Maternity FFT - antenatal, birth ward, post birth ward and post birth community
The FFT question is asked at four 'touch points' along the patient maternity journey - antenatal, birth, postnatal ward and postnatal community. The Trust scores are on a par with the national FFT % recommending scores for each.

Community hospitals FFT
The community contract has continued to report on the friends and family test results and feeds this back into the community hospital inpatient units to provide learning.

FFT results for 2017/18 are given below.

FFT linked actions
Linked actions are generated when an 'unlikely' or 'extremely unlikely' response is reported in a Friends and Family Test (FFT) survey. They give a ward/department the ability to rectify issues before they become concerns or complaints and to track any trends that arise. Once an 'unlikely' or 'extremely unlikely' is reported, it generates a linked action alert.

Improvements made as a result of FFT feedback
- ✓ Waiting times in Emergency Department now displayed on the reception desk for patients to see when they register in ED.
- ✓ Improved communication in clinics so that patients are aware when there are delays in clinic.
- ✓ Now using TV screens to display some patient information where appropriate.
- ✓ Staff reminded that special or cultural meals (eg Halal meals) are available.
- ✓ Magazines now available in Outpatient Department.

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Inpatient FFT return %	42.5	37.5	36.2	34	37.1	38.3	34.7	34	29.2	34.7	47.7	31.9
Inpatient recommenders %	98.07	97.54	97.9	97.19	96.67	97.66	96.86	97.39	97.05	97.4	96.2	97.59
ED FFT return %	17.9	18.8	20	16.9	14.3	9.5	12	9.5	6.1	7	10.2	9.2
ED recommenders %	67.93	77.19	75.2	80	77.18	80.5	78.86	81.44	80.94	84.1	82.6	81.71
Outpatient FFT return %	8.3	11.9	11.6	11.9	16.6	14.6	15.2	16.7	18.61	12.1	12.3	7.9
Outpatient recommenders %	96.9	96.52	97.13	97.97	96.85	97.62	96.82	97.62	98.61	97.2	97.7	96.99
Maternity FFT return %												
Antenatal return %	25.8	37.1	38.6	27.5	38.7	34.2	41.4	30.9	38.2	41.9	35.5	23.1
Antenatal recommenders %	97.89	99.2	99.25	100	97.99	97.58	98.57	97.9	100	100	97.2	100
Birth return %	36.7	42.5	35.3	30.4	31	27	34.2	23.4	25.5	34.7	32.7	27.8
Trust-wide Birth recommenders %	98.15	96.18	97.09	95.75	96.97	100	96.61	98.39	98.59	98.7	98.7	98.48
Postnatal ward %	35.7	40.6	47.9	33.4	24.5	30.03	31.6	21.97	25.8	34.7	26.7	36.9
Trust-wide Postnatal ward recommenders %	96.19	94.4	95	93.75	94.87	97.85	98.17	94.83	100	100	95.5	98.75
Postnatal community %	32.4	46.6	27.9	25.5	40.2	35.9	38.5	36.7	39.3	33	37.8	27
Trust-wide Postnatal community recommenders %	97.56	100	98.75	98.61	99.08	99.01	98.28	98.28	98.95	98.99	100	96.88

Patient experience
Patient and public involvement, community engagement and patient feedback

Values-based questions

The Inpatient questions are refreshed every year to reflect new Trust priorities. In addition, questions have been introduced to Emergency Department and Outpatient surveys. All results are reported via the Trust's Accountability Framework. These questions provide a fuller picture of patient experience as well as a monitoring tool for key objectives.

The table below illustrates that trust-wide the performance has consistently exceeded the minimum scores required. Performance for Q1 is variable as the new questions bed in.

Indicator	Target score	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Emergency Department questions													
Did staff introduce themselves to you?	**95**	0	100	62	*	*	*	*	*	*	*	*	*
Did staff ask about the things that matter to you?	**95**	0	0	14	*	*	*	*	*	*	*	*	*
Did you have enough time to discuss your health or medical problem with the nurse or doctor?	**90**	0	100	100	100	100	94.3	100	100	100	100	97.2	100
If you had a family carer were they involved in decisions about your treatment and care?	**90**	0	0	50	*	*	*	*	*	*	*	*	*
Do you think staff did everything they could to control your pain?	**90**	0	0	100	100	87.1	100	100	100	100	100	100	100
Were you informed of how long you would have to wait?	**90**	0	0	0	33.3	28.3	28.6	14.3	57.6	33	31.6	56.3	50
Did a member of staff tell you who to contact if you were worried after you left?	**90**	0	100	75	96.2	97.9	96.9	95.2	100	40	80	73.3	75
Inpatient questions													
Did staff introduce themselves to you?	**95**	97.4	94.5	96.5	97.3	97.7	97.1	96.3	97.1	98.3	98	97.4	97
Did staff ask about the things that matter to you?	**95**	90.3	87	90.2	90.7	89.3	90.9	88.3	91.5	91.6	90.7	90.2	91
If you had a family carer were they involved in decisions about your treatment and care?	**90**	91.7	92.1	92.1	92.8	91.3	92.5	91.5	93.8	93.9	91.2	91.2	95
If you had issues or concerns did you feel able to talk to a member of staff?	**90**	97.6	97.2	97.7	97.6	97.9	97.9	97.1	98.7	97.8	98	98.2	99
Call bell answered in 5 minutes?	**85**	96.6	95.9	95.9	96.2	95.6	95.9	95.4	97.1	97.5	96.6	98.3	97
Did staff keep you informed of discharge plans?	**90**	93.4	92	94	95.4	92.9	93.5	92.3	95.7	96	93.4	95	95
Did you get enough help from staff to eat your meals?	**95**	94	96.4	98	95.7	96.8	96.2	96.2	97.1	96.3	94.3	95.6	96
Outpatient questions													
Did staff introduce themselves to you?	**95**	94	97	96	99	98.8	98.4	98.3	99.3	98.4	98.2	97.1	100
Did staff ask about the things that matter to you?	**95**	86	89	86	91.2	92.2	94.5	94.9	97.8	96.1	90	92	97
Were you involved as much as you wanted to be with decisions about your treatment and care?	**80**	85	96	96	98.4	99.4	100	98.8	98.5	100	98.6	97.8	99
If you had a family carer were they involved in decisions about your treatment and care?	**90**	67	76	86	*	*	*	*	*	*	*		*
Did the healthcare professional explain the reasons for any treatment or action in a way you could understand?	**80**	0	96	95	99.4	94.8	99.2	98.2	100	100	99.5	97.7	99
Were you given information on your treatment and how it was likely to progress?	**70**	0	95	97	97.2	84.8	95	98.2	99.2	100	97.7	97.8	96
Were you told how long you would have to wait once you had arrived?	**75**	0	68	68	73.2	81.4	61	59.4	61.8	46.6	63.9	73.5	62

* No Score recorded

Patient experience

Patient and public involvement, community engagement and patient feedback

Compliments are always welcome and they are passed on to the staff in the areas involved. They are an equally important method of identifying trends which enable good practice to be shared widely, as well as a morale boost for staff.
Many compliments are sent directly to the wards, usually in the form of cards, chocolates and biscuits.

When letters of compliment are sent to the Chief Executive, these are always responded to with a letter of thanks. All compliments are shared with the staff concerned. Over the course of a year there are many more compliments received than the number of formal complaints.

Feedback from 'Comments and Compliment' cards:
The feedback stations across the Trust have encouraged further comments and compliments posted through the numerous post boxes. The completed cards are returned to the ward/clinic/area for the wards to display or use for revalidation.

The themes/trends emerging from the comments are:

Positive comments

- Focus around care, staff kindness and understanding

Negative comments:

- Waiting times
- Staff attitude
- Communication
- Car parking, and the anxiety of worrying about finding somewhere to park to get to their appointment, and the price.

Social media/online feedback

Feedback left on the NHS Choices and Patient Opinion websites is monitored and responded to with prompt, detailed responses and are highlighted to the relevant ward, clinic or area. Stories from NHS Choices also appear on Patient Opinion. Comments are also recorded from Google, Twitter, Iwantgreatcare, Instagram, Facebook and Healthwatch Suffolk feedback sites.

The Patient Experience team has been working closely with a number of departments who have been offering responses online directly to comments, queries and concerns relevant to their area/ ward.

Twitter and Facebook The Trust has an active presence on Twitter and Facebook and receives stories/comments via these profiles.

Healthwatch Suffolk is proactive in seeking out comments to post via events and visits to clinics etc. In June, they noted three concerns raised via a home care agency related to one particular ward. The Trust was able to respond swiftly, take action and reassure those who raised concerns and Healthwatch Suffolk.

Social media and on-line feedback, 2017/18

	Total number of comments	Positive comments
Q1	366	269
Q2	547	437
Q3	431	351
Q4	329	297

Carers' feedback

Carers are offered a number of ways to give feedback - carers comment cards, on-line surveys and phone calls to carers of someone with a dementia. In 2017/18 120 carers gave feedback via phone calls. 100% were confident to leave their loved one with us, and felt always or mainly supported whilst at the hospital as carers.

Community engagement

Ongoing attendance and engagement continued with:

- Healthwatch Suffolk BME/ Diversity Group, working with the Emergency Department on information for patients and carers
- The Suffolk Disability Health Action Group, working to produce the 'About Me' passport, downloadable from the Ipswich Hospital website:

www.ipswichhospital.nhs.uk/a-zofservices/Documents/PatientInformation/My%20Health%20Passport.pdf

The Ipswich Mela took place in July and Ipswich Hospital Trust shared a table with our commissioners (the CCG). Attendance at events such as the Mela and the One Big Multi-Cultural Festival which takes place every August, allow the Trust to reach out to a wider range of communities as the events are very well attended by a diverse mix of people.

The Patient Experience team is now involved with the following groups:

- Sickle Cell Health Inequalities Action Group, looking at producing a patient-held Crisis card.
- Non-Binary and Transgender Health Inequalities Task & Finish Group, via Suffolk County Council, supporting transgender patients and staff.

Comments and compliments

Type	Q1	Q2	Q3	Q4	Total
Cards/gifts direct to wards	84	58	192	772	1,106
Your Views Matter	91	89	75	79	334
Comment/Compliment cards	68	77	67	89	301
Total	**243**	**224**	**334**	**940**	**1,741**

Patient experience

Patient and public involvement, community engagement and patient feedback

'You said, we did'

Using feedback to make a difference

You said:
"Would be great to be able to ask senior staff questions in a relaxed environment."

We did:
We have introduced 'Tea with Sister' to enable carers, visitors and relatives to speak with senior members of staff

You said:
"Can we have something to break up the daytime routine?"

We did:
From our charitable funds we have purchased equipment and arranged activities that are scheduled on the ward, breaking up the day and actively encouraging patient participation.

You said:
"Can we have some more information on the medicines that are being used?"

We did:
We have developed medicine information sheets for parents – please ask a member of staff.

You said:
"It would be nice to have an area that can be used for recreational activities and for eating together."

We did:
We have purchased, from charitable funds, a table and chairs that are being used so patients are able to socially interact away from the bedside.

You said:
"It would be nice if my partner could stay with me overnight."

We did:
Working with Healthwatch Suffolk, we undertook a public engagement exercise. The results of the exercise show that more than half of new mums wanted their partner to stay overnight with them but couldn't, and 44% of birthing partners would have liked to stay the night but were not given the opportunity.

Partners are now welcome to stay throughout the birth and this development has been introduced on all three of the hospital's maternity wards – Orwell, Brook and Deben.

You said:
"It would be nice to be able to sit back in the chairs."

We did:
We repurposed some reclining chairs from a redundant area so patients can be more comfortable and relaxed when sitting in the chairs for long periods.

You said:
"It can be difficult to read the log-in screen if you have a visual impairment."

We did:
The screen closest to the Eye Clinic has had the colours changed to aid people with a visual impairment, the other screens can be changed by touching the eye logo.

You said:
"The doors to the clinic can be difficult to open for some patients."

We did:
We now have automatic doors operated by a touchpad for easier access to the department.

You said:
"It would be nice to have access to cold drinks and/or ice during the day and night."

We did:
Working with the Cardiology User Group and the Director of Nursing, we have installed an ice machine so cold drinks and ice are available 24/7.

Patient experience
Ipswich Hospital User Group (IHUG)

IHUG is made up of the chairperson or a representative from all the user groups.

Meetings are held every six weeks to discuss a wide variety of issues; members of the Trust Board also attend, with key Trust staff members attending as and when the agenda requires. When members raise an issue at IHUG it is often resolved quickly, as the issues are taken straight to the people who can implement the changes needed, or who are able to take the issue to the correct department for resolution. All members share the same passion to help improve the lives of all patients, whether they are outpatients or inpatients, children or adults.

Our volunteers' contribution to the life of the hospital, helping us to make improvements large and small, is so important and very much appreciated. We currently have 16 user groups and are always seeking new members.

- Cancer Services User Group
- Cardiology User Group
- Diabetes User Group
- Endoscopy User Group
- Eye Clinic User Group
- Hearing Services User Group
- Hotel Services User Group
- Inflammatory Bowel Disease (IBD) Patient Panel
- Musculoskeletal Action Group
- Maternity Voices Partnership
- Parents User Group
- Pain Management User Group
- Stroke Services User Group
- Voice 4 change - children and young people involvement group
- Liver Disease Action Group
- Learning Disability Action Group

Additional information about IHUG can be found on the notice boards in the hospital corridors, or on the Ipswich Hospital website at www.ipswichhospital.nhs.uk/getinvolved/join-a-user-group.htm

IHUG award winners

Outstanding colleagues were honoured at an awards ceremony at Ipswich Town Hall in October.

Fifteen members of staff from several areas of the hospital were recognised for their excellent care over the last year with an Ipswich Hospital User Group (IHUG) "You Made a Difference" award.

The winners, who have to be nominated by patients, relatives or carers, were selected by a panel of IHUG members. The award-winning colleagues were congratulated by the Mayor of Ipswich, Cllr Sarah Barber - who works as a recovery nurse at the hospital - and Director of Nursing, Lisa Nobes.

The presentation ceremony was hosted by IHUG and included afternoon tea courtesy of the Mayor. This is the second time the awards have been held.

Roll of honour

Andy Page (Porter on the Assessment Ward)
Laura Barham (Midwife)
Lisa Mann (Oncology Macmillan Nurse - Radiology)
Jennifer Bolt (Gynaecology Nurse, Stour Ward)
Fran Vale (Outpatients Nurse)
Ross Harrington (Chief Orthodontic Technician)
Julia Degutis (Ward Clerk, Stradbroke Ward)
Anne Oliver (Midwife, Deben Ward)
Halty Davis (Therapy Assistant, Sproughton Ward)
Leanne Logan-Smith (Senior Nurse, Shotley Ward)
Nikki Williams (Somersham Ward)
Petra Claxton (Day Unit, Chemotherapy)
Satnam Kaur (Ward Clerk, Bergholt Ward)
Dr Ben Scoones (Anaesthetics)
Alex Lingwood (Washbrook Ward).

Some of the IHUG award winners, pictured with Mayor of Ipswich Sarah Barber, Managing Director Neill Moloney and Director of Nursing Lisa Nobes

Patient experience
Ipswich Hospital User Group (IHUG)

Improvements initiated by IHUG and user groups

- ✓ Adopt a Ward initiative embedded and expanded.
- ✓ Shortlisted for PENNA award for joint work on simulation suite training.
- ✓ 'You Made A Difference' awards given to staff by IHUG.
- ✓ Organised an end of life workshop for staff and patients.
- ✓ East of England Patient Experience seminar co-designed and led by patient leaders.
- ✓ Participated in a review of disabled toilet facilities, from the perspective of a person in a wheelchair.
- ✓ Instigated the now flourishing and very positive relationship with the CHUFT governors.
- ✓ Presented at NHS Improvement conference in Birmingham on the work IHUG does.
- ✓ Presented at the Westminster Health Forum on effective service user involvement.
- ✓ Presented to University of Suffolk service user group on IHUG's role.
- ✓ 2 IHUG members accepted onto the Q Community and undertook bronze level QI (quality initiative) training.
- ✓ Members have assisted with staff training, particularly with Human Factors, Breaking Bad News, Care of the Deteriorating Patient and Trainee GP training.

First Patient Experience Seminar

In March we held the first East of England Patient Experience Seminar, with the theme of 'Working Together' co-hosted and co-produced with the Patient Panel at Princess Alexandra Hospital, Harlow. This seminar attracted over 90 delegates from all corners of the East of England from around 30 NHS organisations ranging from Patient Participation Groups to Hospitals. The staff/service user ratio was 2:1 and many organisations were attending to find out more about how to engage with their patients. Neill Moloney opened the day and welcomed everyone to Ipswich. We were very honoured to have Lynne Wigens attend in her capacity as Regional Chief Nurse NHS East of England (Midlands & East).

Our first speaker, Pete Fleishmann from SCIE (Social Care Institute for Excellence) gave what many found to be the most comprehensive and straightforward guide to what co-production really is.

We were then led through various workshops by our facilitator Ceinwen Giles who works with many NHS organisations. Along with the patient panel, we showcased some of our work, including 'Adopt a Ward' and our involvement in the simulation suite. Huge thanks go to Matron Sarah Watson and Jo Wesley from the simulation suite for helping to present. For me one of the best things was later that evening at home when I read a comment on Twitter, where an attendee had tweeted "I attended this event today, it was awesome!" Just what you need when you are exhausted from running such an event! I'd like to take this opportunity to say a heartfelt "thank you" to Sarah Higson, Pam Talman and Steve Bruce from the Ipswich Patient Experience Team for all their assistance in making this day such a success.

Gill Orves, Chair IHUG

Left: Neill Moloney, Managing Director. Middle: Matron Sarah Watson with Gill Orves, Chair IHUG. Right: Lynne Wigens, Regional Chief Nurse NHS East of England (Midlands & East).

Patient experience
Learning from complaints

What are complaints?

Complaints are written expressions of dissatisfaction from patients and/or relatives who are unhappy regarding an aspect of their interaction with Ipswich Hospital. Complaints are a valuable tool to identify trends which enable us to improve the service where it may be necessary.

The Ipswich Hospital NHS Trust is committed to providing a complaints service that is fair, effective and accessible to all. Complaints are a valuable source of feedback about our services. We undertake to be open and honest and where necessary, make changes to improve our service.

Complaints service

Complaints are always taken seriously as they highlight the times we let down our patients and their families. Each complaint is treated as an opportunity to learn and improve the service we provide. The Trust listens and responds to all concerns and complaints which are treated confidentially and kept separately from the complainant's medical records. Making a complaint does not harm or prejudice the care provided to the complainant.

How complaints are managed

We aim to respond to complaints within 28 working days from receiving the complaint. This year, 100% of complaints received were responded to in 28 working days or a revised timescale agreed with the complainant, against a Trust target of 100%. Every effort is made to contact each complainant within 24 hours of the complaint being logged by the complaints team. These calls, known as 24 hour courtesy calls, are made by a senior manager and are seen as an opportunity to:

- take time to understand the exact nature of the complaint as this will help to ensure a thorough and meaningful response;
- gain insight to understand the key issues that need to be resolved;
- help build relationships with the complainant, help them to feel part of the process and demonstrate that we take their concerns seriously; and
- explain the 28 working day timeframe for our response and establish the method in which the complainant would like to receive our feedback, for example a letter, telephone call or a face to face meeting.

This year 96.5% of courtesy calls were made within the 24 hour standard.

All complaints are assigned to a complaints co-ordinator who liaises with the complainant and ensures the department responsible for investigating and responding to a complaint does so within the agreed time limits.

Once a complaint investigation has been completed, it is checked by the Associate Director of Nursing or their deputy for the appropriate Division to ensure all issues raised have been answered, before being passed to the Managing Director or another Executive Director to review and sign the letter of response.

Reopened complaints

During 2017/18, 45 (6.9%) of the complaints received were reopened. One of the main reasons for reopening a complaint has been identified as poor or inaccurate investigation. In these cases, complaints are returned to the investigating team for further explanation and clarification. Analysis of re-opened complaints is being undertaken to ensure that we understand why first responses are not meeting the satisfaction of complainants and to enable the complaints team to offer Divisions appropriate support.

Complaints are categorised in three ways, depending on their severity:

High level	Multiple issues relating to a longer period of care including an event resulting in serious harm.
Medium level	Several issues relating to a short period of care including, for example, failure to meet care needs, medical errors, incorrect treatment, attitude of staff or communication.
Low level	Simple, non-complex issues including, for example, delayed or cancelled appointments, lack of cleanliness, transport problems.

Patient experience
Learning from complaints

Complaints to the Parliamentary and Health Service Ombudsman (PHSO)

During 2017/18, 7 cases were investigated by the Ombudsman as the complainant was unhappy with the response received from the Trust.

Of these, 1 investigation has been completed, with the outcome being the complaint not being upheld by the PHSO. At the time of reporting, six cases remain under investigation by the PHSO.

The Ombudsman now publishes data on an annual and quarterly basis. This data is published to give statistical insight into the complaints the Ombudsman receives and investigates to encourage discussions and help organisations assess the efficiency of their own complaints handling process.

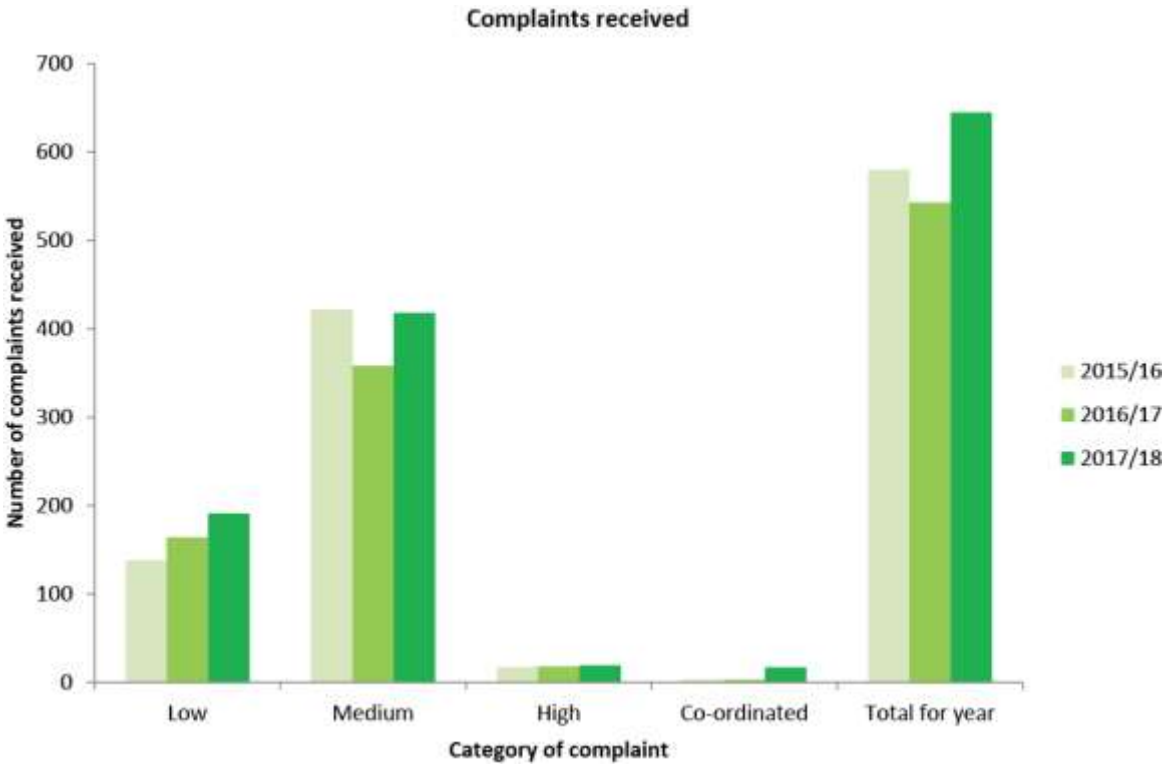
Learning from complaints

While information drawn from surveys and other forms of patient feedback is important, every complaint received indicates that for that person or their family, they did not receive the high quality care they rightly expected.

Complaints are an important method by which the Trust assesses the quality of the service it provides. We take all complaints seriously and have taken action in response to them in various ways to improve the quality of care we provide, as the examples on the next page show.

We carry out an annual survey of 100 complainants to understand their experience of the complaints procedure and make changes to our processes where appropriate.

Chart 10 – Our performance over the last three years: Complaints



Patient experience
Learning from complaints

Top three subjects of complaints		
2015/16	**2016/17**	**2017/18**
Elements of treatment	Elements of treatment	Elements of treatment
Poor communication	Aspects of care	Attitude of staff
Attitude of staff	Attitude of staff	Aspects of care

Complaint	Action taken
Lack of communication with nursing home following discharge of a patient and antibiotics not given, so these had to be obtained from the GP.	A 'Safe Discharge' sheet has been displayed on the ward for all members of staff to read. The complaint has been discussed at a recent ward meeting in order that members of staff can reflect on the discharge process and ensure that all procedures and protocols are followed to ensure the safe discharge of patients, in particular in regard to medication.
Outpatient appointment for a child had been cancelled without the parent being informed so family had a wasted journey and the mother had booked time off work.	Urology administration team were reminded of the importance of effective communication at all times, New appointment made for patient.
Poor disabled toilet facilities in Outpatient Department at Ipswich Hospital	New toilets at the appropriate height have been installed.

For the period April 2017 - March 2018, our PALS team dealt with the following queries	
PALS Level 1 Enquiry/Concern Matters that simply require straightforward information or signposting other service providers such as dentists, mental health services and GPs.	1,217
PALS Level 2 Enquiry/Concern Matters that simply require resolution such as concerns relating to the quality of care received, pain management, discharge arrangements and difficulties experienced in trying to communicate with ward staff, chasing appointments or test results.	1,138
Total	**2,355**

Patient Advice and Liaison Service (PALS)

The PALS team handles queries and concerns in a practical way, resolving and addressing issues at source to prevent matters escalating. This is seen as a positive step towards taking more responsibility for issues as they arise.

PALS offer patients, carers and visitors:

- advice and signposting - helping to navigate the hospital and its services;
- compliments and comments - PALS can pass on compliments and ideas to improve services; and
- PALS can address a non-complex issue informally, often preventing the need to raise a formal complaint.

PALS contacts are graded as either PALS 1 or PALS 2:

PALS 1 are contacts that require straightforward information or signposting, for example, ward visiting times or how a patient can apply for a copy of their medical records.

PALS 2 are contacts relating to a matter which needs to be resolved or addressed, for example, lost property, waiting list enquiries or waiting times for appointments.

Typical matters raised with PALS include:

- Ward-related concerns such as pain management or discharge arrangements;
- Litter from cigarette ends and staff smoking in groups;
- Lost property;
- Car parking concerns;
- Resolving matters where patients are unable to contact the department of their choice by telephone.

Patient experience

Patient-Led Assessment of the Care Environment (PLACE)

Good environments matter, and every patient should be cared for with compassion and dignity in a safe and clean environment. PLACE assessments provide a clear message, directly from patients about how the environment or services could improve. Patients must make up at least 50% of the assessment team. Anyone who uses the service can be a patient assessor, including patients, their family, visitors, carers or patient advocates. The assessment teams go into hospitals to assess how the environment supports patients' privacy and dignity, food, cleanliness and general building maintenance. The assessments take place every year, and results are reported publicly.

Patient-Led Assessment of the Care Environment (PLACE) is a self-assessment of a range of non-clinical services by local volunteers (patient assessors) which contribute to the environment in which healthcare is delivered in both the NHS and independent healthcare sector in England.

The annual PLACE assessment provides a snapshot of how an organisation is performing against a range of criteria impacting on patient experience. Local volunteers (patient assessors) go into hospitals to assess how the environment supports delivery of care. The assessments focus entirely on the environment and do not cover clinical care provision.

The role of the assessors is to:

- assess what matters to patients/the public;
- report what matters to patients/the public; and
- ensure the patient/public voice plays a significant role in determining the outcome.

Patient assessors must make up more than 50% of the inspection team. At least 25% of inpatient ward areas must be assessed, and the complete inpatient meal service must be observed and patient food tasted and scored.

The assessments take place annually, with Trusts given six weeks' notice of the specified timeframe during which the PLACE assessment must occur. Results are reported publicly by NHS Digital to drive improvement. The PLACE process requires organisations to respond formally to their assessments and develop a plan for improvement. The PLACE assessment at Ipswich Hospital was undertaken on 16 May 2017.

The assessment has six categories:

- Cleanliness;
- Food and hydration;
- Privacy, dignity and wellbeing (how the environment supports delivery of this);
- Condition, appearance and maintenance of premises;
- Disability Access; and
- Dementia friendly environment

It is recognised that hospital buildings vary in age and design; which may limit their ability to meet the criteria. However, it is important that the assessment is based on standard criteria and no allowances are made for such factors. The scores awarded reflect what was seen on the day.

Support for assessors
The term 'patient assessors' covers people whose experience of the hospital is as a user, including relatives, carers, friends, patient advocates and volunteers. The number of patient assessors should always be at least equal to the number of hospital staff.

PLACE assessors were drawn from the pool of Trust volunteers, user representatives, Healthwatch Suffolk and groups already actively engaged with the Trust. Training sessions were held for assessors in March 2017. All of the patient assessors attended for training, with 'new' assessors being accompanied by a patient assessor who had previous PLACE experience.

Each assessment team consists of at least two patient assessors, accompanied by other members of staff. Staff members included members of the Patient Experience team, Estate and Facilities team, senior nursing staff, infection control, and hotel services contractors, with one member of each team acting as 'team leader'.

Scope of the assessment
A minimum of 25% of wards (or ten, whichever is the greater) and a similar number of non-ward areas must be assessed. Each area assessed must be:

- sufficient to allow the PLACE team to make informed judgements about those parts of the hospital it does not visit;
- where possible, focus on areas of the hospital not included in recent PLACE assessments so that over a period of time all areas will be assessed;
- include all buildings of different ages and conditions; and
- include departments/wards where a high proportion of patients have dementia or delirium.

Each team makes the final decision on which patient areas they will inspect, but they must ensure that the wards and areas chosen are reflective of the range of services and buildings across the hospital. Different areas are selected each year so that all areas are assessed over a period of time.

Patient experience

Patient-Led Assessment of the Care Environment (PLACE)

Scoring
Scores are based on the conditions seen at the time of the assessment. It is made clear to assessors that they must score the hospital on how it delivers against the defined criteria and guidance. No allowance is made for infrastructure, age or design of the Trust's buildings.

To achieve a pass, all aspects of all items must meet the definition/ guidance as set out in the assessment criteria. There is no margin whereby an item can fail to meet the required standard but still achieve a pass.

Assessment teams need to exercise judgement, and will discuss and agree which score to apply where it is obvious that a pass is not appropriate. As an example, a small amount of fluff on a floor would not be deemed as a fail, but fluff under every bed and/or in every corner would be a fail.

Food audits
Teams must base their scoring on what is observed and said rather than rely on assertions of what usually happens. Assessors must:

- undertake the assessment on the ward, from the same food as provided to patients;
- if possible, assess both the lunchtime and evening meal services to obtain a rounded view and to improve the accuracy of the assessment;
- taste all food on offer to patients;
- taste food at the end of patient meal service to ensure that temperatures have been maintained at an acceptable level for the last patient to be served;
- watch how food is served to check for the care taken in presentation; and
- observe how staff are involved in the meal service and how they provide help for those patients who require it.

Areas assessed in 2017
The following areas were assessed in 2017:

Wards

- Bramford
- Deben
- Debenham
- Kirton
- Martlesham
- Needham
- Orwell
- Somersham
- Sproughton
- Woodbridge

Outpatient Clinics

- Antenatal Clinic
- Child Health Clinic
- Clinics A, B, C & F
- CT Scan Suite
- Frailty Assessment Base
- Heart Centre
- Musculoskeletal Department
- Neurophysiology
- Ophthalmic Day Case Unit
- Pain Management Unit
- Plastic Surgery
- Radiology Department

Food audits were conducted on

- Bramford Ward
- Kirton Ward
- Needham Ward
- Somersham Ward
- Sproughton Ward

General areas (these must be assessed every year)

- Emergency Department
- communal areas inside the hospital building
- external grounds.

Findings
There has been improvements and one deterioration in scores from the 2016 PLACE inspection. However, it is important to note that from 2015, the criteria have changed with the 'Food' element being scored across three areas (Food overall, Ward food, Organisation of food) and a new element of 'Disability' compliance added.

An action plan following the 2017 PLACE survey has been written, and below are some key comments made by the patient assessors during the assessment.

Cleaning

- Light dust on some of the ward equipment.
- Light dust on some environmental surfaces.
- Alcohol hand gel not available at every bedside.

Condition and appearance

- Many areas require redecoration or refurbishment: vinyl flooring, paint scuffed, furniture worn.
- No facilities for patients to lock away valuable property.
- Inadequate variety of seating in dayrooms and waiting areas.
- Some bathrooms not fitted with modesty curtain inside door.
- Signage and way-finding inadequate.
- No hearing loops or visual displays at reception areas.

Dementia

- Lack of handrails.
- Inappropriate vinyl flooring.
- Mirrors not able to be covered or removed.
- Doors not painted to either emphasise or disguise them.
- No displays of calendars, clocks, ward and hospital name.

Disability

- No assistance in reception/ clinic areas for visually/hearing impaired.

Patient experience

Patient-Led Assessment of the Care Environment (PLACE)

Catering

- Temperature of some items.
- Main course and dessert not served separately.
- Lack of separate dining areas away from bedside on most wards.
- Patients not made ready for meals.
- Lack of involvement by ward staff at meal time on some wards.
- Protected mealtimes not in universal operation.

Privacy & Dignity

- No private rooms on wards for confidential conversations.
- Patients cannot leave most outpatient areas without passing back through the waiting room.
- Reception desks lacking confidentiality.
- Lack of communication aids for hearing/visual impairment.

Next steps

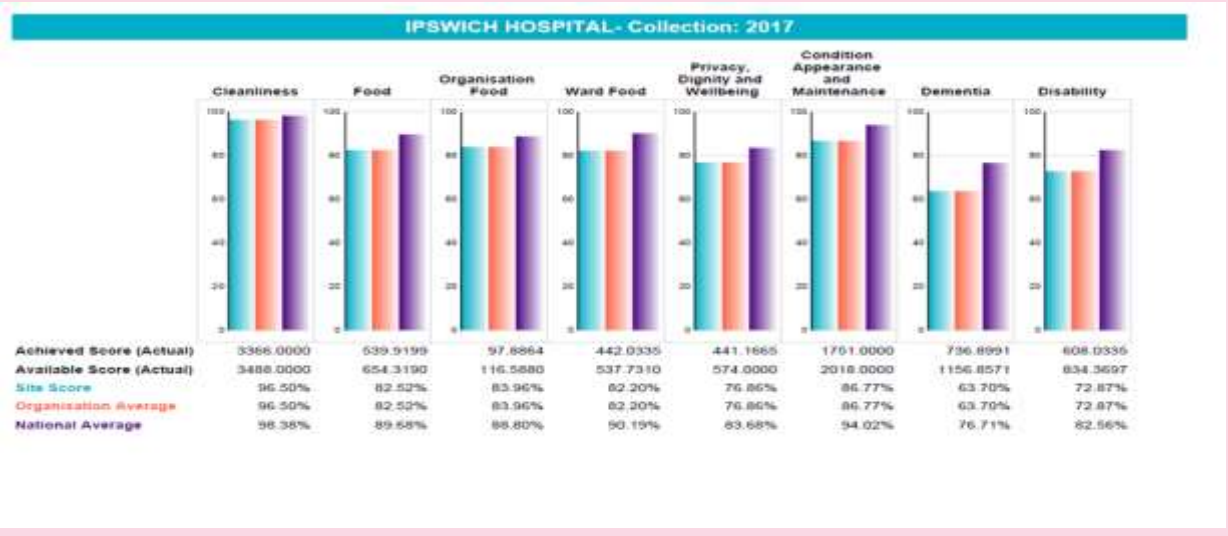
All Trusts are required to formally respond to the findings of a PLACE assessment and develop an action plan for improvement. This high level action plan has to be published on the Trust's website.

The Trust's detailed action plan will be shared with each ward and department that was audited and where appropriate those actions listed will be the responsibility of that ward or department to deliver. Where other actions require building/decoration works or capital investment, these will be managed by the Estates and Facilities team, under the responsibility of the Director of Estates & Facilities.

What are we doing to make improvements?

- ✓ Old signage has been removed, updated and replaced.
- ✓ Foliage around signs cut back and signs cleaned.
- ✓ Additional seating purchased to provide for the range of patient needs including chairs of different heights, chairs both with and without arms and bariatric chairs.
- ✓ All bedside lockers are being replaced so they have two lockable compartments.
- ✓ Large-face clocks now easily visible in all patient bedside areas and in day rooms.
- ✓ Ongoing work to ensure there is clear signage in the reception areas, prominently displayed showing the department name.
- ✓ Replacement and upgrading of flooring where required.
- ✓ Redecoration where required.

Chart 11 – Ipswich Hospital PLACE audit scores 2017



Patient experience

Patient-Led Assessment of the Care Environment (PLACE)

The annual PLACE self-assessments of community hospitals took place on 18 May 2017 at Bluebird Lodge, on 25 May 2017 at Aldeburgh, and on 8 May 2017 at Felixstowe.

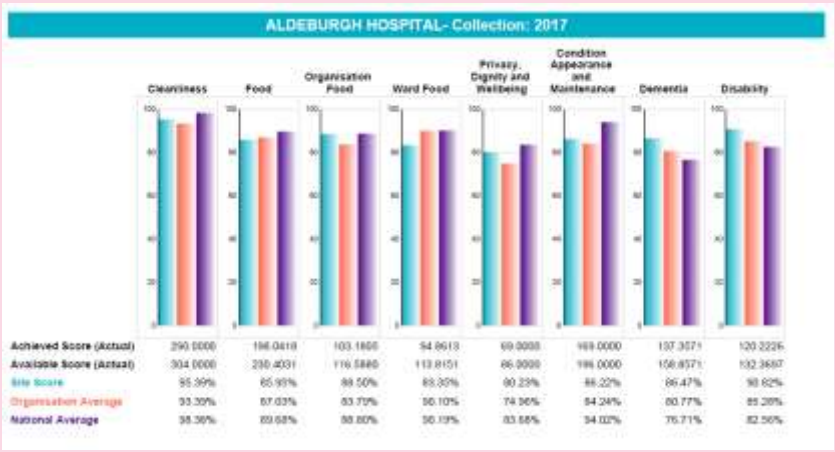
What are we doing to make improvements in the community hospitals?

Each community hospital was given an action plan based on the issues noted during the PLACE assessment and the following actions have been completed:

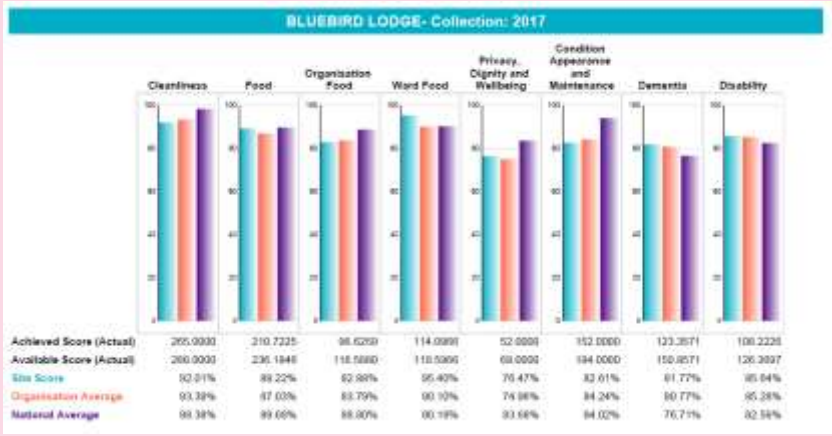
- ✓ All bedrooms at Bluebird redecorated
- ✓ Shower drains changed at Bluebird Lodge
- ✓ Provision of extra course for lunch and dinner meals
- ✓ Provision of an extra starter at lunch and dinner
- ✓ Provision of an extra preserve at breakfast
- ✓ Changing the evening meal service time by 30 minutes
- ✓ Extra choice added to the breakfast menu
- ✓ Introduction of dementia-appropriate signage to toilet doors
- ✓ New day-room furniture to be provided in Felixstowe

Chart 12 – Community Hospital PLACE audit scores 2017

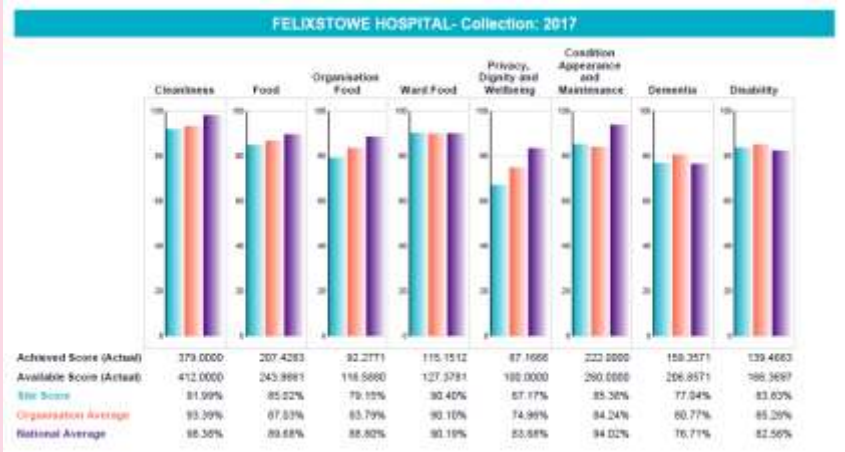
Aldeburgh Community Hospital



Bluebird Lodge Community Hospital



Felixstowe Community Hospital



Workforce

The Trust continues to work towards the achievement of the NHS pledges as outlined in the NHS Constitution to ensure that all staff feel valued, trusted, actively listened to, provided with meaningful feedback, treated with respect at work, have the tools, training and support to deliver compassionate care, and are provided with opportunities to develop and progress.

Our ambition is that our staff will highly recommend Ipswich Hospital as:

- a place to work;
- a place to receive treatment; and
- a place to be trained.

Indeed, this year, this is what our staff have told us in the annual staff survey.

National NHS Staff Survey

The national NHS staff survey took place in Quarter 3 with all staff invited to participate. In previous years, only a sample of staff have been surveyed. The response rate of 46% was above average for acute trusts in England (44%) and was equal to the response rate as in the 2016 survey.

Key Findings

Our staff engagement and motivation score showed an improvement from 3.81 to 3.87, (1 being poorly engaged staff to 5 being highly engaged staff). Ipswich Hospital NHS Trust was in the highest 20% of acute trusts. However, we continue to encourage further engagement and to increase staff ability to contribute towards improvements at work.

Staff recommendation of the organisation as a place to work or receive treatment has improved on prior years (3.80) and is above the national average of 3.76.

There are no statistically significant changes in the scores from last year.

15 key findings were better than average and 7 are in the top 20%.

We were below average in only one key finding - the percentage of staff willing to report harassment, bullying or abuse.

The Trust has 7 scores in the top 20%:

- Staff agreeing that their role makes a difference to patients and service users;
- Experiencing physical violence;
- Experiencing discrimination;
- Reporting errors, near misses and incidents;
- Ability to contribute towards improvements at work;
- Confidence in reporting unsafe clinical practice; and
- Staff motivation at work.

Areas to address

We plan to continue on the great work already achieved, and work to improve communication, being able to contribute effectively and involvement with changes to working.

Feeling valued and looking after the health and wellbeing of our staff have all led to a greater level of motivation and satisfaction. We will continue to build on that over the next year.

We will further improve our communication with staff, and improve the quality and value of appraisals and our training and development opportunities for all staff groups.

Table 8 – Key findings from Staff Survey

Questions - Key Findings (weighted by occupational group)	**Key Finding 1** Staff recommendation of the organisation as a place to work or receive treatment	**Key Finding 2** Staff satisfaction with the quality of work and care they are able to deliver	**Key Finding 3** Percentage of staff agreeing that their role makes a difference to patients/service users	**Key Finding 4** Staff motivation at work	**Key Finding 5** Recognition and value of staff by managers and the organisation	**Key Finding 7** Percentage of staff able to contribute towards improvements at work
2017 score	3.80	3.95	92%	3.98	3.50	74%
Average for acute trusts	3.76	3.91	90%	3.92	3.45	70%

Workforce

In December 2016, we appointed a Freedom to Speak Up Guardian to ensure there was a dedicated 'go to' person when staff need to speak up and other avenues are not suitable. We will also be looking at all ways in which to improve this score (see page 77).

Taking care of health and wellbeing is a key priority in the challenges we face going forward. We appointed a specialist partner in 2016 to provide an Employee Assistance Programme for support and advice, and we have also worked closely with Public Health England on 'healthy hospitals.' In addition, we are working with Suffolk MIND to implement a plan to train and support staff on emotional wellbeing and resilience programmes.

Listening to and engaging with our staff
Evidence shows that engaged staff really do deliver better healthcare and it is our intention to continue to improve the health, wellbeing and workplace experience for our staff.

We have undertaken an intensive 16 week programme called *Engage, improve, succeed* to listen to our staff and ask them 'what matters to you' when they come to work each day.

The Trust's vision and values were developed by staff, patients and key stakeholders and apply to all with crucial linkage between good patient and workforce experiences. We plan to have a stronger focus on having conversations with staff on what matters to them.

The findings from the staff survey will help inform targeted, robust actions for continuous improvement as essential steps to restore our workforce position and ensure the Trust is a good place to work and train.

Recruitment of staff
Recruitment initiatives have been undertaken to address difficult to fill posts and to reduce the number of vacancies and the times that staff are required to work extra hours. We continue with international nurse recruitment campaigns and have taken a number of actions to address our 'difficult to recruit to' posts.

Workforce Race Equality Standard (WRES)
The NHS WRES was introduced in 2015 to help enable Black and Minority Ethnicities (BME) to have equal access to career opportunities and fair treatment in the workplace after research indicated potentially less favourable treatment of these groups in the NHS.

The Trust measures progress against 9 indicators of workforce race equality which focus on any differences between the experience and treatment of White and BME staff. This also marks the level of BME representation at senior management and board level and helps to plan evidence based action. A national database will be benchmarking national and local progress.

The Trust is developing an action plan and has widely consulted with staff.

The full and summary survey reports for Ipswich Hospital are available at www.nhsstaffsurveys.com

Table 9 – Our performance over the last two years (unweighted scores)

Key Finding		2016 score	2016 Average for acute trusts	2017 score	2017 Average for acute trusts
KF21 Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.	White	91%	88%	87%	87%
	BME	62%	76%	81%	75%
KF26 Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	White	28%	24%	21%	24%
	BME	26%	27%	31%	27%

Workforce

Equality and Diversity

Equality is about fair and inclusive treatment. It is protected in law with the aim that we can all live and work in a society where everyone can participate, have opportunity to fulfil potential and fair access to services and employment.

Diversity supports equality, recognising and understanding the broad range of differences which makes someone unique such as their culture, belief, gender, age, physical or mental abilities, and also their experiences, needs, expectations or responsibilities.

Being fair and inclusive means valuing and respecting a person's diverse requirements, thoughts and contribution. Equality and diversity work in unison to achieve all this.

Why this agenda is important
The people we serve and employ are becoming increasingly diverse with varied needs, but everyone needs to feel valued and included and treated fairly and respectfully. The Trust, our patients, staff and stakeholders have all identified and made a commitment to this within our shared values and our expectations of conduct. Everyone is responsible for supporting this agenda.

Our responsibilities and ensuring delivery
Equality, firmly underpinned in the Equality Act 2010, ensures people do not receive unfair treatment or be subjected to discrimination or harassment due to their age, race, gender, belief, sexual orientation, transgender, in marriage or civil partnership or in pregnancy or maternity. To ensure we meet these responsibilities, the Equality Diversity and Inclusion Steering Group overviews this agenda for the workforce and patients, providing assurance to Trust committees and the Trust Board.

NHS Equality Delivery System
Like all NHS organisations, the Trust uses the Equality Delivery System (EDS2) to implement equality and diversity strategies and the Public Sector Equality Duty. There are four overarching goals:

1. better health outcomes;
2. improved patient access and experience;
3. a representative and supported workforce; and
4. inclusive leadership.

More details can be found at: www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf

Engagement and involvement with patients, staff and stakeholders
A key part of EDS2 is identification of stakeholders from patients, staff, or local interest groups to secure meaningful engagement to help assess and evaluate where we are and how to progress. This partnership approach to engagement and involvement with communities helps us focus on what matters most for our patients, communities and staff.

Embedding equality and diversity
EDS2 helps identify, develop and implement objectives to continue to make real, sustainable improvement to our services and working conditions whilst delivering better outcomes and benefits to meet the needs of staff and service users. The equality objectives and priorities are also aligned to the Trust's organisational priorities to ensure relevance and to realise full benefits within the Trust's corporate, workforce and patient strategies. This helps embed the agenda into our governance structure and into all activities for effective implementation.

NHS Accessible Information Standard (AIS)
Application of the AIS helps to meet needs in relation to a disability, impairment or sensory loss which affects the ability to communicate. The AIS applies to patients, carers or parents. We try to address any information/communication support needs to enable better access to services and care to give a better patient experience.

Commitment to promoting equality and diversity in the workforce, and inclusive leadership is crucially associated with increased patient-centred innovation, care, staff morale and access to a wider talent pool.

Workforce Race Equality Standard (WRES)
EDS2 covers all areas of diversity across services and the workforce. The WRES focuses on workforce and race as a particular NHS need to improve performance in this area where there is potentially less favourable treatment and experience of BME staff in the NHS.

Workforce Disability Equality Standard (WDES)
The WDES is a new development to improve performance. We will also be looking to improve services for those with a disability.

Gender Pay Gap Reporting (GPGR)
NHS employers by law are now required to publish statutory calculations each year showing how large the pay gap is between their male and female employees. We will be analysing the information we have and acting upon any gaps identified.

Care Quality Commission (CQC)/ equality diversity and human rights agenda
Equality and diversity is inspected by the CQC as part of the 'well led' domain of the NHS inspection programme. This includes analysis of EDS2 and WRES reports, action plans and how issues arising from equality data are addressed.

Our commitment continues
The Trust aims to achieve a diverse workforce reflective of and sensitive to the needs of the community. We will work towards eliminating discrimination, promoting equal opportunity and removing barriers to fair and equal treatment of staff and patients. Support from the Trust Board ensures full ownership and accountability for this agenda. The Board is involved in and approves equality developments and understands its role, and legal requirements.

Workforce

Freedom to Speak Up Guardian

Tom Fleetwood our Freedom to Speak Guardian, has now been in post for one year. During that period a significant number of changes have been made to our way of doing business and we have embedded Freedom to Speak principles within our working practices. We now include a session on both raising concerns and freedom to speak up, within our induction process and Tom also speaks to many other groups including junior doctors and those starting out on their nursing careers.

Our policy has been reviewed and amended and we now reflect national guidance. We have also launched a poster campaign that advertises to all those working within the Trust the various routes that they can follow to seek advice and gain support for any concerns they might have. This campaign was relaunched in the spring with further emphasis on intranet accessibility and with a recruitment process to encourage other members of staff to become additional Freedom to Speak supporters.

Tom reports on a quarterly basis through the Workforce Development and Education Committee and to the Trust Board once a year. He is also firmly embedded within the National Guardians Network and is part of the East Of England Freedom to Speak forum. A number of individuals from across the Trust have already contacted Tom and he remains available to support and offer advice whenever required.

Tom Fleetwood, Freedom to Speak Up Guardian.

Dr Mark Garfield, Guardian of Safe Working Hours.

Guardian of Safe Working Hours (GSWH)

The Guardian of Safe Working Hours (GSWH) has been introduced to protect patients and doctors by making sure doctors and dentists are not working unsafe hours.

Dr Mark Garfield, a consultant anaesthetist, undertakes this role for the Trust. He is responsible for protecting the safeguards outlined in the 2016 terms and conditions of service for doctors and dentists in training. It is a role intended to be undertaken by a consultant or someone of equivalent seniority. The guardian reports directly to the Trust Board and is independent of the management structure within the organisation.

To fulfil this role, the GSWH:

- acts as the champion of safe working hours;
- receives exception reports and records and monitors compliance against terms and conditions;
- escalates issues to the relevant executive director, or equivalent for decision and action;
- intervenes to reduce any identified risks to doctors/dentists or to patient safety;
- undertakes work schedule reviews where there are regular or persistent breaches in safe working hours; and
- distributes monies received as a consequence of financial penalties, to improve training and service experience.

The GSWH is a member of the regional network and has attended National Guardian events. The network supports the ongoing development of the GSWH role and the sharing of best practice.

The 2016 contract has been implemented across the Trust for all levels of junior doctors in training.

The Trust uses an electronic exception reporting system (Allocate) which enables doctors to submit exception reports from any IT

Workforce

device. The system also supports the management of exception reports and work schedule reviews so the GSWH can monitor progress with resolving issues. A doctor can submit an exception report if their working pattern varies from the work schedule or they have missed educational opportunities. A meeting with the doctor's educational supervisor is then held to discuss the issue and agree any actions. If necessary, a work schedule review can be undertaken to formally review the doctor's working pattern. To date, there have been 67 exception reports submitted. 65 relate to working patterns and 2 relate to education. No work schedule reviews have been required.

Junior Doctors Forum
The GSWH and the Director of Medical Education have established the Junior Doctor Forum which is a requirement of the 2016 contract. In order to increase attendance, the Junior Doctor Forum and Trainee Committee have been combined into a single meeting. The meeting provides the opportunity for junior doctor representatives to raise any general matters relating to working patterns or educational opportunities as well as reviewing the exception reports and identifying any trends or concerns so that appropriate actions can be taken.

Rota gaps
There are a number of gaps in rotas across the Trust mainly due to vacancies. These are proactively managed and covered in a number of different ways, including the appointment of Trust doctors, use of temporary staff (bank and locums) and the reassignment of some medical roles to nurse specialists, in order to limit the impact on patients.

Our key achievements

- ✓ Transition of junior doctors to the new contract according to the national timeline, with phased implementation now completed.
- ✓ GSWH Quarterly Board reports submitted and shared with the Junior Doctor Forum and the Local Negotiating Committee.
- ✓ Training events and ongoing ad-hoc training continue to be offered via the medical staffing team with regards to exception reporting and work schedule review processes with junior doctors.
- ✓ Support and on-line training continue to be provided to educational supervisors regarding their role regarding work schedules and exception reporting.
- ✓ Review of the Exception Reporting and Work Schedule Review Policy.
- ✓ Implementation of junior doctor rotas to ensure compliance with the 2016 contract requirements, consequently, followed by reviews where necessary to reflect service needs. This has included reviews in Obstetrics and Gynaecology, General Surgery, Oral Surgery and General Medicine.
- ✓ Development of a champion of flexible training to provide support and advice to less than full-time trainees.
- ✓ Review of the Equality Impact Assessment for the implementation of the 2016 contract.

Looking after our staff

The Healthy Hospital model championed by Public Health England is a concept that brings together anything additional to regular clinical care that improves the health of patients, staff or the local community. Longer-term it aims to support the NHS by preventing disease and increasing self-care. It helps to improve staff wellbeing, productivity and retention.

The project supports a smoke free environment, and supports people to stop smoking, particularly prior to having surgery.

Longer term, the project aims to support:

- Health coaching
- A workplace wellbeing charter
- Direct referrals to lifestyle support for patients
- Suicide prevention training for staff working in emergency areas
- Flu vaccination planning

In October 2016, the Trust launched a wellbeing support programme including a new counselling service, joining forces with national organisation CiC. The service includes access to 24/7 telephone counselling and aims to help and advise staff requiring emotional and practical support. CiC is an external, independent organisation and staff are assured the service is confidential.

The Trust runs a number of wellbeing campaigns and activities throughout the year such as quitting smoking, Dry January, pre-retirement seminars, yoga classes, running club, and monthly 'coffee and catch up' events hosted by the Chaplaincy service.

Workforce

Schwartz Rounds

Schwartz Rounds are structured, monthly one-hour meetings open to all staff and volunteers in the organisation. The purpose is to reflect on the experience of working in healthcare, rather than to solve problems or look for answers. Evidence shows that staff who attend Rounds feel more supported, valued and connected with others.

We have experienced Rounds with varying degrees of emotional content and audience sharing, and noted how people are becoming more willing to share their personal experiences.

One particular Round held in June 2017 focused on 'A new country, a new life and new challenges'. We heard from four panellists who talked about their experiences of leaving their homeland and families to come and work in the UK. They delivered their stories with honesty, emotion and good humour and talked about how they had overcome obstacles and barriers with strength of spirit and resilience, reinforcing the importance of an open, supportive working environment.

Their warmth and passion emanated to the room and it was evident from looking at the faces of the audience what a privilege it is to have such kind and caring staff working at Ipswich.

Personal experiences of the audience were recounted; these experiences were respected and 'held' by those in the room with connections made between personal stories and experiences and how every day we choose to come to work in a place where 'all this is going on' for our staff as well as patients.

Some of our Schwartz Round panellists

Workforce

Appraisal & Revalidation

Medical staff

The Trust is required to provide assurance to the Board, our regulators and commissioners that we have effective systems in place to ensure we meet with nationally agreed standards for medical appraisal and revalidation.

Licenced doctors are required to have a formal link known as a prescribed connection with a single organisation, identified as the designated body, which will provide support with their appraisal and ultimately their revalidation.

Following the launch of Medical Revalidation in 2012 the Trust has been committed in strengthening its processes and ensuring that all doctors with a prescribed connection are in the system of an annual appraisal and revalidation.

Revalidation is the process by which a doctor's licence to practise is renewed and is based on local organisational systems of medical appraisal and clinical governance. The Trust is required to provide assurance to the Board, our regulators and commissioners that we have effective systems in place to ensure we meet with nationally agreed standards for medical appraisal and revalidation.

The Annual Organisational Audit (AOA) Report is a tool used to achieve a robust consistent system of revalidation compliant with the Responsible Officer Regulations. The mandatory audit contained within the AOA report provides a process by which every Responsible Officer, on behalf of their designated bodies, provides a standardised return to the higher-level Responsible Officer. The collated audits then form the basis of a report to Ministers and ultimately the public, on the overall level of performance of revalidation across England. For the 2017/18 appraisal year (which runs from 1 April - 31 March) the Trust is required to submit its AOA return by 1 June 2018 and the annual report with a statement of compliance by 28 September 2018.

For the 2017/18 appraisal year, the Trust was the Designated Body for 307 doctors. During this period 295 appraisals were completed giving the Trust an overall compliance of 96% for medical appraisal. In addition, the RO made 23 recommendations to the GMC; 19 of which were for positive recommendations to revalidate and 4 were for deferral. The deferrals were made following long term sickness and to also allow two doctors more time to provide sufficient evidence for revalidation.

Nursing staff

Every three years nurses and midwives are required to renew their registration with the Nursing and Midwifery Council (NMC) by demonstrating they have met certain requirements showing they are keeping up to date and actively maintaining their ability to practise safely and effectively. They are also required to pay an annual fee to remain on the register.

Ipswich Hospital currently employs 1,710 NMC registrants who are required to undergo revalidation, including central bank staff. All NMC registrants, hospital and community based, are contacted and offered support and all confirmers provided with training. Registered Nurses (RNs) approaching revalidation are sent monthly reminders to their home address and via email in the 3 months preceding their revalidation date. Compliance is monitored on a central database with clear policy and escalation processes in place.

Since the inception of NMC Revalidation in April 2016, 797 RNs have undergone the revalidation process successfully. 13 RNs have been granted exceptional circumstances due to maternity and sick leave and whilst there have been no unexpected lapses, two RNs arranged for a lapse of their registration due to change in their employment.

The NMC Revalidation intranet site has been kept up to date with extra help guides and templates. This will continue to be updated as new information emerges.

Workforce

Students say hello to Britain

International nursing students from the Philippines had a taste of British culture when hospital colleagues treated them to a fish and chip supper - for some it was the first time they had ever tasted vinegar.

Education and Training team colleagues Vicki Nunn and Kay Pilkington-Blacker organised the Saturday night event to give the students a break from their OSCE (Objective Structured Clinical Examination) studies. The nurses undertake several weeks' preparation for their OSCE which the Nursing and Midwifery Council requires them to pass before they can be registered nurses here.

Student nurse Haydee Faeldo said: "Events such as the fish and chips supper give us time out to socialise and relax and to integrate ourselves with the culture in England." Usual dressings for chips in the Philippines are tomato ketchup and mayonnaise.

But it is not just the food that they have been getting to grips with. Fellow student nurse Pamela Musni said: "It is fun getting to know the area, using the bus, going to the shopping mall near the town. We also enjoy going to car boot sales and bartering." Kay said: "The students work so hard to become registered nurses, and events such as this give them time to have a break from the classroom."

Our latest cohort of international nurses,
pictured with matron Louie Horne (centre).

"When we were preparing for our OSCE exam, we've received the utmost support of the Trust especially from the Education Centre. Everything that we need was provided to us, we were not only supported in mentally preparing for the test itself, but also they were able to help us emotionally in coping with the stress that we had at that time. Starting our career in a new country where we don't have any idea on how things work is really scary, but because of the support that we received, we were able to manage and cope. We will be forever grateful."

Mark Besa
international nurse, and
new member of #teamIpswich

Workforce

Volunteers

Every one of our volunteers makes a real difference to people in hospital.

This year has been a year of re-establishing voluntary services in the Trust and beginning to lay foundations for the future.

A number of projects identified and started in 2017 will continue through to completion in 2018. This work includes an administrative catch up, updating our policy and re-introducing a volunteer handbook, an audit of our volunteers and data cleanse, expanding our database and work on the internal intranet site which will become a one stop shop for all information on volunteering for anyone working in the Trust.

During 2017 we also re-established links with the National Association of Voluntary Services Managers (NAVSM), which provides us with support and guidance on best practice in NHS volunteering. We have started to build relationships with external organisations with a view towards growth for the future through visits to Suffolk New College to present to students and working with community litter pick organisers to collaborate on a litter pick event at the Heath Road site - the initial event held in October 2017 was a great success and we look forward to another one in April 2018. Our team of volunteers continue to deliver their support to our patients and staff whilst also helping to shape the future of the service by providing invaluable feedback through our volunteer forum.

The coming year will see us continue with all the work we started in 2017, seeing it through to completion. We look forward to working with our colleagues across multiple sites to develop the volunteering offer. If you would like to join the team, please visit the volunteering pages of the website at www.ipswichhospital.nhs.uk/volunteers/, email volunteers@ipswichhospital.nhs.uk or phone 01473 704473.

Staff Volunteering

The Staff Volunteering Programme remains in place as a back up to our front line staff during the busiest time of the year. The programme is open to all staff members who can join any of our four teams of bed makers, porters, mealtime supporters or administration supporters. If you are a colleague and would like to find out more or join the programme please contact voluntary services via email to volunteers@ipswichhospital.nhs.uk

Commendation winners

Our Dermatology team has won a staff award after launching clinics for patients with skin lesions which has cut waiting times from 18 weeks to just two weeks. The dermatology screening clinics are for patients with skin lesions sent to see a hospital specialist by their GP. The new innovative, fast-paced clinics see several patients invited to the department for appointments simultaneously. Each patient's appointment is led by a senior dermatology nurse. The consultant dermatologist then visits each appointment room in turn to spend a short amount of time making a diagnosis and treatment decision. The consultant can see up to 100 patients in one morning and the team runs up to four of the clinics each month.

Sam Fuller, deputy head of Operations, said: "An expert dermatologist will make a decision on the diagnosis and treatment plan for a patient within seconds of seeing a lesion. These new clinics make the best use of the consultants' time and ensure patients are seen much quicker."

When patients see their GP with a skin lesion, the GP refers them to one of the specialist screening clinics. Traditionally, appointments with hospital doctors are 20 minutes long but the screening clinics free up the doctor's time as other members of the Dermatology team help with tasks including handing out and explaining patient information leaflets, and completing the forms and letters which are sent to the GP. The doctors can then use the additional time to see other Dermatology patients (with conditions other than lesions) sooner. The department has 1,000 referrals every month and waiting times have fallen across the department from an average of 24 weeks for a routine first appointment, to 10 weeks.

The screening clinics are based on a clinic model created in South Wales, adapted to suit our hospital. Both patient and staff feedback about the new clinics has been overwhelmingly positive. The screening clinics have replaced a tele-dermatology service previously set up for skin lesion patients.

Members of the Dermatology screening clinic team.

Workforce
Education and training of staff

The Trust is committed to providing a multifaceted learning environment for all staff and trainees to ensure it has a high quality workforce which is committed, engaged, trained and supported to deliver safe, effective, dignified and respectful care.

One of the Trust's key aims is for people in training to recommend us as a place to train.

Postgraduate medical education

All our junior doctors in training post are allocated by Health Education East of England (HEEoE) (previously known as the East of England Deanery). They set how many posts we have in each specialty and at each level (Specialty, Core and Foundation). This process is delegated to regional specialist training committees (STC) for each specialty.

There are about 180 trainees at any one time in Ipswich; this fluctuates a little, as there may be doctors here for an incomplete year or posts may be unfilled.

About one-third of these posts are Foundation training (the first two years after graduation) and around 20 posts are GP specialist training (18 months of the 3 year GP training programme is spent in hospitals). In each specialty there will be a set overall number of training posts, controlled by HEEoE and allocated across the different Trusts in the region. For example in urology we have two Specialty and one Core training posts. If there are less trainees than posts in the region (eg a doctor on maternity leave or taking year out for research), HEEoE cannot appoint more trainees and so posts are not filled. This is also the case where there are insufficient applicants, then there will be unfilled vacant posts.

HEEoE fund 50% of the basic salary for training posts plus an additional training tariff. The Trust pays the other 50% of basic salary and any additional payments. The identifiable training tariff is specifically for training such as educational supervisor Planned Activities, library and support staff in the Education Centre.

Trainees are given some choice as to where they want to go within the region. More senior trainees expect, and would be expected, to take posts in teaching hospitals as there will be opportunities not offered in other trusts (for example more specialised surgery), but this is not the case for all specialties and we do have senior specialist trainees at Ipswich, however the majority of senior trainees will go to Cambridge and Norwich. The above is one of the reasons for rota gaps.

Trainee perception
"Ipswich is perceived as a great place to train."
There is evidence that doctors who have been to Ipswich as medical students have chosen to return; junior doctors have chosen to come back as Consultants. The GMC survey is not a good assessment tool for overall satisfaction, but Ipswich scores well in comparison with local peers.

The key to good training is the learning environment. If it is a good place to work then it will be a good place to train. Ipswich is a friendly hospital. There is a culture of staff wanting to support and help trainees, and they are approachable, making trainees feel valued. Medical staff are keen to teach and enjoy training and give up time to do this. The Doctors Mess is popular and always mentioned; it is accessible and enables development of community which is an important component for wellbeing and overall satisfaction. This is a large busy hospital meaning there is lots to see and many opportunities for training. Like all Trusts there is a heavy workload, but no more than others.

The future
There will be very major changes in healthcare delivery over the next 5-10 years with a shift to more care being delivered in the community. This will require changes in how and where we deliver education and training, with flexibility and adaptation of the education we provide to fit with the new models as they evolve. Overall these are exciting times. There are many changes about to happen; we cannot predict all, and will need to adapt and prepare ourselves to move with these; ensuring that we promote the highest standards of medical education for the benefit of all our patients.

Physician Associates

Ipswich Hospital works in partnership with the University of East Anglia (UEA) to train a new role of healthcare professional know as Physician Associates. Once qualified the Physician Associates work alongside doctors providing medical care as part of a multidisciplinary team with a defined scope of practice and limits of competence. Physician Associate students will already have an undergraduate degree in a life science and undertake a two-year full-time intensive post-graduate course in medical science and clinical reasoning. They will be on placement in a clinical environment for 50% of their course and must pass a national examination at the end of the course in order to qualify and practice as a Physician Associate.

Undergraduate medical education

Ipswich Hospital NHS Trust plays host to student doctors from the two regional medical schools; University of Cambridge School of Clinical Medicine and Norwich Medical School, and annually will have in excess of 250 student doctors on placement. The two medical schools offer very different styles of learning. Cambridge

Workforce
Education and training of staff

students are on placement in the Trust from anything between four and six weeks at a time and are attached to the clinical teams, learning whilst working alongside the clinicians. Norwich students undertake one of four placements offered at Ipswich; urology, renal, neurology or obstetrics & gynaecology. These placements vary from two to four weeks in length and involve both classroom based and experiential learning.

Ipswich Hospital is highly regarded by the students that come on placement and is thought to be the best district general hospital in the region for student doctor teaching and learning. This is due in part to the commitment of the staff involved in the teaching but also the warm and friendly environment provided by the staff in general in all departments. One of the many rewards of having such a good reputation is that many of the students who have been on placement return as junior doctors and later in their careers, as consultants.

Pre-registration nursing

Number of students, 2017/18:

Return to Practice	6
Child Health	31
General Nursing	282
Midwifery	24

This year has seen the development from work-based learning programmes to degree-level apprenticeship, with the first group starting in February 2018. They will qualify as Registered Nurses in February 2020. These are all nurses who have already completed their foundation degree, and so are entering their apprenticeship at the mid-way point, qualifying in 2020.

Preceptorship

A preceptorship programme continues to run for all newly-qualified healthcare professionals including nurses, midwives, physiotherapists and occupational therapists with the aim of supporting them through their first year as qualified practitioners. It continues to receive positive feedback from all those attending.

Allied Health Professionals

Our AHPs have continued to professionally develop their skills this year. This has enabled them to take on advanced roles such as non-medical prescribing, working as advanced clinical practitioners in the Emergency Department and running therapist-led clinics such as respiratory physiotherapy clinics. We successfully recruited one Return to Practice Operating Department Practitioner.

We now provide acute practice placements for paramedic students studying BSc Paramedic Science.

National RCN education forum international conference and exhibition, 2017

A team of colleagues from Health Education England, University of Suffolk, West Suffolk Hospital and Ipswich Hospital presented at the above conference and were joined by two students who shared their experience of PEBLs. PEBLs is a coaching methodology for educating student nurses in practice, empowering them to think critically about the care they provide, differing from other models of education which use an apprentice methodology.

Practice-based education

A coaching methodology for educating student nurses has now been rolled out to other clinical professional groups such as occupational therapy, physiotherapy and diagnostic radiography. This is now enabling students to be prepared and fit for practice as a newly-qualified registrant when they complete their course.

Health Care Assistant training

Number of HCAs 2017/18:

Number of HCAs	109 (65 completed)

All Health Care Assistants and Maternity Care Assistants now undertake the Care Certificate, which is seen as an indicator of quality by the Care Quality Commission. The Trust has a new group of trainee health care assistants commence in the Trust every month and is supported by a team of health care assistant trainers who are experienced health care assistants themselves.

Support staff

Our Trust has signed up to a national pledge which helps widen access to working in the NHS and then provides support to develop through apprenticeships and employment opportunities. Ipswich Hospital NHS Trust is included on the national list of organisations who have signed the pledge which was signed by Chief Executive Nick Hulme and Estates colleague Trevor Hodgkins, chairman of the of the hospital's Joint Union Committee.

Left to Right: Helen Vickery, Clinical Educator, West Suffolk Hospital, Sue Pettitt, Clinical Education and Workforce Development Lead, Ipswich Hospital, Sandra Gover, Clinical Learning Environment Manager, Health Education England, Anna Campbell, Lecturer, University of Suffolk, Stephen Warren, Student Nurse, University of Suffolk, Christopher King, Student Nurse, University of Suffolk, Sarah Hunter, Clinical Educator, Ipswich Hospital, Vicki Nunn, Clinical Educator, Ipswich Hospital

Workforce
Education and training of staff

We continue to progress with the Talent for Care programme, which looks at widening access to working in the NHS, undertaking apprenticeships and education whilst working (earn as you learn), and going further into professional qualification (growing your own workforce), is now embedded within the Trust with a group of staff coming together on a bi-monthly basis to develop opportunities for support staff regarding skills acquisition and progression through the organisation. Progress is monitored through the Clinical Education Group and Workforce Development and Education Committee.

Apprenticeships

Number of apprentices, 2017/18:

Number of apprentices	104

We have a national target to appoint 98 apprentices to the Trust by 31 March 2018. At 31 January 2018, we had 41 apprentices working in the Trust.

We have apprenticeships covering a range of roles such as medical administration, pharmacy, business administration, estates & facilities, IT, degree nurse apprentice, leadership, team leading, assistant practitioner, hospitality, cleaning and support services and medical engineering.

International Nurses

26 international nurses have joined the Trust, 24 from the Philippines and two who were previously working as HCAs elsewhere in England (1 Filipino, 1 Indian). 19 have undertaken their OSCE (Objective Structured Clinical Examination), for which we have achieved a 95% pass rate. Before taking their OSCE, the education team provide a 6 week preparation programme. We continue to have nurses from the Philippines arriving on a monthly basis. We are also supporting 12 nurses who currently work within Ipswich Hospital and Suffolk Community Health as HCAs but are RNs in their country of origin to go through the process to register in the UK.

Work experience

This year we have welcomed a wide variety of people seeking work experience prior to undertaking a clinical training programme such as nursing, midwifery, pharmacy, radiography, physiotherapy and medicine. We have also supported international students on the ERASMUS programme, all of whom have evaluated their experience at Ipswich Hospital as a positive learning experience. We are expanding the opportunities for work experience for those in schools and colleges and continue to run workshops such as "So you want to be a doctor?" to encourage students to take opportunities to work within the NHS.

Health Education England Risk & Quality Governance Framework (RQGF)

The RQGF aims to measure, identify and improve quality in education and training environments for all learners in health and care. It demonstrates a multiprofessional approach to managing education provision which is consistent and proportionate. There are six quality domains and 27 associated standards. Each organisation is required to submit a multi-professional self assessment measured against these standards. This was achieved within the required timeframe, and feedback is awaited.

The self assessment includes identification of risks, and how they have been mitigated, but also what successes have been achieved over the year which we wish to share with others.

Quotes from students on placement:

(source: Health Education England, December 2017)

"Claydon ward was a great opportunity as a student to deliver cardiac care. All staff were very friendly and made me feel welcome and part of the team, and my two mentors went above and beyond their role to provide support for me and the patients they looked after."

"I have found the staff in my current placement extremely supportive and helpful. It is a great learning experience."

"The staff were welcoming and provided numerous opportunities for learning."

"Comparing the OSCE preparation in Ipswich Hospital to the training of our friends in other NHS Trusts, Ipswich offers the best training in terms of time for practice, materials used, educators, and assistance from previous cohorts who passed the exam. Thank you for your unfailing support!"

"It has been a brilliant placement, there is a great deal of encouragement and support given to students by the staff. Feedback is timely and appropriate, all persons involved understand the student process."

Celebrating the #teamIpswich awards 2018

Team of the Year

Winner:
Trauma & Orthopaedic
Enhanced Recovery team

Highly Commended:
Outpatient Parenteral Therapy team

Leader of the Year

Winner:
Rebecca Walker
Service lead, Reactive Emergency Assessment Community Team, (REACT)

Highly Commended:
Suja Varughese
Sister, Debenham ward

Living the Values Colleague of the Year

Winner:
Stewart Taylor
Frailty Assessment Base administrator

Highly Commended:
Pam Talman
Patient Experience coordinator

Celebrating the #teamIpswich awards 2018

Supporter of the Year

Joint Winners:
Baby Bereavement Group
Somersham Ward Support Group

Trainee of the Year

Winner:
Lara Burgess
Trainee therapeutic radiographer

Winifred's Prize for Outstanding Contribution

Winner:
Theresa Heath
Senior Hospital Coordinator

Highly Commended:
Inge Nijkamp
Fundraiser

Highly Commended:
Nick Schindler
Paediatric registrar

Statements from key stakeholders

Ipswich and East Suffolk Clinical Commissioning Group, as the commissioning organisation for Ipswich Hospital NHS Trust, confirm that the Trust has consulted and invited comment regarding the Quality Account for 2017/2018. This has occurred within the agreed timeframe and the CCG is satisfied that the Quality Account incorporates all the mandated elements required.

NHS Ipswich and East Suffolk Clinical Commissioning Group

The CCG has reviewed the Quality Account data to assess reliability and validity and to the best of our knowledge consider that the data is accurate. The information contained within the Quality Account is reflective of both the challenges and achievements within the Trust over the previous 12 month period. The priorities identified within the account for the year ahead reflect and support local priorities.

Ipswich and East Suffolk Clinical Commissioning Group is currently working with clinicians and managers from the Trust and with local service users to continue to improve services to ensure quality, safety, clinical effectiveness and good patient/care experience is delivered across the organisation.

This Quality Account demonstrates the commitment of the Trust to improve services. The Clinical Commissioning Group endorses the publication of this account.

Lisa Nobes
Chief Nursing Officer

Healthwatch Suffolk thanks the Ipswich NHS Trust for the opportunity to comment on its Quality Account for the year 2017/18. The Quality Account is well set out and should be readable by its intended audience. The Account is honest about adverse events, serious events and never events which have occurred during the year.

healthwatch Suffolk

The Quality Account (QA) reviews the priorities for the year 2017/18. There were five priorities: Patient Safety, Clinical effectiveness as well as three patient experience priorities. The quality account sets out the Trust's success in achieving its priorities and, where they have not quite achieved the priority, the QA is open and honest about giving the reasons for not fully achieving the priority. However, they are to be congratulated for the number of significant achievements described in this QA. The Trust describes its achievements in dealing with patient slips, trips and falls. The increase in the numbers of patients who are elderly, many of whom are also suffering from confusion or delirium, has made this area of care increasingly important. For the coming year 2018/2019 the Trust has set out the same basic priorities i.e. Patient Safety and Patient Experience. The Trust's priorities are clearly set out describing how they intend to achieve the goals they have set themselves.

Several members of Staff have received Commendations. The Ipswich Commendations are awarded to staff who are living up to and exceeding the Trust's Values. Healthwatch Suffolk congratulates all the recipients of these Commendations.

Patient and Carer Views of the Trust.
Healthwatch Suffolk has received 223 comments from patients or carers in the past year. The Trust received an overall rating of four stars out of five. We note that in the case of the following categories, cleanliness, staff attitude and quality of care, the Trust received ratings of 4.5. Some 52 percent of the comments are positive, with 19 percent negative, the remainder being assessed as neutral.

Healthwatch Suffolk looks forward to working with the Trust in future years. As the changes in Health and Social Care begin to mature, we believe the Trust will be a driver of the improvements that these changes will bring about.

Statements from key stakeholders

Suffolk Health Scrutiny Committee

As has been the case in previous years, the Suffolk Health Scrutiny Committee does not intend to comment individually on NHS Quality Accounts for 2018. This should in no way be taken as a negative response. The Committee has, in the main, been content with the engagement of local healthcare providers in its work over the past year. The Committee has taken the view that it would be appropriate for Healthwatch Suffolk to consider the content of the Quality Accounts for this year, and comment accordingly.

County Councillor Michael Ladd
Chairman of the Suffolk Health Scrutiny Committee

Response to stakeholder comments

The Ipswich Hospital NHS Trust thanks its stakeholders for their comments on the 2017/18 Quality Account.

The Trust is proud of its staff and all they have achieved in order to deliver high quality, compassionate care for our patients and their families, but accepts there is always more we can do to make consistent, sustainable improvement.

This Quality Account aims not only to provide the regulated requirements, but to share our achievements and we have strived to give a transparent and honest account of our services.

Since the stakeholder comments have been received, typographical errors have been corrected, and where data was unavailable at the time of issuing the draft Quality Account to stakeholders, this has now been added.

Statement of assurance from the Board of Directors

Statement of directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (in line with requirements set out in Quality Accounts legislation).

In preparing the Quality Account, directors should take steps to assure themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the reporting period;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measurement of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review.

The Quality Account has been prepared in accordance with any Department of Health guidance.

The directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

By order of the Board

David White, Chair
Date: 29 June 2018

Nick Hulme, Chief Executive
Date: 29 June 2018

Glossary

ACS Adult Community Services.
Bed days The measurement of a day that a patient occupies a hospital bed as part of their treatment.
Care Quality Commission (CQC) The regulatory body for health and social care organisations in England. It regulates care provided by the NHS, private companies, local authorities and voluntary organisations, aiming to make sure better care is provided for everyone in hospitals, care homes and people's own homes.
CHUFT Colchester Hospital University NHS Foundation Trust.
Clinical Coding The translation of medical terminology as written in a patient's medical records to describe a problem, diagnosis, treatment of a medical problem, into a coded format.
Clinical Commissioning Group (CCG) Responsible for commissioning (planning, designing and paying for) NHS services.
Clinical Delivery Group (CDG) CDGs are sub-groups of the Trust's three clinical divisions. Each CDG is accountable to its Divisional Governance Board for all aspects of performance, including patient safety, patient and carer experience, operational standards, financial performance and staff engagement.
Clostridium difficile* or *C.diff A spore-forming bacterium present as one of the normal bacteria in the gut. *Clostridium difficile* diarrhoea occurs when the normal gut flora is altered, allowing *Clostridium difficile* bacteria to flourish and produce a toxin that causes watery diarrhoea.
Colonisation The presence of bacteria on a body surface (such as the skin, mouth, intestines or airway) without causing disease in the person.
CQUIN The CQUIN (Commissioning for Quality and Innovation) framework enables commissioners to reward excellence by linking a proportion of the Trust's income to the achievement of local quality improvement goals.
Datix A Trust-wide computer system used to record and aid analysis of all incidents, claims, complaints and PALS enquiries.
Deconditioning A complex process of physiological change following a period of inactivity, bedrest or sedentary lifestyle. It is often associated with hospitalisation in the elderly and has been linked to falls, functional decline, increased frailty, immobility and ability to accomplish activities of daily living.
Delayed Transfer of Care (DToC) Occurs when a patient who is ready to leave hospital is still occupying a bed. A patient is ready for transfer when a clinical decision has been made that they are ready for transfer and it is safe to do so.
Dementia A set of symptoms which include loss of memory, mood changes, and problems with communication and reasoning.
Division The Trust is divided into three distinct clinical divisions: Medicine, Therapies & Community Services; Surgery & Gastroenterology; and Cancer, Pathology, Women & Children. An additional division manages corporate functions (Governance, Operations, Human Resources, Education, Finance & Performance, and Information). Each Divisional Board is managed by a consultant (Clinical Director), nurse and operational lead. The Associate Director of Nursing/Midwifery provides senior nursing and quality of care expertise, with the Head of Operations providing expert operational advice to the Divisional Boards.
DNACPR Do not attempt cardio-pulmonary resuscitation. A formal decision made when it is not in the best interests of the patient to be resuscitated in certain circumstances.
Dr Foster Provider of comparative information on health and social care issues.
ED Emergency Department, also known as A&E, Accident & Emergency or Casualty.
Evolve Electronic medical records system.
GMC General Medical Council.
Gillick competence a term used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.
Harm-free care National patient safety initiative targeted at high impact areas such as pressure ulcers, catheter care, venous thromboembolism (VTE) and falls.
HealthWatch Champions the views of local people to achieve excellent health and social care services in Suffolk.
HSMR Hospital Standardised Mortality Ratio. An indicator of healthcare quality that measures whether a hospital's death rate is higher or lower than expected.
Ipswich and East Suffolk Clinical Commissioning Group The main commissioner of services provided by The Ipswich Hospital NHS Trust.
MDT Multidisciplinary team.
Meticillin Resistant Staphylococcus Aureus (MRSA) An antibiotic-resistant form of the common bacterium Staphylococcus Aureus, which grows harmlessly on the skin in the nose of around one in three people in the UK. MRSA bacteraemia is the presence of Meticillin Resistant Staphylococcus Aureus in the blood.
Morbidity and Mortality (M&M) meetings M&M meetings are held in each CDG. The goal of such meetings is to derive knowledge and insight from surgical error adverse incidents. M&M meetings look at: What happened? Why did it occur? How could the issue have been prevented or better managed? What are the key learning points?
NCEPOD National Confidential Enquiry into Patient Outcome and Death.
Nervecentre A wireless patient observation, escalation and task management system.
Never Events Serious, largely preventable patient safety incidents which should not occur if the available preventative measures have been implemented.
PALS Patient Advice and Liaison Service. For all enquiries to the hospital such as cost of parking, ward visiting times, how to change an appointment etc.
PLACE Patient-Led Assessment of the Care Environment. Annual self-assessment of a range of non-clinical services by local volunteers.
Q1 or Quarter 1 April - June 2017
Q2 or Quarter 2 July - September 2017
Q3 or Quarter 3 October - December 2017
Q4 or Quarter 4 January - March 2018
Quality Committee The Trust Board sub-committee responsible for overseeing quality within the Trust.
RCA Root Cause Analysis. A structured investigation of an incident to ensure effective learning to prevent a similar event from happening.
SHMI Summary Hospital-Level Mortality Indicator. An indicator for mortality. The indicator covers all deaths of patients admitted to hospital and those that die up to 30 days after discharge from hospital.
SIRI Serious Incident Requiring Investigation.
SLA Service Level Agreement. A contract to provide or purchase named services.
STEMI/nonSTEMI ST-Elevation Myocardial Infarction (STEMI) is a very serious type of heart attack during which one of the heart's major arteries (one of the arteries that supplies oxygen and nutrient-rich blood to the heart muscle) is blocked.
Suffolk Family Carers A registered charity working with unpaid family carers across Suffolk, supporting family carers with information, advice and guidance.
SUS Secondary Uses Service. Provides anonymous patient-based information for purposes other than direct clinical care such as healthcare planning, public health, commissioning, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.
Sustainability and Transformation Plan (STP) Each STP in England, led by a named individual, covers a population averaging 1.2 million people. The five year plans cover all aspects of NHS spending, aiming to improve quality and develop new models of care; improve health and wellbeing; and improve efficiency, with a focus on integration with social care and other local authority services.
The King's Fund A charity that seeks to understand how the health system in England can be improved and helps to shape policy, transform services and bring about behaviour change.
UoS University of Suffolk.
WTE/wte Whole-time equivalent staff.

Appendix A

Independent Chartered Accountant's Limited Assurance Report to the Directors of The Ipswich Hospital NHS Trust on the Annual Quality Account

We have been engaged by The Ipswich Hospital NHS Trust to perform an independent assurance engagement in respect of The Ipswich Hospital's NHS Trust's Quality Account for the year ended 31 March 2018 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011, the National Health Service (Quality Account) Amendment Regulations 2012 and the National Health Service (Quality Account) Amendment Regulations 2017 ("the Regulations").

Scope and subject matter
The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following indicators:

- Percentage of patients risk-assessed for venous thromboembolism (VTE);
- Rate of clostridium difficile infections;

We refer to these two indicators collectively as "the indicators".

Directors' responsibilities
The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibilities
Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by the Department of Health in March 2015 ("the Guidance") as supplemented by the Quality Accounts: Reporting Arrangements 2017/18 letter dated 26 January 2018; and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

Appendix A

Independent Chartered Accountant's Limited Assurance Report to the Directors of The Ipswich Hospital NHS Trust on the Annual Quality Account

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2017 to May 2018;
- papers relating to quality reported to the Board over the period April 2017 to May 2018;
- feedback from the Commissioners dated May 2018;
- feedback from Local Healthwatch dated May 2018;
- Latest national and local patient surveys dated October 2017, November 2017, January 2018 and June 2018;
- the latest national staff survey for 2017;
- the Head of Internal Audit's annual opinion over the trust's control environment for 2017/18;
- the annual governance statement for 2017/18;
- the Care Quality Commission's quality and risk profiles dated January 2018.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of The Ipswich Hospital NHS Trust as a body in accordance with the terms of our engagement letter dated 19 May 2017. Our work has been undertaken so that we might state to the Directors those matters we have agreed with them in our engagement letter and for no other purpose.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and The Ipswich Hospital NHS Trust for our work or this report or for the conclusions we have formed save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed
We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

Appendix A

Independent Chartered Accountant's Limited Assurance Report to the Directors of The Ipswich Hospital NHS Trust on the Annual Quality Account

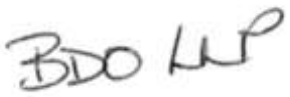
The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by The Ipswich Hospital NHS Trust.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.



BDO LLP
Chartered Accountants
Ipswich, UK
Date 29 June 2018

Definitions for performance indicators subject to external assurance

Percentage of patients risk-assessed for venous thromboembolism (VTE)

Detailed descriptor
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period.

Data definition
Numerator: Number of adults admitted to hospital as inpatients in the reporting period who have been risk assessed for VTE according to the criteria in the national VTE risk assessment tool during the reporting period.
Denominator: Total number of adults admitted to hospital in the reporting period.

Details of the indicator
The scope of the indicator includes all adults (those aged 18 or over at the time of admission) who are admitted to hospital as inpatients including:

- surgical inpatients;
- inpatients with acute medical illness (for example, myocardial infarction, stroke, spinal cord injury, severe infection or exacerbation of chronic obstructive pulmonary disease); trauma inpatients;
- patients admitted to intensive care units;
- cancer inpatients;
- people undergoing long-term rehabilitation in hospital;
- patients admitted to a hospital bed for day-case medical or surgical procedures; and
- private patients attending an NHS hospital.

The following patients are excluded from the indicator:

- people under the age of 18 at the time of admission;
- people attending hospital as outpatients;
- people attending emergency departments who are not admitted to hospital; and
- people who are admitted to hospital because they have a diagnosis or signs and symptoms of deep vein thrombosis (DVT) or pulmonary embolism.

Timeframe
Data produced monthly for the 2017-18 financial year.

Detailed guidance
More detail about this indicator can be found on the NHS England website. The data collection standard specification can be found here.
Source: NHS England

Data relating to the percentage of patients risk-assessed for venous thrombo-embolism (VTE) can be found on page 32.

Rate of *Clostridium difficile* infections

Detailed descriptor
Rate of *Clostridium difficile* infections ("CDIs") per 100,000 bed days for patients aged two or over on the date the specimen was taken during the reporting period.

Data definition
Numerator: The number of CDIs identified within a trust during the reporting period.
Denominator: The number of bed days (divided by 100,000) reported by a trust during the reporting period.

Details of the indicator
The scope of the indicator includes all cases where the patient shows clinical symptoms of *clostridium difficile* infection, and has a positive laboratory test result for CDI recognised as a case according to the trust's diagnostic algorithm. A CDI episode lasts for 28 days, with day one being the date the first positive specimen was collected. A second positive result for the same patient, if collected more than 28 days after the first positive specimen, should be reported as a separate case, irrespective of the number of specimens taken in the intervening period, or where they were taken. Specimens taken from deceased patients are to be included.

The following cases are excluded from the indicator:

- people under the age of two at the date the sample of taken; and
- where the sample was taken before the fourth day of an admission to the trust (where the day of admission is day one).

Timeframe
Thirteen month data on the number of CDI cases per trust is produced on a monthly basis. Annual reporting on the number and rates of CDI cases per trust for the financial year.

Detailed guidance
More detail about CDIs can be found on the Public Health England website.
The latest published 13 month data for CDI cases for each trust and the latest published annual data for the number and rate of CDI cases can be found here.
Source: Public Health England

Data relating to the rate of C.*difficile* infections can be found on page 32.

How to provide feedback on this Quality Account

If you would like to provide feedback on this quality account or would like to make suggestions for content for future accounts, please email press.office@ipswichhospital.nhs.uk or write to:

Governance Directorate
(Quality Account) [S618],
The Ipswich Hospital NHS Trust,
Heath Road,
Ipswich IP4 5PD

Thank you

We would like to take this opportunity to thank all those involved with The Ipswich Hospital NHS Trust: our fantastic staff and volunteers, all of our patients and visitors, our valuable fundraisers, local media organisations, our local Members of Parliament and health colleagues across the East of England.

Thank you for all that you do to make this an organisation we can all be proud to be part of.

Find out more about the hospital by visiting
our website at www.ipswichhospital.nhs.uk

The Ipswich Hospital NHS Trust
Heath Road, Ipswich, Suffolk IP4 5PD
Tel: 01473 712233

This report is available online in this format at
www.ipswichhospital.nhs.uk/qualityaccount