From: Davidson, Laura <[redacted]>
Sent: 28 November 2018 16:47
To: [redacted]
Cc: Wickington, Tracey; Allinson, Fiona
Subject: RE: ENQ1-5267606746 (Jessica Rae Rudland) - Ipswich Hospital

Dear Mr Rudland,

Thank you for meeting with Tracey and Fiona yesterday, 27/11/2018. I hope you found it useful. I wanted to respond to your previous email to summarise what was discussed and confirm the actions we will be taking with the trust. As I understand it, there were three main aspects of concern for you which were:

- concerns that the response received from Crawford Jamieson does not adequately reflect and answer the recommendations made in the final SIRI.

- concerns regarding wider learning, both within this trust and externally, to help prevent harm to other patients presenting at ED with [redacted]

- concerns relating to Regulation 20 Duty of Candour, which did not take place in Jessica's case and the trust fully accepts this.

At our last inspection of the emergency department in August and September 2017, we assessed, as part of our comprehensive review, **a number of aspects of care which overlap with your concerns:**

We assessed staff awareness of the duty of candour and found not all staff were aware of the principles related to the **duty of candour**.

We also assessed the **availability, maintenance and staff awareness of resuscitation equipment** and found **insufficient processes** to monitor equipment servicing to ensure items were safe for use, and there were gaps in checking of resuscitation equipment.

We issued a **requirement notice** in relation to these concerns; namely that the trust must ensure that there are effective processes in place for equipment maintenance and servicing; and must ensure there are processes in place to manage effective equipment checks, for example, all resuscitation equipment is checked daily. We reviewed the process of learning from incidents and found there were processes in place to ensure this and staff awareness of learning and actions following incidents were generally good.

We assessed mandatory training compliance and found that mandatory training, including basic life support training, **was not meeting the trust target compliance rate**.

We issued a **requirement notice** in response to these concerns, namely that the trust must ensure that staff are up to date with mandatory training in accordance to their roles, specifically basic, intermediate and advanced life support.

We will be following these specific concerns up again at our next comprehensive inspection of the trust to assess whether there has been any improvement. However, we fully understand your wish to be assured that positive changes in practice have taken place to reduce the risk of similar incidents happening again and your concerns, discussed yesterday with Tracey and Fiona, that the action plan provided in response to the Dr Chrispin independent review, **lacks specific measurable actions and outcomes.**

Therefore, we will continue to follow up concerns sooner and on an ongoing basis, through engagement with the trust and planned focus groups with staff. As part of this, we will be doing the following:

- Reviewing the action plan with the trust at our next engagement meeting next week and specifically raising the concerns about **the lack of measurable actions or specific actions in relation to patients presenting** with [redacted]. In particular, we will be asking them about:

1. How are they **assured** that the appropriately trained and senior staff are available in ED and via the resuscitation team?

2. Evidence that **compliance** for life support training is improving?

3. Audits to assess **compliance** with NEWS, PEWS and MEWS to ensure the escalation of patients at risk are happening in a timely manner?

4. Whether they are aware of and implementing the new **FICM guidance** on Care of the critically ill woman in childbirth; enhanced maternal care?

5. Their guidance as to **senior consultant review** and the process for accessing a senior consultant in the event of deterioration and escalation, and whether this has been made clearer and staff are aware of it?

6. Whether they are undertaking records audits to ensure anaesthesia charts are documented or a clear entry is made in the patient record **when anaesthetic occurs outside of a theatre environment?**

7. The results of the RCoA **audit?**

8. Actions in relation to the **consent process and how are they assured consent** for specific procedures is consistently and appropriately obtained?

9. Their **oversight and assurances** of notes being scanned accurately and completely

10. Holding a focus group with staff in ED to assess their awareness of the specific concerns identified, **the action plan and any learning or changes in practice**. Focus groups are now part of our regular engagement work with NHS trusts under our new regulation methodology.

We have been in touch with the CQC relationship owners for the other trusts you have mentioned where patients who have presented at ED with [redacted] have sadly suffered and/or died.

They will be able to speak with their respective trusts about actions and learning. We will be raising this with our **CQC maternity working group** and also asking the trust about how they are communicating actions and learning more widely outside the trust.

We are already aware the trust is doing some deep dive work into the emergency department at Ipswich to identify root concerns more broadly in their care and service delivery, and what can be done to improve the service.

Once again we really appreciate your keeping us informed of your ongoing concerns and we sincerely hope you found the meeting yesterday valuable. Please do not hesitate to contact me with any further concerns or specific points you feel CQC should be raising with the trust.

Kind regards,
Laura